Achievement Chart

Name of Practice: Leacroft Medical Practice (PACE SETTER Lead:Dr Patience Okorie), Crawley CCG

Please complete all in pink ink so your entries are clearly visible.

Children and Young Peoples Service PACE SETTER Award UK

Achievement Chart for Primary and Community Care

PACE Element 1: PATIENT and CARER EXPERIENCE

Key Activity (KA)	What are we going to do?	What have we done?	–Celebrating Success – PACE SETTER Achievements, Lessons learned, Plans for the Future
KA 1a - Patient & Staff Engagement Exercise	The Panel (26.10.15) feels "that overall the insight that the practice has into it's population and the team's ongoing discussions about how to help their patients (from many different nationalities) to access care appropriately and to promote Self Care within these communities is fantastic and worth highlighting."	Patient Consultation: Survey Questionnaire was drafted and issued to 25 patients (~1% of eligible population). This was a survey of their perception of health care services offered to CYP at our practice. All surveys were returned and analysed. Whole Team Consultation: The project was introduced at one of the practice meetings.	The PACE SETTER Panel following the first Write Up form noted on 26.10.15 - "It is good to note that the **PACE SETTER Award** engagement covered not only patients but also Staff and that the multidisciplinary team members are being deployed (including administrative, GP and nursing team members) to help to achieve the Key Activities which is excellent. The high response rate of Patient survey questionnaires is very good and it was notable that it included questions about distributing Advice leaflets." It was also interesting to note that many of our parents felt Patient Information leaflets will be useful following consultations.

		Activities involved were outlined and it was made clear that all staff including administrative and healthcare had a role to play. Two members of the practice (nurses) were designated with duties to achieve our key activities.	
PACE Element 2: ACCESSING SERVICES			
Key Activity 2: AUDIT THE NUMBER OF CYP WITH COMPLEX MEDICAL PROBLEMS / REVIEW THEIR CARE – MAKE PASSPORTS FOR THEM TO ENSURE SEEN PROMPTLY	Aim of the activity: To ensure all CYP with complex medical problems have easier access to GP care and that all GPs are aware of them. What will you do? Find the no. of these patients; make passports for them and ensure they are promptly seen and know what to do.	***How will you know you have succeeded?*** Patient feedback to see if this has helped. [The plan eventually is to meet/engage with all the parents/families in 6 months / 1 year to seek their feedback and other areas for improvement.]	This audit has enabled us group children and young people with complex medical problems into one easily identifiable group. [The exercise to identify the relevant patients was undertaken by the GP in collaboration with the colleagues from the CCG Proactive Care team using the Risk Profiling Artemus – Intelligent Commissioning System (ISC). They looked at frequent attenders and found that using the word "seizures" as a key word was helpful and identified 21 patients (with at least 2 cases from the same family). The lead GP reviewed the notes of each of these cases including listing such information from the Acute Trust that eg this patient should not have frequent X-rays to be included in the alerts. The practice have put an alert on the first page of each of these case's medical records which has ensured that it is highlighted that these patients are particularly vulnerable and so that these patients are given priority when requesting appointments. Indeed even if these parents do not specify that their child has special needs the whole team are now easily able to speedily identify that these cases have complex needs and could potentially offer them the opportunity to speak to a GP even if there are

			no appointments available at that time. Therefore, this initiative has enabled all health care and administrative staff in the practice to become aware of these young people to ensure appropriate help and care is given to them. It has also helped clinicians to be mindful of information that may help in taking decisions when caring for these patients. This has made decision making about care of these patients easier. The lead GP also commented that her peers have asked why their own practices do not have PACE Setter as this Medical Passport idea for Complex Needs is so helpful for patients and their families.
PACE Element 3: CLINICAL PATHWAY IMPLEMENTATION			
KA 3a – Safeguarding **The practice is able to confirm that they are CQC compliant for CYP**	Safeguarding Procedures and Processes - they have a designated Safeguarding GP responsible for CYP in the practice and this lead regularly attends Safeguarding meetings / case conferences involving any of their patients which is good practice. This practice's awareness around Safeguarding is to be commended.		The practice has a safeguarding lead clinician (Dr Charlotte Ruglys) who continues to work and liaise with social services other clinicians to constantly identify patients who are vulnerable or families in difficulties. She also attends regular case conferences when needed and/or feeds in with a report. Every DNA for immunisations is followed up by the team. We also hold monthly MDT meetings where vulnerable patients are discussed with the health visitors and other members of the Practice team

Key Activity 3b: EVALUATION OF SERVICES PROVIDED TO PATIENTS WITH CHRONIC ILLNESS DIAGNOSED WITH ASTHMA	<u>Aim of this activity:</u> To ensure our CYP with Asthma understand the disease and are getting the appropriate help and have the confidence to know when they should seek help. We planned to: - Audit of our CYP with Asthma - A&E attendance review - Medication review - Use of Personal Asthma Action Plans (PAAPs)	***How will you know you have succeeded?*** When there is a reduction in the no. of patients presenting in crisis at A&E with Asthma.	At the outset, the practice had an Asthma Register but as CYP were not part of the QOF system these were not reviewed regularly. We decided to evaluate the care provided to Children and young people with chronic illnesses and Childhood Asthma was chosen as our focus as this is the commonest chronic condition in CYP at Leacroft Medical Practice. We have ensured up to date review of all our patients with asthma particularly those who had attended A&E in a crisis and this actually made us realise by probing their knowledge that some of our patients and their carers did not understand that Asthma could be a chronic illness. We also realised that more than 3 out of 10 patients /carers did not understand what the inhalers were for and how to use them effectively. Compliance was found to be an issue - When asking about the brown inhalers some of the CYP were surprised to hear that they had not been asked to use them daily by their patients and commented that they only relied on the blue inhalers…. We, at the practice, have found the Personal Asthma Action Plan leaflets very useful to direct the discussions as we personalised it for our patients to take home with them. (CYP like to have their name written on the document as this makes them feel important and gives them ownership). Therefore the PAAPs have enabled the patient to be directly involved in the management of their Asthma. (One child ran around the house with his PAAP showing his mother to remind her to give him right medication.)

PACE Element 4: EDUCATION – WHOLE-TEAM AND CLINICIANS			
Key Activity 4: HEALTH EDUCATION OUTREACH EVENT TO LOCAL PRIMARY SCHOOLS – DISCUSSING AND PROMOTING CONFIDENCE IN MINOR ILLNESS MANAGEMENT EG COUGH & COLD, D&V	Aim of this activity: To ensure that CYP are aware of common illnesses and how and when to seek help. What will you do? Outreach visit to the local schools by the nursing team to talk about cough, D&V and coping with them.	***How will you know you have succeeded?*** When patients and carers begin to seek help appropriately; Reduction in no. of A&E attendances for these illnesses.	We went out to the local Primary school to talk about common illnesses like cough and cold, diarrhoea and vomiting and also heath education on simple hygiene to prevent spread of theses diseases. They presented at an Assembly in front of the whole school (see film clip attached). This was very rewarding, we had a demonstration session on effective handwashing with the use of a lightbox. This was very exciting for the pupils. The teachers commented that sometimes a child will be sick at 11 am at school (having vomited a few times during the night before school) – now pupils will also be more aware that they can be contagious and so impart this information to their parents following this type of health education.
Any other comments/information to share? SHARING BEST PRACTICE – PACE SETTER TOP TIPS….			
This has been a very useful exercise as it has enabled us to review the services we provide and to offer more holistic care to our Children and Young People. It has helped us to ensure our time is spent more effectively by Promoting health, Preventing illnesses and Recognising sick children promptly and intervening promptly and appropriately.			