



Regis Primary Care Network

Improving services for dementia patients and those receiving end-of-life care

AT A GLANCE

CLEAR CHALLENGE

High number of GP appointments for dementia and end of life patients with poor quality data resulting in reduced referrals to the most appropriate services

KEY CHANGES

Three physician associates employed as clinical data analysts to prepare personalised care plans for dementia patients and improve coding to identify patients in greatest need of proactive care

FORECAST BENEFITS

Earlier diagnosis and treatment for patients and productivity gains of £144,690 after four years from a 5% reduction in GP appointments

THE CHALLENGE

Patients with dementia and those receiving end-of-life care in Regis Primary Care Network (PCN) had a high number of GP appointments but the quality of their health data was poor, making it difficult to identify their needs and resulting in reduced referrals to more appropriate services. Diagnosis of dementia was made later in more deprived areas.

Care plan coding for dementia patients and the coding of discussions on resuscitation for end-of-life patients needed improving.

WHAT THEY DID

The CLEAR team conducted 17 interviews with a range of healthcare professionals working across the PCN's nine GP practices and other relevant services.

Data representing more than one million appointments involving dementia and end-of-life patients between January 2018 and December 2021 was collected from the practices' clinical information system. This was analysed and combined with insights from frontline staff to recommend quick wins and new ways of working to improve services.

CLEAR RECOMMENDATIONS

The team recommended that three physician associates (PAs) should be employed as clinical data analysts, working three days a week running advanced care planning clinics preparing individual care plans for dementia patients. The PAs would be able to produce 250 personalised care and support plans from two clinics – one based in a rural practice and another in an urban practice.

For the remaining two days a week, they would help practices improve the coding of dementia and end-of-life patients and collate regional data for the two patients groups to be presented at PCN meetings. Some of the data could be made available to community partners, voluntary and patient groups.

As a quick win, the team recommended the development of a new organisational chart outlining the services available to dementia and end-of-life patients which would be maintained and disseminated to increase referrals and reduce duplication.

FORECAST IMPACT

Improved coding and data analysis would have a significant impact identifying patients in greatest need of proactive care, leading to earlier diagnosis and treatment. Increasing the number of individual care plans and using data-based evidence to signpost patients to other more appropriate services would reduce the need for primary care appointments.

Based on a conservative 5% reduction in GP appointments, there would be productivity gains of £144,690 after four years. There would be a likely reduction in ED attendances and emergency hospitals admissions. It is estimated that the new model of care would be cost neutral within 18 months.

Unnecessary duplication of work would be reduced and levels of satisfaction among patients, their carers and families increased - with greater awareness of the services available, a higher rate of referrals to the appropriate teams and shorter GP waiting times.

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