Cross counties PCN The Croft Medical Centre (the “CW Partner”),2 Glen Road, Leicester, LE2 4PE Together, (the “Parties”)

Project Name: Cross Counties PCN Heart Failure (HF) primary care register and medicines optimisation reviews

Project Summary:

The objective of the CWP is to improve the detection and treatment of Heart Failure (“HF”) in primary care via this solution consisting of a quality improvement program to ensure better awareness, identification and management of and outcomes for patients with HF in primary care by the addition of Consultant and Cardiac Nurse Specialist (CNS), each holding two (2) clinics a week funded by Novartis, to work with the CW Partner’s teams to standardise processes and implement them in the following:

1. The review of **primary care HF patients medical records and data cleansing**

a) Cross Counties PCN with a patient population of 41,087 with approximately 356 patients on the HF register including

i) The Billesdon surgery

ii) The Croft Medical Centre

iii) South Leicestershire Medical Group (Formerly Two Shires Medical Practice and Kibworth Health Centre)

2. **Stratification of HF patients** by the Consultant and Specialist Nurse that are on the HF register databases at Cross Counties and North Blaby

i) Delete from HF register

ii) Optimise in Primary Care by the development of HF care plan

iii) Refer to secondary care

3. The PCN pharmacist will continue the care of the HF patients and **optimise from the treatment plan**

i) When needed will seek Advice and Guidance (A&G) on individual patient via the health economy recognised route.

ii) PCN pharmacists to virtually present complex cases at the HF Multi- Disciplinary Team (MDT) meeting

4. **Write up** of the project and business case to present as evidence to the wider health economy.

5. **Formal write up and review of the CWP** with publication of the data via the development of a HF data cleansing guide to share with other PCN Pharmacists

These steps will improve primary care HF registry data, uptake of HF medications, reduce unnecessary

cardiology referral to secondary care, timely referral of urgent HF assessment in line with NICE, reduction in HF hospital admissions, enable PCN teams to undertake Quality Outcomes Framework (QOF) recommended HF reviews.

The Croft Medical Practice will contract on behalf of the GP surgeries listed above

**PCN pharmacists and General Practitioner with Special Interest (GPwSI) and proactive nurses with interest in HF*

Planned Milestones:

1. Kick off meeting and collection of project baseline data. PCN pharmacist to run HF registry list along with other tests and share information with consultant and specialist nurse

2. Stratification of 25% of HF patients with case note review and medicines optimisation by CNS nurse / consultant and patient stratification of HF register of Surgeries within Cross Counties PCN

3. Stratification of 50% HF patients with case note review and medicines optimisation by CNS nurse / consultant and patient stratification of HF register of Surgeries within Cross Counties PCN

4. Stratification of 75% HF patients with case note review and medicines optimisation by CNS nurse / consultant and patient stratification of HF register of Surgeries within Cross Counties PCN

5. Stratification of 100% HF patients with case note review and medicines optimisation by CNS nurse / consultant and patient stratification of HF register of Surgeries within Cross Counties PCN

6. Develop Business model and case study to present to the wider health economy

7. Develop a “Guide to primary care HF register data cleansing for PCN pharmacists”

8. Write up project outcomes

Expected Benefits:

ANTICIPATED BENEFITS FOR PATIENTS

- Earlier patient access to guidelines directed therapies,
- Medicine optimisation leading to better outcomes.
- Care closer to home and access to specialist in the community.
- Increased Patient education on HF
- Individualised HF care plan
- Longer term raised awareness will lead to quicker diagnosis and additional avoided admissions.

ANTICIPATED BENEFITS FOR THE ORGANISATION(S)

- Integrated approach to care delivery
- Increased data efficiency
- Increased awareness and education surrounding HF in primary care HCPs. Earlier patient access to guidelines directed therapies,
- Medicine optimisation leading to better outcomes.
- Care closer to home and access to specialist in the community.
- Increased Patient education on HF
- Individualised HF care plan

- Longer term raised awareness will lead to quicker diagnosis and additional avoided admissions.

ANTICIPATED BENEFITS FOR NOVARTIS

- Insight on the appropriate use of ASCVD licensed medicines in line with NICE guidelines, including Novartis's medicine
- Enhanced reputation, and supporting Novartis' vision that no patient should have to wait for an extraordinary life
- Ethical, professional, and transparent relationship between Novartis and the Healthcare Organisation

Start Date & Duration: February 2023

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