Health and Wellbeing Board
23 April 2013

Agenda – Part: 1	Item: 7.3
Subject: Update - Primary Care Strategy for Enfield	
Date: 16th April 2013	

REPORT OF:

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1. EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board on work to date to implement the primary care strategy across the borough of Enfield.

The paper describes the work in progress to deliver the primary care strategy in Enfield.

There are 25 approved schemes with a budget allocation of £2.7m in 2012/13 which has been fully committed.

The project team will report jointly to the CCG and the Health and Wellbeing Board.

2. RECOMMENDATIONS

The Enfield Health and Wellbeing Board are asked to note the report.

NHS Enfield – Primary Care Strategy

NHS Enfield Primary Care Strategy
April 2012- April 2013 Update

1. Introduction

This paper updates the Health and Wellbeing Board on work to date to implement the primary care strategy across the borough of Enfield.

2. Background to the Primary Care Strategy

In Jan 2012 NHS North Central London published a Primary care Strategy to:

- Improve access
- Improve patient experience
- Improve Health Outcomes

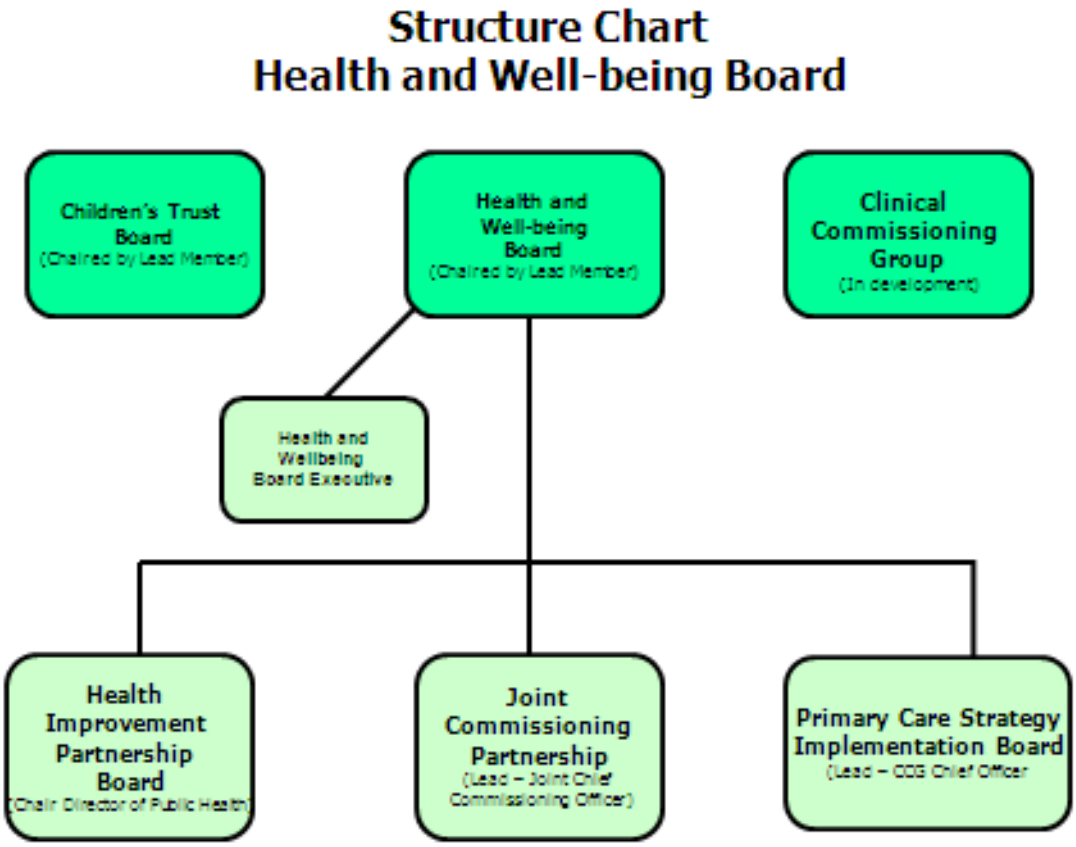
for the populations of Enfield, Haringey, Barnet, Camden and Islington – the five boroughs that comprise NHS North Central London.

In order to support the delivery of that strategy NHS North Central London committed £47m over three years, of which Enfield will have £11m over the years as £3m, £4m and £4m.

In June 2012 NHS Enfield published an Implementation plan following consultation with local stakeholders including GPs, public, council members and representatives of interest groups. This dialogue has remained open throughout the delivery of various schemes being implemented in order to further test, refine and monitor progress.

3. Link with Health and Wellbeing Board

The Health and Wellbeing Board established a work group now known as the Primary Care Strategy Implementation Board (PCS IB) comprising of local NHS managers, GP's, pharmacy representatives, public, council and public health to oversee the development and implementation of schemes aimed to deliver the improvements set in the strategy documentation. The table below shows how this fits within the governance arrangements for the Health and Wellbeing Board.



The work of the Primary Care Strategy Implementation Board is committed to both the vision and objectives of the Health and Wellbeing Board.

'Our vision is for a healthier Enfield, where everyone is able to benefit from improvements in health and wellbeing. We want to reduce health inequalities in Enfield and for its people to have a healthier, happier and longer life. We want Enfield to be a healthy and happy place to live, work, raise a family and retire in'.

4. Update on the Primary Care Strategy

There are a number of schemes and enabling workstreams that continue to be monitored through the Primary Care Strategy Implementation Board that is chaired by the Medical Director of Enfield Clinical Commissioning Group (CCG). These schemes include:-

4.1. Improving Access

It is recognised that people in poorer neighbourhoods often make increased demands on health care, due in part to additional needs, but also where issues with delivering services fails, due to processes of accessibility, language or affordability of treatment. Several schemes developed locally aim to improve access to primary care these include:

4.1.1. Enhanced Access Scheme – where GPs are paid additional sums to deliver face to face and telephone sessions, adopt new practices in booking patients and using skill mix to better utilise GP time. Training sessions have been well attended (90 GPs and 60 receptionists) and 10 practices completing a detailed analysis of their demand and capacity and implementing a change action plan. Commenced January 2013, and has provided additional slots for 6,000 patient contacts to date.

4.1.2. Minor Ailment scheme – using pharmacy skills patients with minor ailments who need advice or simple over the counter medication can obtain a "passport" card to avoid a consultation with a GP, freeing up the practice time, better using their skills and providing patients with a one stop service. Service commenced January 2013 and is providing around 600 patient contacts per month. Some 5% of activity is referred back to GPs where presented symptoms warrant it.

4.1.3. Carers Health support – following the drafting of the LBE Carers Strategy the team have worked closely with LBE and the Carers Association on a small range of measures to improve health checks and access for carers with regards their own health needs. This will commence in March 2013.

4.1.4. Integrated Care – At a recent workshop on integrated care it was agreed that local GPs would pilot a scheme for patients seen as "frequent flyers" where traditional approaches in delivering their healthcare was failing. This commenced in Feb 2013. This work has involved multidisciplinary teams having case conferences and agreeing care plans for individual patients. To date over 60 patients have had their cases reviewed and is leading to a more integrated approach in care delivery.

4.2. Improving Patient Experience

Traditionally many complex services are delivered in hospitals. Increasingly those oldest and poorest in society find it difficult to attend hospital and find compliance with advice and treatment sometimes difficult. We have a number of schemes that provide additional training and education or equipment into GP practices. This means patients are able to obtain this higher level of care closer to home, increasing the likelihood of people being seen and treated and reducing the need to go to hospital for their care.

Such schemes include:

4.2.1. Deep Vein Thrombosis

Whilst this only affects a small number of patients each year, attending A&E for a simple investigation and treatment can be avoided through using a simple test at a local practice. Nine practices act as a hub to others across Enfield. Started in January 2013 with 11 patients being seen and treated in local premises.

4.2.2. Anti- Coagulation community service

Patients on long term warfarin therapy for clotting disorders who are stable (no change in medication) are able to have their blood tests and monitoring carried out locally. There is a quick referral back into the hospital should it be required. To start late April 2013, but pleased to report that training is complete and equipment installed.

4.2.3. Blood pressure Monitoring

It is recognised that across Enfield there is a high level of variation in delivering good blood pressure monitoring. Patients fail to attend sessions for checks and several patients suffer “white-coat” syndrome resulting in artificially high results when attending practice. This scheme uses two technologies – a wrist-watch style device that monitors pressure over a 24-hour period and downloads results to the doctors computer for analysis and the second a stand alone device in GP waiting areas so patients can drop-in for their check, results go into their records and they are called back if changes to medication are required. Eight devices have been installed with all practice locations being covered by June 2013.

4.2.4. Childhood obesity

Is a significant issue for Enfield, especially again in our poorer communities. Practices will be able to access specialist training to help provide a practice based register for obese children and a scheme training practice nurses to provide an enhanced level of support to families and children in dietary needs. Local delivery will improve both uptake of such services and outcomes. 50 practices have agreed to start a register.

4.2.5. Pain Management

Working with Chase Farm clinicians we have commissioned a service to support patients who have undergone unsuccessful treatment for pain and require further support in dealing with the long term effects of poorly resolved pain issues. The scheme will commence later in 2013.

4.2.6. Patient Experience

In order to track the experience of patients using Primary Care services we have invested in modern and extensive reporting and feedback services. Using tablet devices and other systems we will capture a wider range of patients in different settings to ensure we capture and respond to patient experiences.

4.3. Health Outcomes

Across Enfield we have diverse population, both ethnically and economically. The life span of the poorest is c10 years less than the wealthy. Whilst this is in part due to lifestyle choices, accessibility and understanding of health advice and treatment play a part.

A number of schemes assist with this aspect:

4.3.1. Chronic Obstructive Airways Disease (COPD) – using specialist nurses and providing each practice with equipment will see an increase in testing and prevalence of this illness which results in significant numbers of patients attending hospital unexpectedly. Started January 2013 with 14 practices having completed stage one and provided equipment.

4.3.2. Cancer Screening

Data shows patients in Enfield do not regularly attend screening opportunities to help prevent cervical, breast and bowel cancers. The team are putting into place specific processes to assist practices to identify patients who may benefit from more direct interventions.

4.3.3. Education and training and development of the workforce

During the consultation phase it became clear that practice nursing staff required additional opportunities to access update training and special skills treating for respiratory and cardiac illnesses.

Enfield also has challenges in recruiting GPs, with an aging group of practitioners. Utilising the mentorship of University College London (UCL), we are recruiting four newly qualified GPs to work in each locality. Half of their time will be spent seeing local patients as additional capacity (17,000 additional patient contacts). The remaining time will be split between teaching of new doctors at UCL and working across Enfield with other health professionals developing new care pathways and education of primary care teams to deliver enhanced local services. We are currently working with UCL on the recruitment processes.

4.4 Infrastructure Support

In order to directly and indirectly support these changes we have also undertaken significant steps to improve supporting organisational and infrastructure needs.

4.4.1 Enfield practices are being refreshed with new hardware (PCs, printers and iPads for doctors making home visits).

The clinical systems that hold patient records are being upgraded to cloud-based technology – to date 9 practices are now live on the new platform. Five systems that will no longer be supported by the supplier will be migrated to new systems.

We will provide a document management system to allow electronic discharge summaries from hospitals and help practices move towards a paper-less system with electronic prescribing.

Practices have started to use a text messaging system that allows patients to be reminded of appointments, health campaign information and to cancel an appointment no longer required. Early data show c170 appointments per month are available for re-use by practices.

4.4.2 The formation of clinical delivery networks is a key component of supporting patients in accessing a full range of services, not

traditionally available in smaller premises. The programme is supporting GPs to work together in defined localities with the aim of providing services that would otherwise not be available, and using peer-support for practices struggling to make health gains. One example of this is a new Local Enhanced Service (LES) for Coronary Heart Disease (CHD) where practices already achieving above average scores will be rewarded for assisting and sharing best practice with GPs who are underperforming.

4.4.3 We have provided £180,000 towards auditing all premises and grants for improvements such as flooring and sinks as well as access and toilet facilities. We aim to provide similar funding across all three years for this on going work. In addition the PCT is supporting several schemes aimed at providing refurbished or new build facilities including a joint venture with LBE at Ordnance Road.

The schemes are on target to spend 100% of the budget allocation in 2012/13 and 75% in 2013/14. The programme are working with stakeholders to ensure maximum gain from the remaining 25% to be allocated.

5.0 Next Steps

The Health and Wellbeing Board are asked to note the next steps for the programme which include:-

- Delivery of improved patient care
- Strengthening programme arrangements and governance through 2013/14
- Communicating the changes widely and effectively
- Continuing to strengthen partnership working
- Engaging more with local people and stakeholders
- Developing key performance indicators which are linked to the benefits realisation of the programme