Health and Wellbeing Board

20 June 2013

Agenda – Part: 1	**Item: 8.3**
Subject: Primary Care Strategy for Enfield	
Date:	

REPORT OF:

Contact officer and telephone number:

Gail.hawksworth@enfieldccg.nhs.uk

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. There are some 25 approved schemes with the budget allocation of £2.7m for 012/13 which has been fully committed.

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

Key Deliverables:

1. 8000 additional practice appointment slots delivered via telephone consultation, face-to-face at practice or home visit for participating practices covering 75% of population
2. The Minor Ailment Scheme provides 500 patient contacts per month. Between commencement on 18 February to end of April 2013, there have been 1168 face-to-face, covering 1244 ailments of which 677 (58%) consultations were for children under 16
3. Pain Management service started on Monday 29 April 2013. GPs refer relevant patients to the Enfield Referral Service where patients are triaged to the community clinics that are currently at Lincoln Road Medical Centre and Carlton House Surgery.
4. There are 44 practices (83%) have engaged by signing up to the Locally Enhanced Scheme. 32 practices have received their equipment and 10 practices have completed their training.

RECOMMENDATIONS

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

NHS Enfield Primary Care Strategy
June 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. 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:-

2.1. Improving Access

2.1.1. Enhanced Access Scheme

39 practices have signed up to the Access LES, which has created about 8000 additional GP slots either telephone triage/consultation or face to face consultations. This covers 75% of the population. A total of 110 GPs have attended Telephone Triage Training, while 152 Reception staff have attended training on enhancing communication skills. The Primary Care Foundation (PCF) is working with a further 10 practices on the capacity/demand processes. Practices are producing Access Action Plans. Further work on access will continue to build on existing work to increase productivity.

2.1.1. Minor Ailment Scheme

The scheme utilises pharmacy skills and capacity to improve access for patients suffering from minor ailments. The scheme creates a direct access pathway for patients entitled to free prescriptions by removing the prerequisite, for the patient, to visit a GP to provide simple over the counter medicine and/or advice, free, via prescription; provision that already exists for paying consumers. Patients with minor ailments, who need advice or simple over the counter medication, obtain a “MAS Passport” that enables the patient to be seen at local Pharmacy(s) freeing up the GP time for patients requiring complex interventions. The Minor Ailment Scheme (MAS) commenced on the 18th February 2013 and provides 500 patient contacts per month. Between February and April 2013, 1168 face-to-face consultations were provided, covering 1244 ailments, of which 677 consultations (58%) were for children under 16. The Scheme has created an estimated 233 hours of extra GP access across Enfield over the analysed period. Figure 1 shows that the main presenting symptoms are fever hay fever, sore throat and urinary tract infection. Fig 2 shows that the majority of patients are children between 0-12 years old.

Fig 1

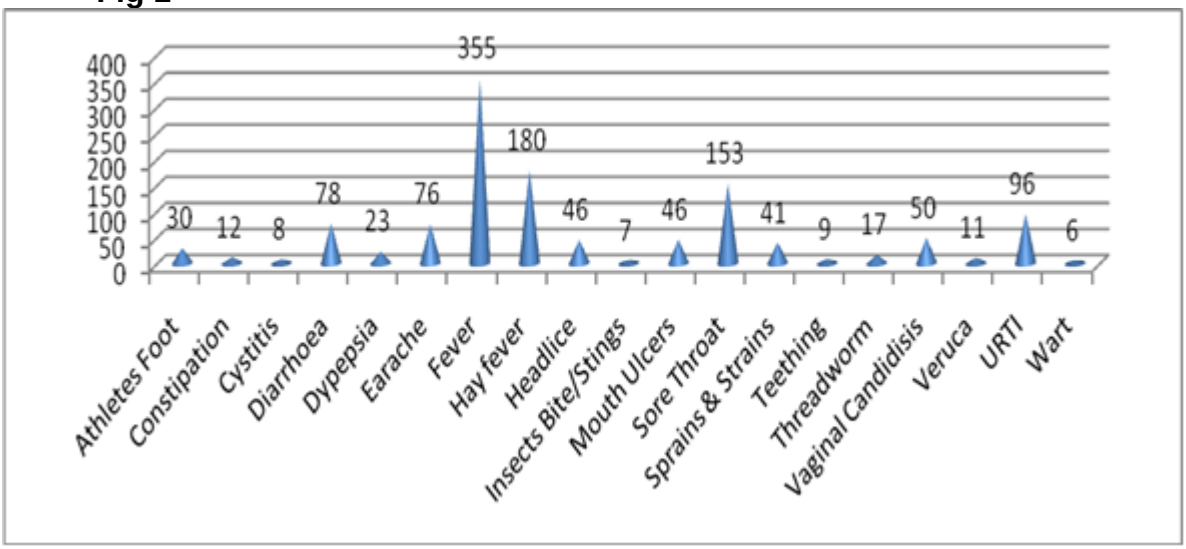

Fig 1 represents the breakdown of activity, per ailment throughout the identified period.

Fig 2

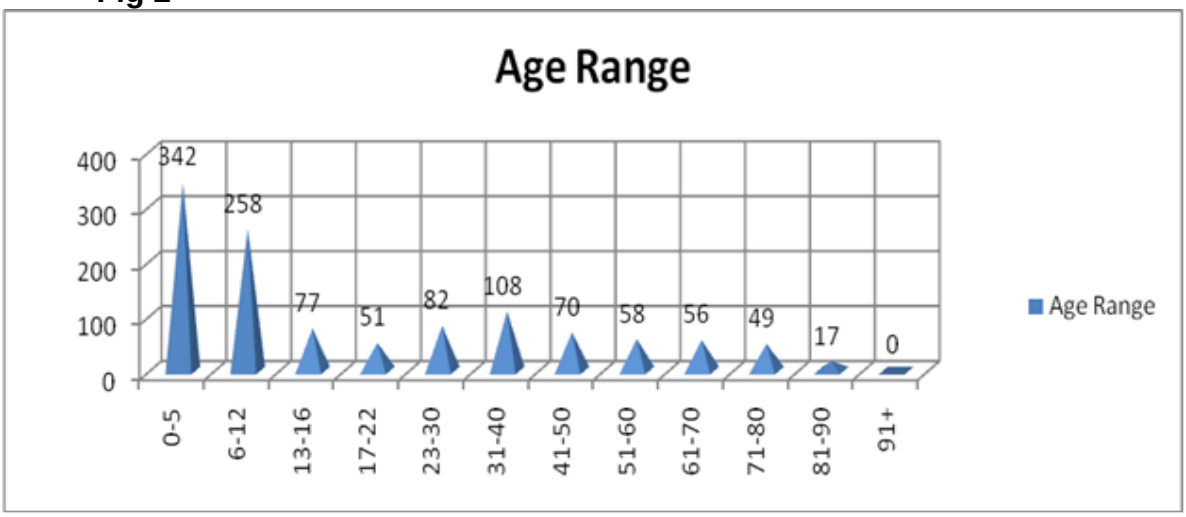

Fig 2 identifies the age range of patients seen via the Minor Ailment Scheme

2.1.2. Carers Health support

A GP Liaison Worker has been appointed to work across practices, based in Enfield Carers Centre. This role aims at:

- Providing a robust link between the carers centre and practices
- Ensuring the carers registers in practices reconcile with the register held by the carers centre
- Work with the Carers Nurse (when appointed) to provide awareness raising sessions in practices
- Ensure carers information packs are up to date and available in practices
- Education practice staff on caring for carers
- Attend meetings in practices where appropriate and at the carers centre

- Raise the profile of caring for carers
- Identifying hidden carers

Approval has been given for the PC Strategy to fund a Carers Nurse however the appointment requires a host practice for employment and as yet this has not been confirmed. The carers centre is not registered with CQC and therefore cannot employ a clinician.

The Carers Nurse role is to support carers of all ages to:

- prioritise their own health care needs
- recognise the importance of maintaining their own good health and well-being
- ensure that carers are well supported to continue their caring responsibilities
- provide regular health checks for carers
- administer immunisations as required and annual flu jabs
- provide advice and information about healthcare and treatments

2.1.3. Integrated Care

Following the notification of a Risk Profiling and Care Management Directly Enhanced Scheme that was sent to all CCGs by NHS England in June 2013, the current MDT LES Pilot, which has been running in 4 practices since Feb 2013, is being reviewed. Whereas the LES targeted patients aged 65 years and over the DES specification requires practices to risk stratify all patients including children. This matter is now under discussion at CCG to develop the best way forward to delivery both the DES and the necessary changes for older people. .

2.2. ECCG/University College of London (UCL) Joint Initiative

Four Academic Clinical Associates or ACAs (newly qualified GPs) are to be employed for a two year fixed term contract (full time). The main objectives for this initiative are as follows:

- Approximately 17000 extra primary care appointments across Enfield over the two year period;
- Service improvements through research and re-design in the following areas:
  - Elderly Mental Health
  - Palliative Care
  - A&E attendance reduction
  - Diabetic management with considerations to both CVD and stroke;
- Raising the profile of Enfield as a borough for newly qualified GPs to settle within long term

The ACAs will be placed for periods of up to one year in practices for part of the week and will also maintain close links with UCL. As at 10.06.13 paperwork for ACA recruitment is prepared. All Enfield

practices have been offered the opportunity to apply to become host sites and 21 have applied. An evaluation is currently taking place to agree the 8 practices that will an ACA.

2.3. Improving Patient Experience

The schemes below enable patients 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:

2.3.1. 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. This service started in January 2013 with 11 patients being seen and treated in local premises and the latest uptake figures are currently being obtained from the practices.

2.3.2. 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. The expected start date for this service is late June 2013. The equipment is installed in the 4 practices across Enfield, one in each locality.

2.3.3. Blood pressure Monitoring

As of early June, a total of 31 stand-alone BP and Body Mass Index (BMI) Monitor known as a PODs are deployed across Enfield; 12 more expected to be installed throughout month. A total of 43 POD's will be located within 48 GP Premises (5 practices co-located and will share the POD). These 'state of the art' PODs, are being deployed in accessible areas of GP Practices and are cost free for patients. The remaining 5 PODs will be located in strategic locations where they can fill the gap in provision, bringing a total of 48 PODs to Enfield. Patients will give their results to their GP practice for inclusion in patient records and they are called back if a change to medication or BP/BMI management is required.

2.3.4. Childhood obesity

The plan with the service provider that will support the management of childhood obesity is to:

- Provide pathway development which will analyse the current strategies and JSNA and develop a set of recommended pathways based on best practice/evidence base to be developed/commissioned for the future.
- Provide weight management interventions – options are currently being reviewed

- Training provision – Will consist of 60 places of 1 day introduction to managing childhood obesity training and 30 places on a 2 day toolkit training which will be more detailed about interventions. This will be offered to all GP practices and School Nurses across Enfield.

It is important to ensure that this project works cohesively with the ECS school nursing team to avoid duplication of effort and to maximise the selection of the right children for the interventions where maximum benefit will be gained. So far 50 practices have agreed to start a register.

2.3.5. Pain Management

1. 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. GPs refer relevant patients to the Enfield Referral Service where patients are triaged to the community clinics that are currently at Lincoln Road Medical Centre and Carlton House Surgery.

2.3.6. Patient Experience

There have been 2 workshops held with practice managers and GPs to provide details of Patient Experience tracker. A list of practices wishing to engage has been complied with 32 practices having agreed to proceed with this project. The numbers and type of hardware, standardised patient satisfaction questionnaire to be developed, training plan to be agreed and finalising the numbers and types of hard ware to be purchased.

2.4. Health Outcomes

The following services help to support the improvement of the health outcomes of the local population:

2.4.1. Chronic Obstructive Airways Disease (COPD)

Following assessment of spirometry equipment and training needs within each practice the CCG are providing necessary equipment, and funding ARTP accredited spirometry training for all. Self-management packs are being provided for all COPD patients. The result of this initiative 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 (as at 10.06.13) 44 practices (89% of COPD patients) engaged. All practices have been assessed, 30 have received equipment and patient information packs and 10 have attended training.

2.4.2. HiLo Initiative

In conjunction with Queen Mary's University London (QMUL) this is a pilot project to improve the management of CHD and BP in general and in particular, those patients traditionally referred to secondary care for management due to poor response in this area of treatment. Negotiations are currently under way as to how many practices will be able to take part within the allocated budget and IT issues are being resolved (previously only EMIS practices have been able to participate) Once these items have been satisfactorily determined, practices will be offered the opportunity to participate and will be selected on the basis of geographical need and size of practice in order to reach the greatest number of the patients

2.4.3. Coronary Heart Disease (CHD)

There are significant variations across the borough in management of blood pressure (BP) and cholesterol levels within primary care. In order to improve the borough average practices are incentivised to support each other to improve. This project started March 2013 with, as at 10 June 2013, 26 practices are engaged.

2.4.4. Cancer Screening

The Cancer Screening information leaflets have been distributed to all over 50's in Enfield a total of 80,000 leaflets have been distributed. Promotional materials have been sent to all pharmacies in Enfield for distribution in June. Two training sessions has been delivered to Health trainers and Pharmacy Assistants in 'Getting to know Cancer' campaign. It has been agreed with Public Health that the recruitment of health trainers will proceed.

3.0 Education and training and development of the workforce

Some focus has been on updating practice nursing skills in the management of both respiratory and cardiac diseases following initial work with practices. 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.

4.0 Infrastructure Support

Improvements to the infrastructure support will enable access to patient's medical records when they receiving services from another practice, not their registered practice, within Enfield.

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 with at least 50% of practices having their hardware updated with new scanners, printers, arrival screens and patient information boards.

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. April 2013 monthly reported figures show that 48 practices are enrolled in Enfield CCG with a combined patient list of over 290,000. In total these practices have the mobile numbers of 129, 094 (43.6%) of that population. A total of over 24,000 messages concerning confirmation of appointments were sent to patients across Enfield and 359 appointments were saved by the use of this system.

5.0 Conclusion

The developments outlined above provide a summary of the progress to achieving long term sustainable improvements in the delivery of primary care services that will support the improvement in the health and wellbeing of the residents of Enfield.

6.0 Next Steps

6.1. Develop the business case for the next 2 years 2013/14 and 2014/2015 for PC Strategy Investment.

6.2. Development of the Investment Programme of Initiatives for 2013/2014