Health and Wellbeing Board

19 September 2013

Agenda – Part: 1	Item: 7.3
Subject: Primary Care Strategy for Enfield	
Wards: All	

REPORT OF:

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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 15 approved schemes with the budget allocation of £3.4 million.

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

Key Deliverables:

1. 27,000 additional practice appointment slots delivered via telephone consultation, face-to-face at practice or home visit for participating practices covering 82% of the population
2. The Minor Ailment Scheme provides 500 patient contacts per month. The Minor Ailment Scheme (MAS) commenced on the 18th February 2013, between February and July 2013, a total of 3159 face to face consultations have been provided. Since July the scheme has introduced a number of patient satisfaction/experience questions into the consultation process. Patient satisfaction data recorded in July reports that out of the 585 patients consulted, 95% of patients were seen (face-to-face consultations) within a 10 minute waiting period, 97% of patients would use the service again and 97% of service users would recommend this service to a friend or family member.
3. From 18 – 30 August, up to 30 overweight and obese children from Enfield were funded to attend a residential summer camp. The children and their families are being offered post-camp support through to November 2013.

RECOMMENDATIONS

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

NHS Enfield Primary Care Strategy
August 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. Access

2.1.1. Enhanced Access Scheme

38 practices have signed up to the Access LES, which has created approximately 3,400 additional GP slots per month (in excess of 40,000 additional appointments for the year of the scheme). The slots are either telephone triage/consultation or face to face consultations. 22 practices have completed the exercise and received a practice visit from the Primary Care Foundation (PCF) and the CCG access lead to discuss the report. 5 practices have submitted their data and are awaiting the practice visit, 6 practices are currently collecting their data. 5 practices have not registered with the PCF and the CCG is in contact with these practices to support them to engage in the process. The scheme covers 82% of the population in Enfield.

A total of 110 GPs have attended Telephone Triage Training and 152 Reception staff have attended training on enhancing communication skills provided by an external company – Effective Professional Interactions (EPI). EPI is providing support to practices that have completed the PCF exercise. This support is in the form of a programme over 12 months and includes practice workshops, GP to GP telephone support and workshops for Practice Managers. 5 practices out of the 22 who have completed the PCF exercise have taken up this additional on-going support.

2.1.2 Minor Ailment Scheme

The scheme utilises pharmacy expertise 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, between February and July 2013, a total of 3159 face to face consultations have been provided. Since July the scheme has introduced a number of patient satisfaction/experience questions into the consultation process. Patient satisfaction data recorded in July reports that out of the 585 patients consulted, 95% of patients were seen (face-to-face consultations) within a 10 minute waiting period, 97% of patients would use the service again and 97% of service users would recommend this service to a friend or family member. The Scheme has increasingly been used by the 16s and under and this now accounts for nearly 50% of total activity. The MAS pilot evaluation is expected to be completed and published in October 2013.

2.1.3 Carers Health support

Enfield Clinical Commissioning Group Primary Care Strategy Programme monies has enabled the Enfield Carers Centre to recruit a GP Liaison Worker, Fiona Jones started in post on the 12th June 2013 on a fixed term contract ending 31st March 2015. Funding was also approved to recruit a Carers Nurse and following a short delay due to issues relating to finding the appropriate employing organisation; a resolution has been found and recruitment is currently in progress with the Carers Nurse expected to be in post by the middle of September.

The aims of this project are to:

- Ensure early identification of carers to enable the provision of the right support when carers need it
- Provide support for GPs and practice teams with carer issues
- Assist the prevention of carer breakdown which avoids hospital admission
- Help Keep carers healthy both physically and mentally
- Provide a link between primary care, the Enfield Carers Centre and other services in the local community
- Provide a clear referral pathway for GPs and practice staff to a GP Liaison Worker and Practice Nurse

There has been a lot of activity and promotion of the service, over 60% of practices have been contacted regarding the service and provided with leaflets, posters and referral forms. Awareness is growing in Enfield regarding the services available for carers and the Carers Centre is reporting an increase in activity due to the project.

Going forward Enfield CCG will be ensuring regular reporting is in place to measure the outcomes and benefits of this project both quantitative and qualitative.

2.1.4 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

These posts are now called 'Principal Clinical Teaching Fellows'. They have been advertised with a closing date of 13 September 2013 with interviews occurring late September/early October 2013.

'Host' Practice applications have now been shortlisted and site visits are due to take place late September/early October 2013.

2.2 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:

2.2.1 Blood Pressure Monitoring

By the end of August, a total of 45 stand-alone blood pressure (BP) and Body Mass Index (BMI) health kiosks known as PODs have been deployed across Enfield, covering 48 GP Practices (practices share PODs where they collocate). These 'state of the art' PODs, are being deployed in accessible areas of GP Practices and are cost free for patients. The remaining 3 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. The project activity is being obtained throughout September and so far the first 8 practices to respond have confirmed that the PODs have been used on 7,587 occurrences. The Primary Care Strategy is liaising with LBE graphics team to mobilise a campaign via the ‘Our Enfield’ magazine to increase awareness.

2.2.2 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 considered for future development.
- Provide a weight management intervention which consists of a residential weight loss summer camp for up to 30 children.
- 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 provide be more detailed about interventions. This will be offered to all GP practices and School Nurses across Enfield.

The project is well underway and so far 50 GP practices have agreed to start a child obesity register. From 18 – 30 August, up to 30 overweight and obese children were funded to attend a residential summer camp. The CCG is awaiting confirmation of the outcomes from their camp attendance. The children and their families are being offered post-camp support through to November 2013. The project is working cohesively with the ECS school nursing team to avoid duplication of effort.

2.2.3 Patient Experience Tracker

The NHS nationally recognises that patients care about their experience of care, as much as clinical effectiveness and safety. The Primary Care strategy has pump primed a ‘turnkey’ solution that will enable GP Practices to better capture their patients opinions and views on the services they provide. The project will enable practices to become more responsive to their patients’ needs and allow GP Practices the ability to focus/tailor their investments into areas expressed by their patients. 34 GP Practices are signed up to the service and the project is currently procuring the tablet devices that will eventually be used within the identified practices. The Steering Group and a Survey Development group are in place and will continue to meet during September to ensure all prerequisites are in place for a November launch.

2.3 Health Outcomes

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

2.3.1 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 following poor improvement outcomes when recommended primary care treatment guidelines are followed. Practices have been selected on a basis of geographical need and size of practice in order to reach the greatest number of the patients and were offered the opportunity to participate. Both practices have accepted and participation is about to commence.

2.3.2 Cancer Screening

Cancer Screening information leaflets have been sent to over- 50's in Enfield with a total of 80,000 leaflets distributed. Promotional materials were provided to all pharmacies in Enfield for distribution in June 2013. Health Trainers have now been recruited to promote cancer screening in the community. Two training sessions were delivered to the Health trainers and Pharmacy Assistants in 'Getting to know Cancer' campaign. Pharmacists are distributing 'Getting to know Cancer' leaflets when they dispense medication.

2.3.3 Domestic Violence

The project aims to work with up to 25 general practices across Enfield to implement a domestic violence identification, training, support and referral programme for primary care staff that will support female patients aged 16 and above who are experiencing domestic violence and abuse. A full time Advocate Educator, supported by an IRIS Clinical Lead will train practice teams and provide expert advocacy.

The Advocate Educator and IRIS Clinical Lead have both been appointed.

3.0 IT Developments

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.

iPLATO text messaging services continues to support GP Practices reduce their 'did not attend' rates. During May 2013 to July 2013 a further 956 clinical appointments or (159 clinical hours- based on 10 minute appointments) have been saved, enabling GP Practices to reallocate this access back into their provision.

4.0 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.

5.0 Next Steps

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

6.2. Continue to the development of the Investment Programme of Initiatives for 2013/2014

6.3 Start the development of Networks.