Health and Wellbeing Board

13 February 2014

Agenda – Part: 1	Item: 10c
Subject: Primary Care Strategy for Enfield	
Date: 13 February 2014	

REPORT OF: Improving Primary Care Sub Board

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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.

The Primary Care Strategy project team reports jointly to the CCG Primary Care Strategy Implementation Board and the Health and Wellbeing Board.

RECOMMENDATIONS

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

NHS Enfield Primary Care Strategy
February 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 (PCSIB) 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

A full evaluation of the Access LES for the six months to June 2013 was completed in December 2013. In summary, this confirmed that the LES:

- Delivered an additional 16,432 GP appointments (632 per week)
- Provides excellent value for money at £16 per appointment compared to the average cost of a GP appointment of £43*
- Covered 82% of Enfield's population (39 practices)
- 60% of patients surveyed as part of the review reported that access had improved in the last year
- 100% of practices said they would recommend the process to other practices

Due to such positive results and as the local health economy moved into the final quarter of the financial year and winter pressures, it was agreed that the LES be extended for a further three months to 31st March 2014 in order to provide the additional primary care capacity required to sustain improving access. The extension has been offered to all GP Practices in Enfield.

2.1.2 Minor Ailment Scheme

This pilot scheme has utilised pharmacy expertise and capacity to improve access for patients suffering from one of a pre-approved list of twenty minor ailments from fifty-two different sites. A total of 1,385 Pharmacy consultations were delivered in November and December 2013, peaking at 776 consultations in December - the highest level since the Scheme's implementation in February. The Scheme has been extended to 31st March 2014, however the CCG's intention to mainstream the Scheme in 2014/15 has been superceded by an indication in NHS England's draft commissioning intentions that it intends to commission this service in 2014/15.

2.1.3 ECCG/University College of London (UCL) Joint Initiative

The main objectives for this initiative are:

- To improve access to primary care by providing additional capacity of approximately 17,000 extra primary care appointments across Enfield over the two year period;
- To deliver service improvements through research and re-design in a priority service development area.
- To raise the profile of Enfield as a borough for newly qualified GPs to settle in the long term

Four Principal Clinical Teaching Fellows (PCTF) commenced their induction with UCL, the CCG and their Host practices on 6th January 2014. Each PCTF will undertake five clinical sessions in their Host practices, two Academic sessions at UCL, two service development sessions at the CCG and have one CPD session per week. Each PCTF will work with a CCG Clinical and Management Lead on one of four development projects, namely Diabetes, Urgent Care, Older People's Mental Health and Palliative Care.

Four Host GP practices (Bounces Road, Carlton House, Gillan House and White Lodge) have a Principal Clinical Teaching Fellow placed with them for twelve months with a further four new Host practices to be identified for the second year of the initiative.

2.2 Improving Patient Experience

2.2.1 Patient Experience Tracker

The project will enable practices to better assess and respond with real-time results to patient opinion and views on the services provided via the use of tablet devices. Thirty-four GP Practices have expressed an interest in this service and mobilisation of this initiative is now underway.

2.3 Improving Health Outcomes

2.3.1 Childhood obesity

The evaluation from the weight loss camp completed by 24 participants and three month follow-up reflects that:

- 100% of campers achieved a reduction in BMI SDS;
- 50% of campers who attended follow-ups achieved further SDS reduction at three months;
- 100% of campers reduced sedentary behavior due to intensive daily activity schedule;
- 80% of campers scored at three months had further reduced their sedentary behavior;
- 57% of campers who started with low self-esteem, increased their self-esteem score; and

- 40% of campers with low self-esteem showed a continued trend of improved self-esteem.

The CCG will continue to work closely with London Borough of Enfield to support the delivery of its Obesity strategy for the local population.

2.3.2 HiLo Initiative

This pilot project is being delivered in conjunction with Queen Mary's University London (QMUL) and aims 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. Two practices (SE and NE localities) identified 744 patients on their CHD register and initial findings are:

Blood Pressure Control

- 404 patients need further support
- Average age of 64 years
- Average baseline reading 152/84
- 173 of these 404 patients are diabetic
- 48 have existing ischaemic heart disease
- 20 have had previous stroke or TIA
- More women than men (212 vs 192)

Lipid (Cholesterol) Control

- 444 patients
- Average age of 64 years
- Baseline Total Cholesterol 5.5 mmol/l
- Baseline LDL 3.0 mmol/l
- Baseline HDL 1.32 mmol/l
- 235 of these 444 patients are diabetic
- 67 have existing ischaemic heart disease
- 21 have had a previous stroke or TIA
- More women than men (250 vs 194)

QMUL will work with both practices over the coming year to improve treatment of uncontrolled risk factors, reduce patient risk of preventable events, improve the confidence of practice staff to manage patients in future, leave lasting changes in healthcare team behaviours to benefit subsequent patients beyond HiLo and build a positive reaction for such interventions for future initiatives, or elsewhere in the CCG area.

2.3.3 Cancer Screening

LBE Health Trainers are continuing to establish and deliver community outreach to promote screening.

2.3.4 Domestic Violence

The aim of this project is to increase the identification and referral of domestic violence and abuse through training and support of practice staff in the IRIS model. Both the IRIS Clinical Lead and Advocate Educator, have been appointed to work with up to twenty-five GP practices. Fourteen practices have so far agreed to participate in the project which went live in November.

3.0 IT Developments

iPLATO text messaging services continues to support GP Practices reduce their ‘did not attend’ rates, enabling GP Practices to offer this released capacity to patients who require an appointment.

4.0 Conclusion

The developments outlined in this report provide a summary of the progress made in 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.