Health in Dacorum
Agenda

Wednesday 29 January 2020 at 7.30 pm

Conference Room 2 - The Forum

Scrutiny making a positive difference: Member led and independent, Overview & Scrutiny Committee promote service improvements, influence policy development & hold Executive to account for the benefit of the Community of Dacorum.

The Councillors listed below are requested to attend the above meeting, on the day and at the time and place stated, to consider the business set out in this agenda.

Membership

Councillor Beauchamp
Councillor Bhinder (Vice-Chairman)
Councillor Bowden
Councillor Durrant
Councillor England
Councillor Guest (Chairman)
Councillor Hollinghurst
Councillor Johnson
Councillor Maddern
Councillor Sinha

Substitute Members:
Councillors

Outside Representatives:

Contributors:

For further information, please contact Corporate and Democratic Support

AGENDA

6. SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP UPDATE (Pages 2 - 15)

(a) The County Council Adult Care Services Report (Pages 16 - 25)

Hertfordshire and West Essex Sustainability and Transformation Partnership

Primary Care Networks

Denise Boardman: Director for Primary Care Development : East & North Herts CCG

Lynn Dalton: Director of Primary Care: Herts Valleys CCG.

Overview of the presentation:

1. NHS Policy Background to Primary Care Networks (PCNs)

2. Geographical spread & number of Primary Care Networks

3. Achievements to date

4. What the art of the possible is & forward looking

5. Questions

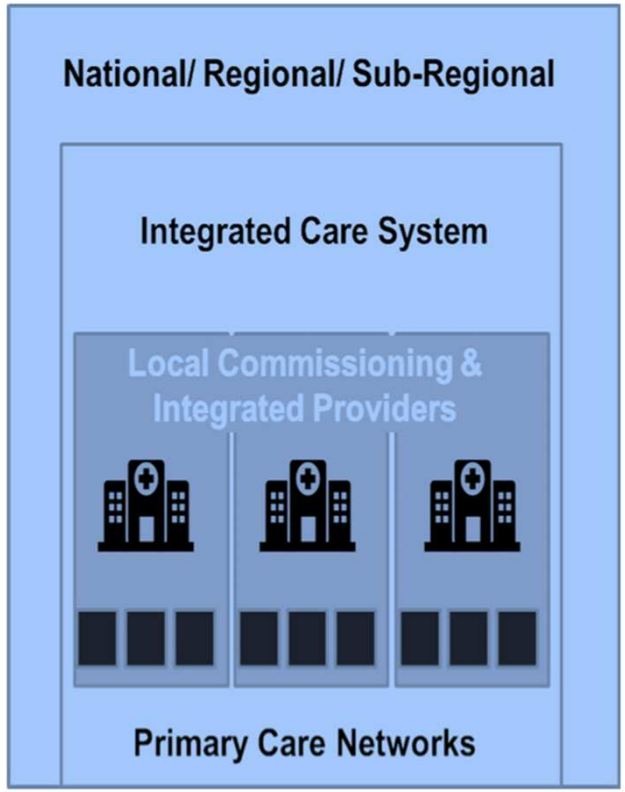
Primary Care Networks

In 2018/19 the NHS England Operational Planning Guidance:
CCGs to actively encourage every practice to be part of a Primary Care Network (PCN) covering a population of at least 30,000-50,000 and that are geographically contiguous

2019/20 national contract negotiations with the British Medical Association: built on the planning guidance with the implementation of the new PCN Directed Enhanced Service for PCNs from 1 July 2019.

PCN provided with additional funding including: new staffing models e.g. Clinical Pharmacists, Social Prescribers, Physicians Associates

PCNs are encouraged to work more closely with other primary, community care and acute health care organisations providing integrated services to their populations.



The NHS Long Term Plan

- Targeted and personalised support (risk stratification)
- Increase focus on population health
- Lead to fully integrated community healthcare
- Working as a member of an Integrated Care Partnership
- Most CCGs have local contracts for enhanced services, and these will normally be added to the network contract

Primary care vision:

To establish a strong general practice foundation, through the development of primary care networks and wider place-based care neighbourhoods

The key pillars of our system are:

- Supporting general practice - working together and in partnership with community and care-providing organisations
- Growing, developing and retaining our primary care workforce
- Creating modern, digital solutions to enable primary care delivery
- Creating a modern, fit-for-purpose infrastructure to deliver high quality services
- Sustaining and improve the quality of care for our patients

Herts Valley CCG
16 PCNs

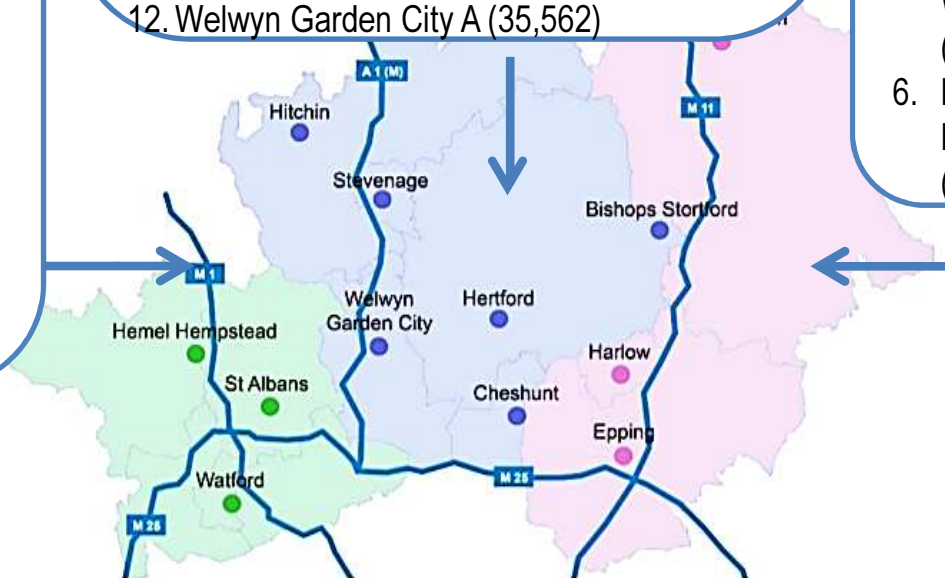
1. Alpha (53,429)
2. Beta (40,186)
3. Delta (33,713)
4. Dannais (41,830)
5. HertsFive (76,095)*
6. Potters Bar (30,137)
7. Grand Union (44,369)
8. The Rickmansworth & Chorleywood (29,145)
9. Central Watford & Oxhey (45,323)
10. Attenborough & Tudor Surgery (29,710)
11. North Watford (38,710)
12. Manor View Pathfinder (29,285)
13. Abbey Health (31,901)*
14. Harpenden (43,787)
15. HLH (38,567)
16. Alban Healthcare (44,018)

East & North Herts CCG
(12 PCNs)

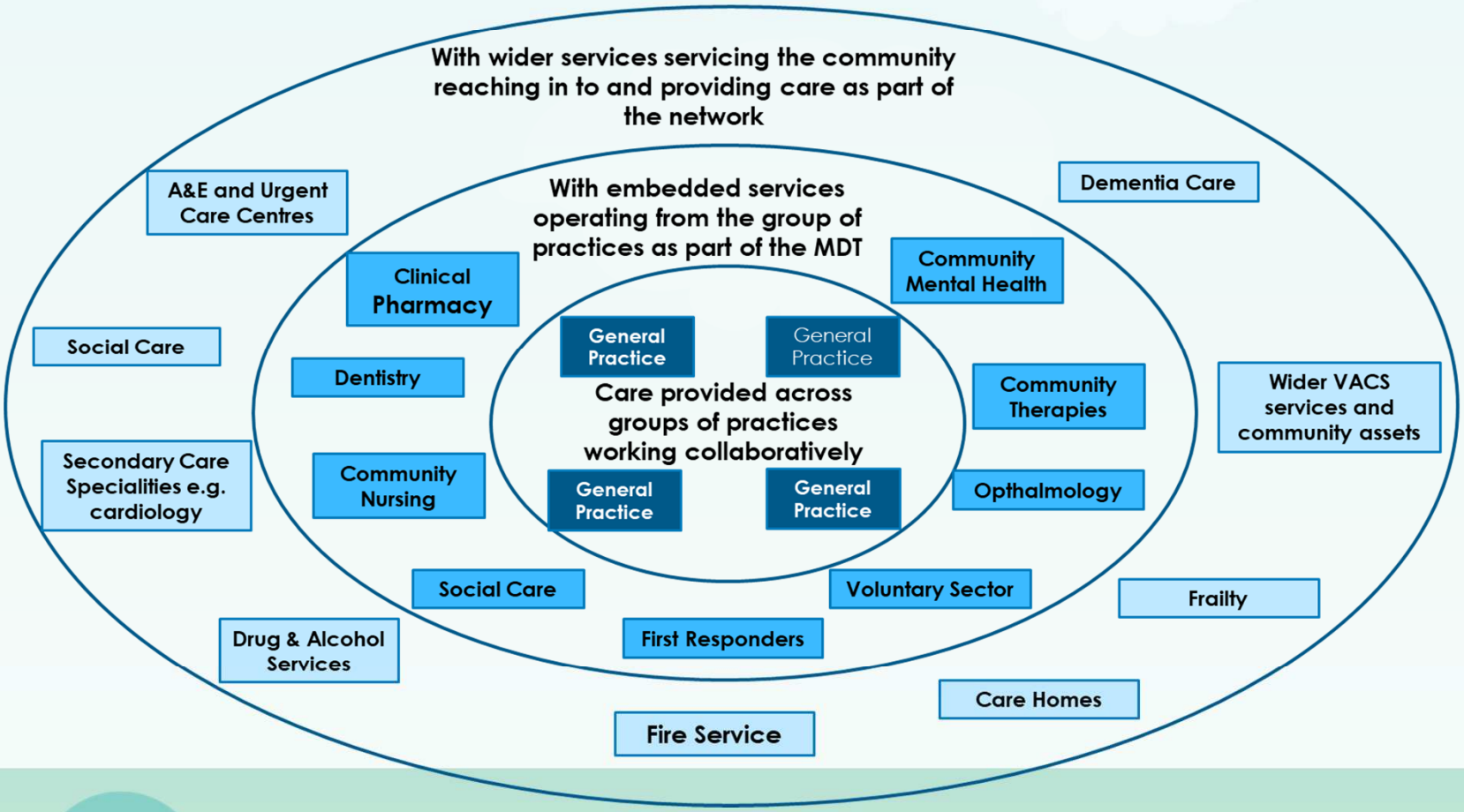
1. Icknield (57,099)
2. Hatfield (50,735)
3. Hertford & Rurals (51,770)
4. Hitchin & Whitwell (47,151)
5. Hoddesdon & Broxbourne (41,541)
6. Lea Valley Health (76,251)
7. Peartree Group & Bridge Cottage (63,763)
8. Stevenage South (48,944)
9. Stevenage North (60,770)
10. Stort Valley & Villages (61,997)
11. Ware & Rurals (32,911)
12. Welwyn Garden City A (35,562)

West Essex CCG
6 PCNs

1. North Uttlesford (39,090)
2. South Uttlesford (51,508)
3. Harlow North (58,705)
4. Harlow South (40,189)
5. Epping, Ongar, Waltham Abbey (64,588)
6. Buckhurst Hill, Loughton & Chigwell (59,836)



Primary Care Networks & System Partners



A Healthier Future

Improving health and care in Herts and west Essex

Hertfordshire and West Essex
Sustainability and Transformation Plan

Essex County Council

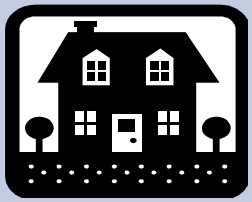
Hertfordshire

NHS

A Healthier Future

Improving health and care in Herts and west Essex

Primary Care Networks



Care Homes : building on Vanguard Initiatives

MDT supporting GP Ward Rounds

Care Home Pharmacist

Social Prescribers, Pharmacists

First Contact Physiotherapists

Physicians Associates

Primary Care Hubs: On the day demand

Direct Access Physiotherapy

PCN SPOC: Call/Recall Hub

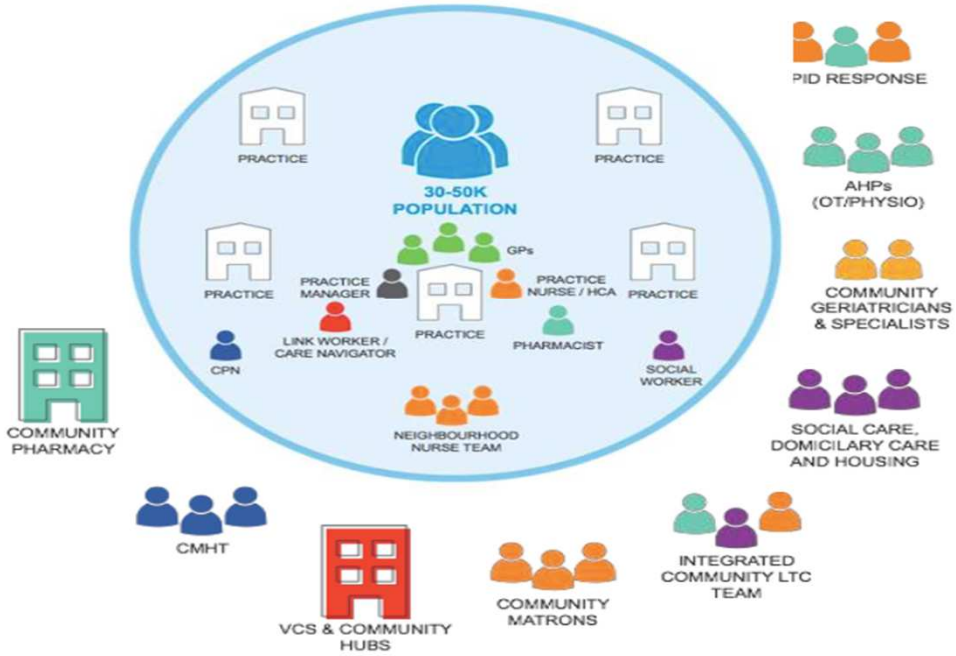
Emerging Picture for PCNs in preparation for transition to Integrated Care Partnerships

Core Team

- Sustained Relationships
- Shared Values And Functions
- Proactive Population Health Management And Data Sharing
- Formal & Informal Multi-Disciplinary Working
- Co-Location where possible and appropriate

Aligned Teams

- Regular Communications With Core Team
- Mostly reacting and responding to referrals



A Healthier Future
Improving health and care in Herts and west Essex

Achievements to Date:

Bernadette Millwood (General Practice Nurse, Primary Care Nurse Tutor ENHCCG & Co-Clinical Director Icknield Primary Care Network

Aspirations for the future

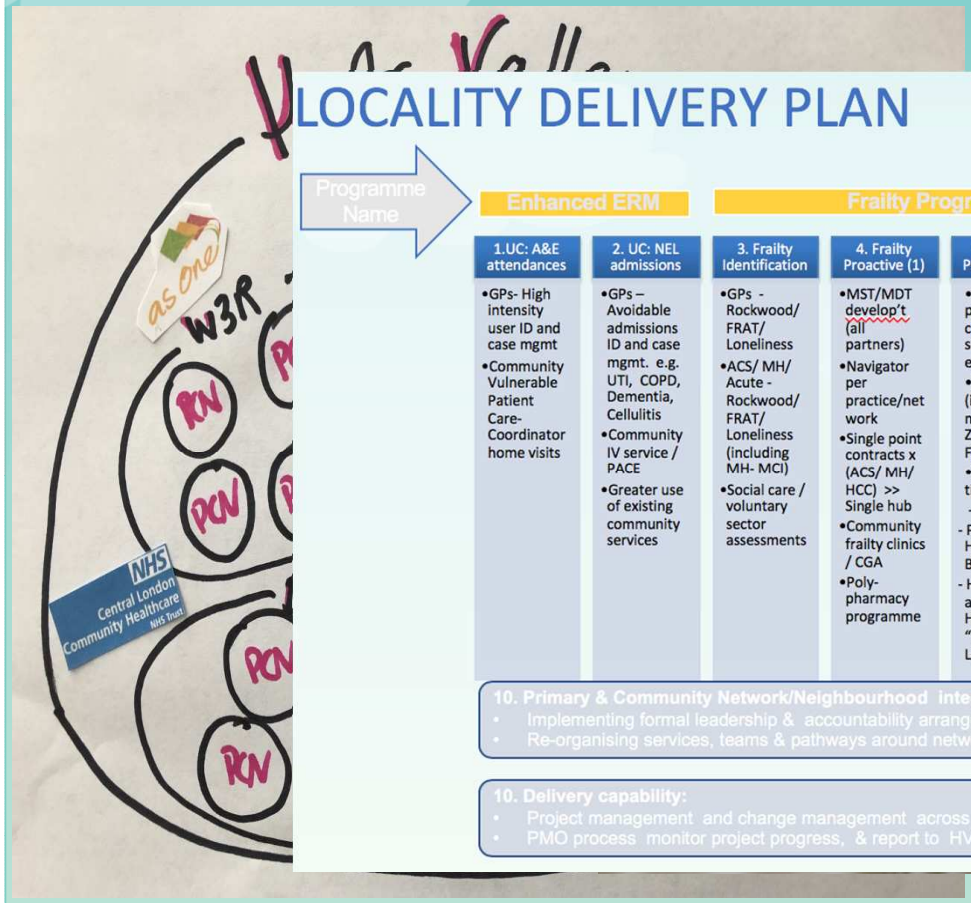
- To provide the PCN population with the **best available health & social care**
- **Sustainability** in General Practice
- **Collaborative working** e.g. Mental Health services e.g. for those under 25 years old
- To create a PCN community that **shares best practice protocols and new ways of working**
- To provide a **well-trained, stable and resilient workforce** by providing **training opportunities**.

How are we doing against these ?

- Currently **integrating** the clinical pharmacists & social prescribers into general practice
- **Reviewing our care home needs** and how best to incorporate skill & expertise of frailty nurses
- Early plans and meetings held regarding **employment of first contact physiotherapists** from April 2020
- **Patient survey** being prepared by Hitchin and Whitwell PCN & Icknield PCN to gather data on the local need for a physio
- Developing a service specification with the CCG to provide a **PCN Spirometry Hub** with the aim of improving the diagnosis of COPD and asthma
- Formed clear and agreed **multi-disciplinary teams with community provider partner** including reviewing estate needs
- Plans to connect with **local voluntary organisations and the local authority** & to include the **PPG representatives** in the planning of our services.

We work well as a single team

- **Commitment** as a single team working together
- **Leadership aspirations** empowering & involving wider colleagues in the work of the PCN
- Attending Leadership conferences & courses in Primary Care NHS England **involving lead nurse colleagues from the PCN.**



LOCALITY DELIVERY PLAN

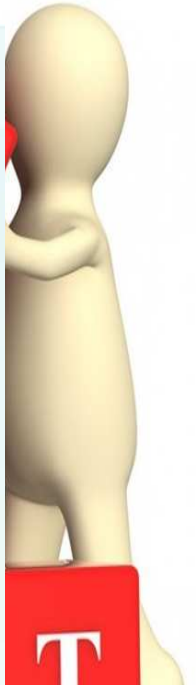
Programme Name

Enhanced ERM		Frailty Programme				Carers	Care Homes	Medicines Mgmt
1.UC: A&E attendances	2. UC: NEL admissions	3. Frailty Identification	4. Frailty Proactive (1)	5. Frailty Proactive (2)	6. Frailty Acute & Emergency	7. Carers	8. Care Homes	9. Medicines Mgmt
•GPs- High intensity user ID and case mgmt •Community Vulnerable Patient Care-Coordinator home visits	•GPs – Avoidable admissions ID and case mgmt. e.g. UTI, COPD, Dementia, Cellulitis •Community IV service / PACE •Greater use of existing community services	•GPs - Rockwood/ FRAT/ Loneliness •ACS/ MH/ Acute - Rockwood/ FRAT/ Loneliness (including MH- MCI) •Social care / voluntary sector assessments	•MST/MDT develop't (all partners) •Navigator per practice/net work •Single point contracts x (ACS/ MH/ HCC) >> Single hub •Community frailty clinics / CGA •Poly-pharmacy programme	•Social prescribing clinics/ services/ events •STP Falls (incl. Pimp my Zimmer); FLS •Personalisation - My Plan - Personal Health Budgets - Holistic adoption of HCC "Connected Lives"	•Acute Frailty units	•Increased identification •Expanded social prescribing & services for carers	•Community Pharmacy reviews in Care Homes •Basic obs by care homes; Video GP consultat'n; OPAT. •Falls prevention initiatives	•Community Pharmacy supporting Care Homes •Community Pharmacy; Domiciliary MURs to reduce stockpiling and better compliance •Medicines optimisation STP programme as applicable

Project Name

10. Primary & Community Network/Neighbourhood integration – to deliver the "place based" care model
- Implementing formal leadership & accountability arrangement between partners, including budget.
- Re-organising services, teams & pathways around networks.

10. Delivery capability:
- Project management and change management across all work streams
- PMO process monitor project progress, & report to HVDB.



What's Next

- NHSE & Improvement PCN Service Specifications
- Support for Local Delivery Board Plans
- Ongoing support in building the emerging network teams
- Integration of services with other providers e.g. Frailty services, Mental Health etc.
- Support to prevent attendances and admissions that can be managed in the community
- Increased use of technology e.g. online consultations

Thank you

A Healthier Future
Improving health and care in Herts and west Essex

Hertfordshire
Integrated Urgent Care Update

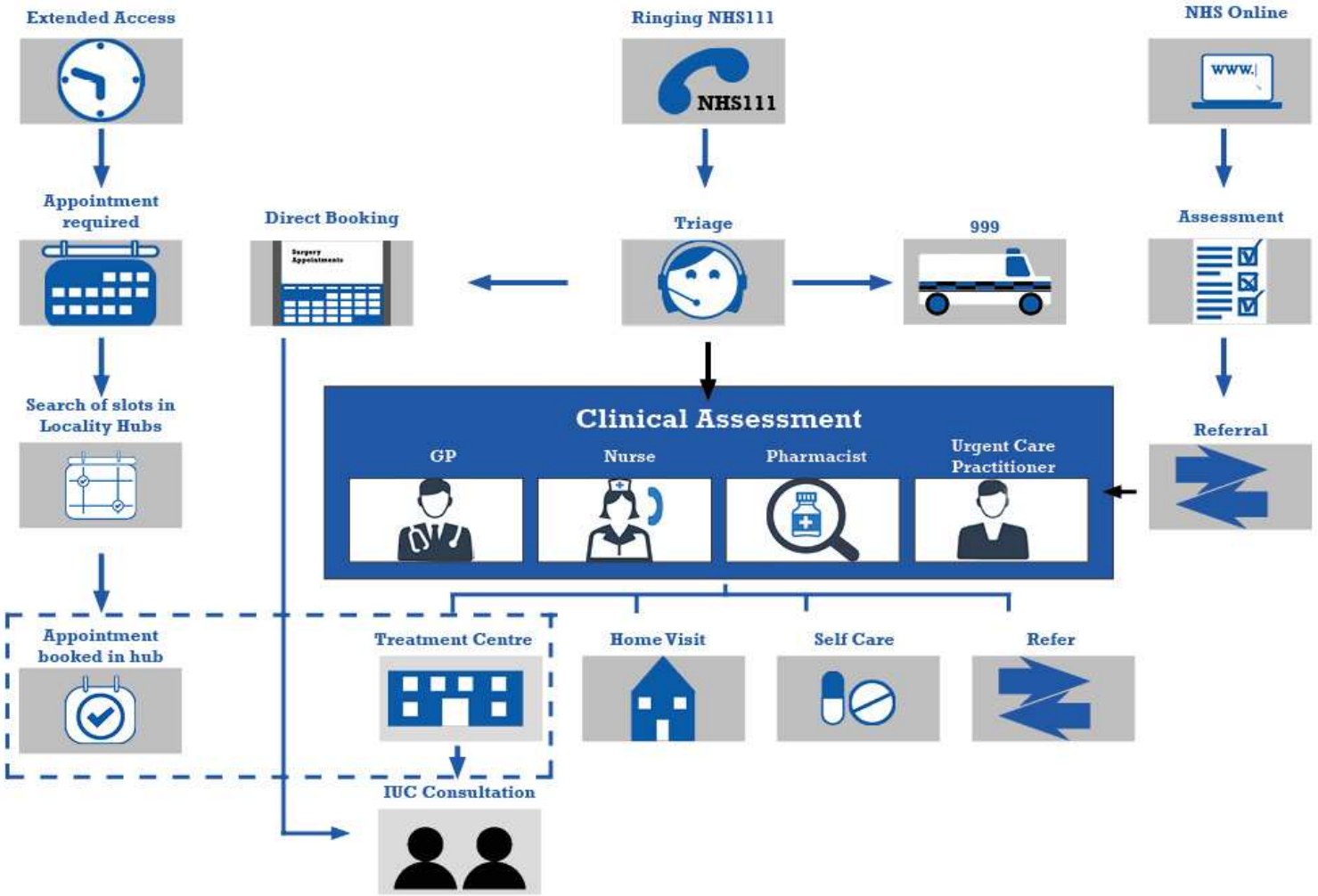
14th January 2020

Putting the patient at the start and heart of our care

Integrated Urgent Care

- Combining Out of Hours Services with NHS 111 and adding in Multi-Specialty Clinical Assessment Service (CAS) and Acute In-Hours Visiting Service (East and North Herts CCG)
- Single, free to call telephone access 24/7
- CAS comprising of:
  - GPs, Nurses, Clinical Advisors, Prescribing Pharmacist, Dental Nurses, Palliative Care Nurses, Paramedics
- Direct booking from NHS111 into IUC Treatment Centres
- Integrated with NHS 111 Online for digital access 24/7
- Home visiting service

Simplified Model



Activity

The following figures are based on average monthly activity:

Hertfordshire	
Calls to 111	31700
Calls to CAS	4500
Calls to OOHs	11500
Advice Calls	4200
PCC Visits	5600
Home Visit	1500
NHS 111 Online	440
Dental	1200

Key Performance Data

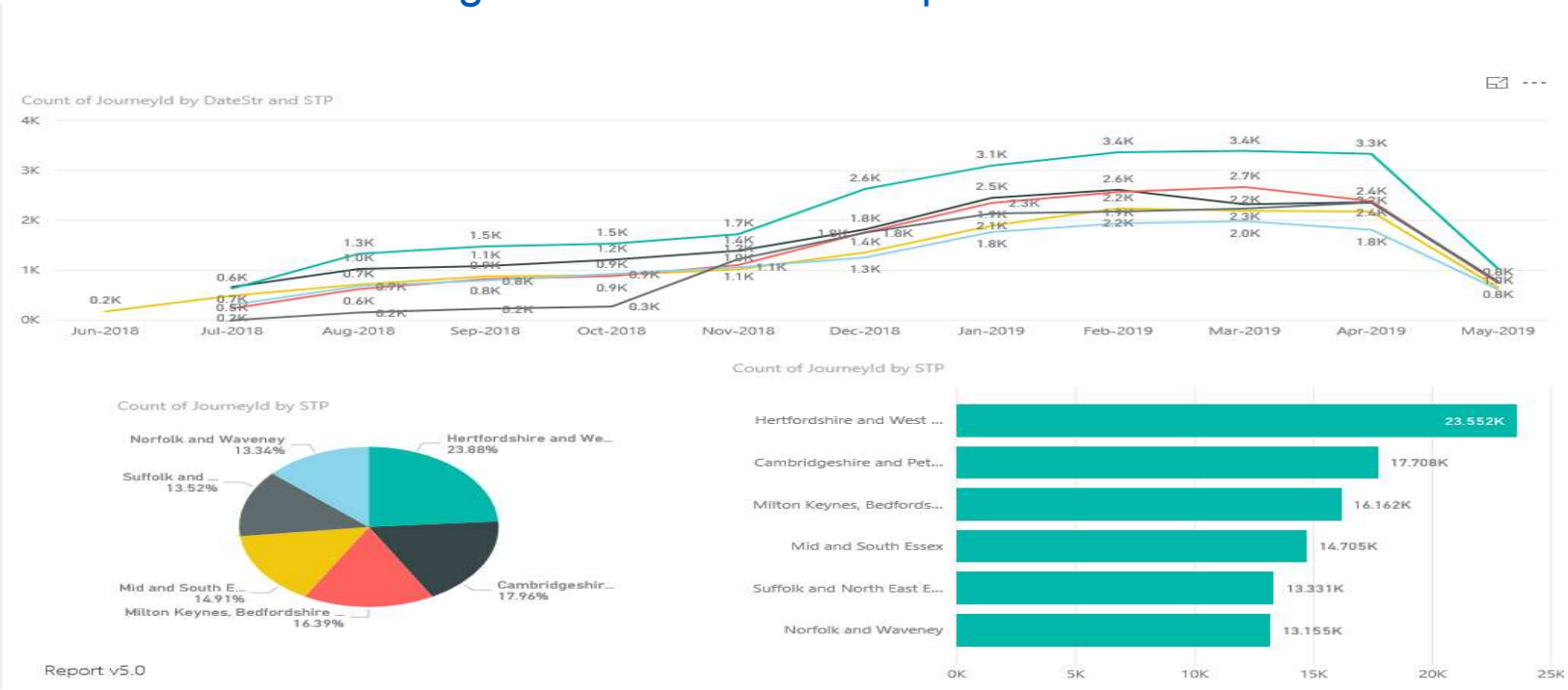
The following table is a summary of key performance metrics that have wider system implications:

	Hertfordshire	National
Time to Answer	33 seconds	35 seconds
CAS Validation of ED	97.5%	40%
CAS Validation of 999 (C3+C4)	98.1%	79%
999 Referral	8.2%	13%
ED Referral	7.5%	9%
Time to triage	14.35 mins	KPI 60 mins
Time for home visit	4.2 hours	KPI 6 hours

Impact of the CAS shows on average (Combined) 89% of Ambulances referrals were managed without referral to EEAST and that 78% of ED referrals into the CAS were managed without further referral.

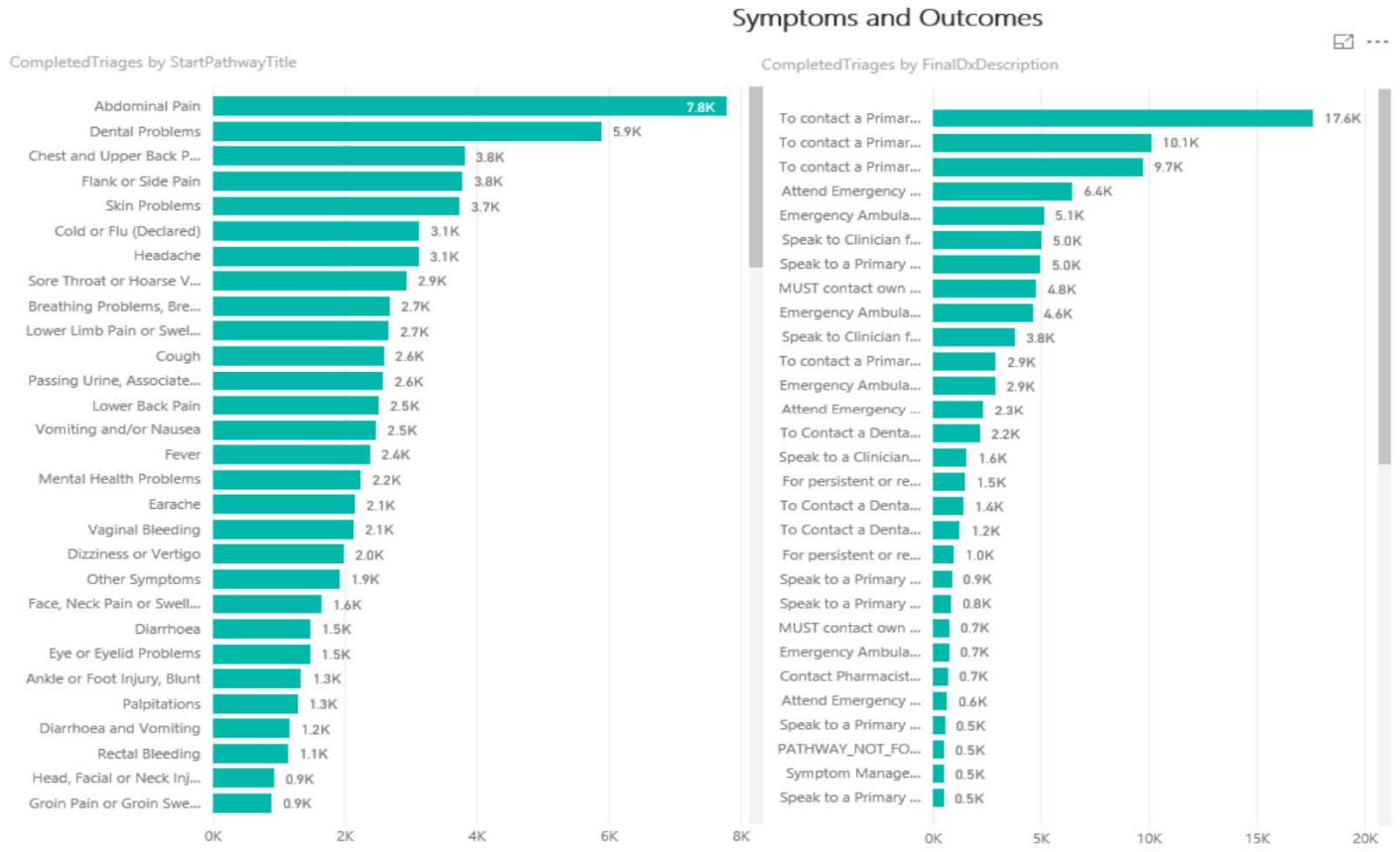
NHS 111 Online Activity

The various charts and histograms illustrate NHS Online activity by STP across the Eastern region from June 18 to April 19



- The majority of activity takes place at weekends and when used during the week the higher period of use is between 18.00 and 20.00
- 10% of triage now taking place on-line, yet no channel shift

Symptoms and Outcomes



Only the Herts IUC CAS nationally is validating online ED and 999 outcomes all other areas direct the patient to call 999 or directly attend ED

Challenges

- Workforce
  - Shrinking clinical workforce prepared to work unsocial hours
  - Change to VTS training removing mandatory 108 hours OOHs
  - High turn over of contact centre staff- ‘call centre culture’
  - Risk of mitigation associated with unplanned care
  - Market forces – multiple service competing for limited workforce
  - Competing services requiring the same clinical workforce
- Acuity of cases and impact on the delivery model
- Level of national scrutiny and performance targets
- Increasing activity and patient expectation
  - National media campaigns
  - NHS 111 Online
  - Volume of patients that need to be seen

Plans and Opportunities

- Remodelling of both OOH elements in light of the impact of the CAS and case acuity
- Development of a regional nurse triage function to manage post 111 triage
- Development of direct pathways from 999 to support EEAST
- Increased integration with Primary Care for the deployment of GP Connect
- Countywide use of NHS111 as EA access facility
- Use of NHS111 as a true single point of access across a wider health and social care services/providers
- Integration and co-location with UTCs and MIU provision
- Increased use of IT to support personalised care provision and streamlined access – Natural Language Processing pilot

Questions and Comments