East and North Herts CCG

**North Herts**
- **12 practices**
- **111,384 patients**
- **£123.9m budget**

**Stort Valley and Villages**
- **9 practices**
- **90,281 patients**
- **£98.7m budget**

**Lower Lea Valley**
- **9 practices**
- **111,067 patients**
- **£117m budget**

**Upper Lea Valley**
- **16 practices**
- **124,635 patients**
- **£121.1m budget**

**Welwyn & Hatfield**
- **9 practices**
- **111,067 patients**
- **£117m budget**

**Main acute trust:** E&N Herts NHS Trust

**Main acute trusts:**
- E&N Herts NHS Trust, PAH, Addenbrookes
- PAH
- Barnet & Chase Farm, PAH

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**Health and Wellbeing Board priorities**

**Healthy Living**
- Reducing the harm caused by alcohol
- Reducing the harm from tobacco
- Promoting healthy weight and increasing physical activity

**Promoting Independence**
- Fulfilling lives for people with learning disabilities
- Living well with dementia
- Enhancing quality of life for people with long term conditions

**Flourishing Communities**
- Supporting carers to care
- Helping all families to thrive
- Improving mental health and emotional wellbeing
Home First is now successfully implemented!

- Proactive and improved case management
- Integrated health and social care
- 1,121 patients seen

What do patients say about HomeFirst?

- 89% respondents felt they were actively involved in the decision about their care
- All HomeFirst clients who responded to the patient experience questionnaire felt they were treated with dignity and respect
- 99% respondents had confidence in HomeFirst team

The way forward.... HomeFirst Plus

- HomeFirst Pharmacy
- End of Life

Lower Lea Valley is establishing and forging new working relationships with Royal Free and Barnet & Chase Farm colleagues. Now working together to review existing and new clinical pathways.

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**Childhood obesity project**

**Target Group**
Tackling childhood obesity by inviting those children (4-5 year olds and 10-11 year olds) who have been identified as being overweight through the National Child Measurement Programme to attend healthy lifestyle review clinics at their GP Practice.

**Engagement:**
8 Lower Lea Valley practices in partnership with Upper Lea Valley

All practices have obesity leads

**Partnership working:**
Children’s Centres, Public Health, School Nurses, Primary Care, Upper Lea Valley, Broxbourne Council and MEND (Mind, Exercise, Nutrition and Do-it!).

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**Key Health Priorities**
1. Tackling childhood obesity (and obesity in general)
2. End of life care
3. HomeFirst (integrated health and social care)

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**Key Aims**
- Reduce health inequalities
- Improve health outcomes
- Enhance partnership working

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**Local Challenges**
- Diverse population (cultural and socio-economic)
- Geography (urban fringe north London)
Stort Valley and Villages

The old way....
Access and patient satisfaction problems

- Long waits for appointments lead to high rates of non-attendance
- Seeing any GP/locum = poor continuity, repeat booking

The new way....

- Calls are allocated to GPs (allowing patients to choose which GP they would like to talk to)
- GP phones patient
- Come in and see preferred GP
- 70%
- 30%
- 60%
- 10%
- 20%
- 10%
- 70%
- Problem solved

- Problem solved
- Admin question
- Reception takes call
- Reception takes call
- Come in and see nurse
- Come in and see nurse
- 10%
- 20%
- 70%
- 30%
- 60%
- 10%
- 70%
- Problem solved

Dedicated in-practice pharmacist

- 1 session a week in each practice
- Improved repeat prescribing and dispensing processes
- Advised on medicine interactions
- Reduced wastage on appliance prescribing
- Role paid for itself in 4 months

Financial success + hardworking locality team = better patient care

Ask us about our winter bids and Productive General Practice model

Reduced locality prescribing costs by £77,400 (ytd)

Locality priorities:
Improved access to GP services; long term conditions and end of life care; cancer and dementia

Sorry, all today's appointments are full. Please call back tomorrow.

Average wait to see a GP down from 5-7 days to same day

From £1.8m overspend in 2011/12 to £300k underspend in 2012/13
Meet the locality team…

• **Steve Kite** (The Maltings, Ware) – Chairman
• **Nicky Williams** (Church Street, Ware) – Co-Chair
• **Mark Andrews** (The Limes, Hoddesdon) – Co-Chair
• **Martyn Davies** (Dolphin House, Ware) – Locality long term conditions lead and CCG COPD lead
• **Jay Kuruvatti** (Wallace House, Hertford) – Mental Health lead
• **Nick Condon** (Park Lane, Broxbourne) – Prescribing lead
• **Funmi Subair** (Hanscombe House, Hertford) – Patient participation lead
• **Gerry McCabe** (Wallace House, Hertford) – CCG diabetes lead
• **Jawad Shahzad** (Ware Road, Hertford) – Leg ulcer lead
• **Lucy Eldon** (Church Street, Ware) – Practice nurse lead
• **Jill O’Brien** (Dolphin House, Ware) – Practice manager representative
• **Tracey Waterfall** – CCG locality manager

### Practice nurse development
Lucy Eldon has been co-ordinating practice nurse development and covered the following topics:

- Smoking cessation and brief intervention training on chlamydia
- Needs of the young person - Youth Connexions
- Clinical supervision meetings
- Holistic and wound assessment
- Pulmonary rehab
- Inhaler devices workshop
- Training on the ‘Desmond’ and ‘Dafne’ diabetic courses
- Heart failure diagnosis and treatment with Clare Young, cardiac specialist nurse.
- Antibiotic update from prescribing team

### Future projects
- **Healthier Communities** – Carer leads and training from Carers in Herts
- **Challenge Fund** - Transforming primary care GP services (extended opening hours, 8am-8pm, seven days a week).
- **Enhanced Residential Nursing Home Management**
- **Developing leg ulcer service**

Upper Lea Valley has best A&E rate in CCG area, but elective referrals still present a challenge

### A&E rate per 1000 weighted population

<table>
<thead>
<tr>
<th></th>
<th>Weighted rate per 1000 population</th>
<th>Rank 1 = lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Lea Valley</td>
<td>238.2</td>
<td>1</td>
</tr>
<tr>
<td>Lower Lea Valley</td>
<td>242.2</td>
<td>2</td>
</tr>
<tr>
<td>Stort Valley &amp; Villages</td>
<td>242.6</td>
<td>3</td>
</tr>
<tr>
<td>North Herts</td>
<td>249.6</td>
<td>4</td>
</tr>
<tr>
<td>Welwyn Hatfield</td>
<td>286.9</td>
<td>5</td>
</tr>
<tr>
<td>Stevenage</td>
<td>318.3</td>
<td>6</td>
</tr>
<tr>
<td>CCG total</td>
<td>264.3</td>
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</table>

**Upper Lea Valley** has best A&E rate in CCG area, but elective referrals still present a challenge.

**Patient representatives from Upper Lea Valley are involved in:**

- Patient Network (Quality)
- Unscheduled Care Programme Board
- NHS 111 visits
- Acting as patient ambassadors for other practices who wish to set up a PPG
New QEII Hospital: On schedule to open in spring 2015

Welwyn Hatfield locality GPs are key members of the QEII development group, ensuring clinical leadership in the commissioning of the urgent care and elective services at the new hospital.

Collaborative working with Public Health to improve patient outcomes. At Q3, Welwyn and Hatfield smoking quit rates were top of the CCG area, including referrals from GPs and pharmacies. Q3 quitter rates for GP referral alone were at 244, which has Welwyn and Hatfield positioned 2nd across the localities behind Upper Lea Valley at 334.

Key health priorities
1. Supporting the frail elderly
2. Pre-operative healthy weight / healthy lifestyles
3. End of life care in heart failure

Key aims
1. Reduce health inequalities
2. Improve health outcomes
3. Enhance partnership working

Who are we?

Chairs: Dr John Constable and Dr Hari Pathmanathan
Long Term Conditions lead – Dr Sarah Hoole
Mental Health lead – Barbara Hannock
Prescribing lead – Dr John Constable
Patient Group lead – Dr Peter Wilson
Council liaison – Dr Richard Lavelle
Cancer lead – Dr Sachin Gupta
Patient group – Dr Sachin Gupta

Spring House Medical Centre

The ‘Federated Model’ in action: Spring House offers GP and walk-in services from 8am – 8pm. Organised by 8 GP practices in Welwyn and Hatfield, Spring House is helping to improve patient access and reducing A&E admissions.
Our winter pressures project started on 3rd February. Two additional GPs provided by Canterbury Way Surgery support all GP surgeries in Stevenage, seeing patients who ring for an emergency appointment. This frees up more time for practice GPs to focus on managing their patients with long term conditions. GPs are also doing rounds in some local care homes on a daily basis. We believe that this will help to pick up winter-related illnesses early and prevent patients with chronic conditions getting suddenly worse and being admitted to hospital.

The Canterbury Way Surgery is responsible for clinical and information governance, administration, finance, clinical quality and other statutory and mandatory requirements related to this service.

**Acute In-Hours Home Visiting Service**

Frees GP time to manage their practice populations in a more innovative way.

- **Patient phones surgery and asks for a home visit**
  - Telephone clinical triage by practice GP within 30 minutes
  - If GP decides a home visit is needed, he/she refers the case to AIHVS

- **Summary of visit sent electronically to the practice within 2 hours**
  - AIHVS visits patient at home or in care home
  - Very urgent (seen within 2 hours)
  - Less urgent (seen within 6 hours)
  - GP practice sends patient’s clinical summary to AIHVS

Stevenage has the highest A&E admissions for minor issues that could easily have been treated in primary care. More GP availability could lead to a reduction in unnecessary A&E attendance.

We are keeping a close eye on any HCT issues you raise with us and agreeing actions to solve problems.

We’re working with partners to make Stevenage the county’s first carer-friendly community.

We are working with East and North Herts NHS Trust on the changes to the Emergency Department at the Lister, which will be complete in October 2014.
12 GP practices; one each in Ashwell Baldock, Knebworth, Whitwell and four each in Hitchin and Letchworth.

The Knebworth practice has a branch surgery in Stevenage, and Ashwell Surgery has a branch surgery in Bassingbourne (Cambridgeshire). Two Letchworth practices also have some patients who live in Bedfordshire.

Our locality priorities are:
• GP surgeries
• End of life care
• Mortality/morbidity figures

Winter pressures project
The CCG is paying for additional weekend clinics provided by Herts Urgent Care (HUC) in practices to prevent people having to travel to the Lister site.

Discharge audit
Ensuring that people are discharged from hospital with the right notes and medication, and the correct treatments coded, to ensure continuity of care with their GP practice and accurate charging.

Good use of contracts hotline
North Herts consistently sends more reports to the hotline than other localities. Practices are encouraged to report contract and quality issues this way.

Telehealth pilot scheme
For patients with COPD – members of one practice’s patient participation group have installed equipment in patients’ homes as part of the project.

Hotline number: 07786 625043

Coming soon!
HomeFirst pilot to be extended to North Herts
Making patient partnership a reality

More than 70 patients and carers have joined Locality Patient Commissioning Groups and a patient network for quality, using their experiences to improve all aspects of health services for everyone in the area.

How do these groups help GPs?

- Sit round the table with GPs and managers, being listened to and working together as equal partners;
- Provide information from their own surgeries to promote good practice in their locality;
- Comment on reports, care pathways and information leaflets;
- Visit hospitals and community services, talking to patients, carers and visitors to monitor quality and assess the patient experience;
- Put time and effort into contributing their perspectives in committee meetings and workshops.

All give their time for free

60% of GP practices have Patient Participation Groups which send representatives to attend Locality Patient Commissioning Group meetings.

Dr Nicky Williams
GP, Church Street Surgery, Ware

"We have some excellent patient members involved in the day to day monitoring of services as well as influencing new projects. Working together, patients and clinicians can make positive changes towards improving the quality of local services."

Martin Connolly, Patient member, Potterells Surgery, Brookman’s Park

"To meet our needs, our NHS wants to listen and care for us as patients. Now is the time to get involved, don’t be fringe patients, it’s rewarding and will make a difference."

If you are one of the 40% not yet signed up to give your support, please encourage your surgery to become involved
Quality

Key achievements

- Incidents and serious incidents
- Mortality data e.g. Hospital Standardised Mortality Ratios
- Quality assurance visits to all main providers
- Falls
- Pressure ulcers
- Infection Control
- Safeguarding

Safety

Key achievements

- Establishment of C diff task and finish group led by newly appointed Head of Infection Control, also has input from a GP clinical lead
- Critique approximately 24 serious incident investigation reports from provider organisations per month; ongoing management of approximately 50 cases per month

Effectiveness

Key achievements

- NICE guidance
- Clinical Audit
- Patient Reported Outcome Measures (PROMs)

Experience

Key achievements

- Patient surveys
- Complaints
- MP enquiries
- Soft intelligence e.g. GP Hotline
- Ensuring patient voice is clearly heard in quality monitoring and helps inform decision making

Julie’s is a key new role. Her focus is on improving care in the independent sector, including care homes and primary care. The wider team now also benefits from a medical advisor and a designated adult safeguarding lead.
### Urgent Care Programme Board: Benefits map

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Projects</th>
<th>Outcomes</th>
<th>Benefits</th>
<th>Strategic Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute medicine pathways (non-elective) Telephone triage for GPs</td>
<td>Pathway – discharge to assess</td>
<td>Activity levels and costs match predictions</td>
<td>Reduced emergency admissions for over 75s</td>
<td>Consistent high quality patient experience</td>
</tr>
<tr>
<td>Secondment from acute trust supporting winter pressures &amp; patient pathways</td>
<td>Urgent Care centre, Lister Emergency department</td>
<td>Consistent and standardised process eliminating duplications</td>
<td>Financial sustainability</td>
<td>Right care, right time, irrespective of place</td>
</tr>
<tr>
<td>Ambulatory Care pathways for emergency presentations</td>
<td>Re-procurement of Cheshunt Minor Injuries Unit</td>
<td>Integrated pathways in place</td>
<td>Reduce length of stay</td>
<td>Empowering self-management</td>
</tr>
<tr>
<td>Ambulance expertise in CCG</td>
<td>Ambulatory Care pathways for emergency presentations</td>
<td>Rapid access diagnostics and treatment</td>
<td>Reduce 30 day re-admissions</td>
<td>Controlled costs</td>
</tr>
<tr>
<td>System wide urgent care network</td>
<td>New QEII local A&amp;E Rapid assessment unit / Ambulatory emergency care</td>
<td>Rapid appropriate access to specialist opinion across health and social care</td>
<td>Fewer inappropriate presentations</td>
<td>Co-ordinated and personalised service linked to planned care</td>
</tr>
<tr>
<td>Unscheduled Care strategy</td>
<td>Re-procuring Out of Hours and NHS 111</td>
<td>Redesigned job roles to meet 7 day working</td>
<td>Improved patient experience</td>
<td>Accessibility: equal and appropriate for all users</td>
</tr>
<tr>
<td>Urgent Care dashboard</td>
<td></td>
<td>Clearer navigation and signposting</td>
<td>Improved clinical outcomes</td>
<td>Improving health and social care outcomes (NHS Outcomes framework)</td>
</tr>
<tr>
<td>Cross working with Planned Care Board, Partnership &amp; Out of Hospital Board</td>
<td></td>
<td>Urgent Care Centre developed with pathways</td>
<td>Improved staff satisfaction through integrated working</td>
<td>Effective strategic and operational clinical leadership</td>
</tr>
</tbody>
</table>

**CALL 111**

NHS 111 makes it easy for Hertfordshire patients to access urgent healthcare services. By calling one free, memorable number, patients get straight through to highly trained call handlers who assess their symptoms and direct them to the right service for their needs, or give self-care advice where that’s the best thing to do.

Unlike some areas of the country, the 111 service in Hertfordshire has been particularly successful because of the strong clinical and managerial leadership since the pilot began in October 2012.

The service continues to work well – including reducing pressure on A&E services during these colder months – and is providing vital information to the CCG about how urgent care services are being used.

**CCG Associate Director:**
Denise Boardman

**Chair:**
Mark Andrews

**Clinical Champion:**
Vishen Ramkisson
All localities have reported an **increased workload from care homes** over and above the standard GP contract.

Often, care homes are looked after by more than one GP practice, all with their different ways of doing things, leading to difficulties for the home and potential continuity of care issues. We are also seeing a rise in the number of emergency short stay hospital admissions from care homes. In 2012/13 there were 2,300+.

The Programme Board has supported the development of a new model, with locality devolved budgets, to match care homes with just one practice. Proposals have been welcomed by the Herts Care Homes Providers Association.

From Spring 2013, this aims to improve the way that care homes, GPs and pharmacists work together and to reduce the number of unnecessary admissions to hospital through better, more targeted falls prevention work.
The Welwyn Hatfield locality identified a need to review services for their heart failure patients. The locality spent 3 months working with multi-disciplinary teams including acute consultants, specialist nurses and the palliative care team. The project is overseen by the Planned Care Programme Board.

They looked at the safety, quality and financial viability of a revised heart failure pathway. When the pathway is signed off it will form part of contract agreements with providers enabling us to make sure it is being implemented correctly. The locality and the programme board are looking forward to utilising the new pathway, once it has been agreed at the end of February.
Broxbourne has the highest prevalence of childhood obesity in the CCG area: 13.4% of four and five year olds are obese, where the regional average is 8.7%, and 17.4% of ten and eleven year olds, where the regional average is 17.2%.

Healthcare professionals are not always clear about what services to signpost overweight patients to, and a lack of services to support local families was reported.

To tackle this problem, obesity has been identified as a priority by Lower and Upper Lea Valley localities. A project to commission a service with Broxbourne Council was developed, with families of obese children initially offered a ‘healthy lifestyle review’ by GP practices.

Partnership working between the council, public health, midwives, health visitors, children’s centres and schools will enhance the support offered to residents to manage their weight. The programme board has helped to develop the project and will assess its efficacy.