Working together for better health and care

NHS Thurrock Clinical Commissioning Group

Agenda Item 8:

Board Meeting
PART 1
27 April 2016

Title of Report:	**Report of the Director of Public Health - Public Health Update**	
Board Sponsor:	Ian Wake, Director of Public Health	
Prepared by :	Emma Sanford – Strategic Lead, Health and Social Care Public Health	
Committees previous consulted:		
Executive Summary:	The purpose of this report is to provide an update to the CCG Board on work undertaken by the Thurrock Public Health Team on behalf of the CCG in support of our aspiration to be recognised for delivering the highest quality 'Public Health Core Offer' to a CCG in England.	
Financial / Resource Implications:		
Fit with CCG strategy/objectives:		
Risks identified / Outcome / Link to BAF:		**BAF Ref:**
Actions Required:		**When By:**
Recommendation to the Committee:	That the Thurrock CCG Board notes the contents of this report and continues to collaborate closely with Public Health staff in order to facilitate delivery of the core offer.	

* Delete as appropriate

1. An Integrated Data Set

1.1 The aim is to have one data set across health, social care, and other community based services that links patients data based on NHS number. This will be for the benefit of patients, care givers and commissioners ensuring that patients get the best possible care/help/support when they need it.

1.2 The project has been agreed by the Integrated Commissioning Executive and is a commitment within the CCG's Operational Plan, BCF, and Health and Well Being strategy.

1.3 We are currently in a phase of market testing, and had positive demonstrations from two potential suppliers on 13th April. We have two more potential suppliers that we are trying to arrange demonstrations with.

1.4 Engagement with NELFT and BTUH suggests that they are also keen to support a solution.

1.5 Next steps include finalising the specification and signing off of a memorandum of understanding between the CCG and Thurrock UA in order that Thurrock can initiate a procurement process on everyone's behalf.

1.6 We currently expect to have a solution commissioned and be in an implementation phase in September.

2. BCF proposal – Falls

2.1 Analysis has shown that a reduction in the number of falls in the 65 plus population of only 10% would save the Health and social care system between £440 K, and £732 K per year. (Acute Hospital Savings £330 K to £550 K).

2.2 The proposed new falls service has been scoped using NICE recommendations and looking at the successful service operating in Basildon and Brentwood.

2.3 Costs of delivering the service were estimated at around £152 K, funding was requested and agreed at ICE in order that we pilot a service for 12 months (plus a 3 month lead in and a 3 month evaluation).

2.4 Since this was agreed a meeting has taken place with NICE who have agreed to look at the paper and move forward to provide a service.

2.5 Next steps are to formalise an outcomes framework and a specification and then to start a recruitment process for various posts.

3. BCF proposal – Hypertension detection

3.1 Analysis has shown that improving the detection of hypertension by 10% and ensuring that management of Hypertension and AF is improved to be in line with the top 20% of practice performance nationally, would prevent around 70 strokes per year in Thurrock. This would result in savings to the NHS of around £770K and savings to Adult Social Care of £660K over a three year period in addition to the obvious public health gain to the population of Thurrock.

3.2 £100 K was requested at ICE for the delivery of a number of pilots aimed at improving our detection of hypertension. The aim is to identify c 5,000 additional patients over a period of three years. Funding was ear-marked subject to CCG QIPP approval.

3.3 QIPP approved on 14th April with the proviso that there be clinical input and a slight revision of funding may need to be included (suggested GP incentive payments may currently be estimated as too low), which will be included as a revision before the next review at ICE. Feedback from clinicians at QIPP was very positive and there was a volunteer for clinical lead.

3.4 Suggested schemes include, more effectively targeting Health Checks, the Introduction of Senior Health Checks, and GP and Pharmacist incentive schemes.

3.5 A Systm One report has already been written by the CCG which identifies 1000s of patients whose last BP measurement was high but who then received no follow-up / treatment. It is thought that this query might help GPs to identify patients who need a review within their own schemes.

3.6 Next steps are to secure the funding for this at the next ICE meeting before any further work towards implementation can commence.

4. Data Portal

4.1 Creation of a Thurrock Data Portal was agreed by the Council's Directors Board in November 2015. Following this, an amount of research into potential solutions and discussions with various partners and future users has taken place to understand requirements. A draft service specification has now been developed, specifying at a high level what the final solution should be able to deliver, taking into account the existing research and consultation work done. This draft service specification is tabled for discussion at the Council's Digital Board on 27th April to agree the high-level requirements and approve the specification for procurement.

4.2 Dependent on Digital Board approval, draft timescales estimate that this could be ready for procurement in approximately one month's time, with a supplier appointed by July and a beta product available around November.

5. Health and Social Care PH programme manager posts

5.1 The DPH is about to go out to consultation on a new structure for the Public Health team. The revised structure includes two new posts to support the development of Primary Care. The posts will be managed by the Strategic Lead for Health and Social Care PH but it is envisaged that they will spend most of their time in the CCG with the Primary care facilitators and as a resource to assist GP practices to implement recommendations of JSNA Public Health Product Analyses relating to the core offer. As such they will help improve quality across the Health and Social Care system. Their work programme will be determined jointly by the outcomes of the work of that the rest of the HSCPH team and Primary Care development team within the CCG.

5.2 We hope that these posts will help to improve the quality of primary care, particularly in the areas of Long Term Condition identification and management and avoidable A&E attendances.

6. Health and Well-being strategy Outcomes framework

6.1 Public Health have been leading on collating baseline data and modelling potential targets for the outcomes framework underpinning the new Health and Wellbeing Strategy 2016-21. This is being done in collaboration with a number of internal and external colleagues – both analysts and the overall objective owners to ensure the proposed targets are both stretching and achievable.

6.2 Overall there are 53 indicators across the five goals, and so far the majority of these have either got baseline information recorded, or plans in place to obtain the baseline data along with setting the 2021 targets.

6.3 There are several indicators that require input and support from the CCG for both baseline and target information, as well as a short piece of commentary text to fully define each indicator (an information request has been received by the CCG to support with this):

- % of patients on a GP depression QOF register with a record of accessing IAPT
- % of people who recover after IAPT treatment
- % of patients with a CVD or COPD, and without a diagnosis of depression, screened for depression in the last 24 months using a standardised tool.
- Number of IHLCs that are operational (with plans agreed for the remaining 2 hubs)
- Number of IHLCs with plans agreed by all partners.
- 2% highest risk frail elderly in Thurrock with a care plan and named accountable professional
- % of GP practices with CQC rating of at least good
- Unplanned care admission rate for conditions amenable to healthcare.
- % of patients who would recommend their GP practice to someone new in the area [baseline information known, support required with establishing a target]
- % of days in the year when hospital is on Black Alert [baseline information known, support required with establishing a target

6.4 A summary position statement highlighting progress against establishing baselines and targets for all strategy indicators is due for presentation to the Health and Wellbeing Executive Committee on 20th May, with the final framework due for presentation to them on 17th June. The final framework, complete with all baselines and targets, will then be presented to the Health and Wellbeing Board on 14th July, along with an overview of key actions to be taken against each objective to address the performance.

6.5 The Health and Wellbeing Executive Committee agreed that they would monitor performance on the outcomes framework four times a year, with the Health and Wellbeing Board reviewing it twice a year.

7. Public Health Service Plan

7.1 The new Public Health Service plan outlining priority projects for 2016-17 has been developed. A copy of the new service plan is attached to this report. Key elements of the plan that support delivery of the Public Health 'Core Offer' for the CCG include:

7.2 Integrate the commissioning and delivery of 0 to19 services
Develop and agree a new commissioning and delivery model the 0-19 care pathway to create new Family Centres for Thurrock that encompass current 0 to 19 services commissioned by Public Health, Children's Services and NHS Thurrock CCG in line with local need and evidence of best practice.

7.3 Improve the commissioning and integration of mental ill-heath and care services. Lead Development of a Mental Health Joint Strategy Needs Assessment Product for Thurrock in association with key partners and the PH Informatics Team

7.4 Identification and Treatment of Undiagnosed Depression
Improve the identification and treatment of depression in older people with co-mordid physical long term conditions by implementing a depression screening and treatment referral programme (in line with objective C4. of the Health and Wellbeing Strategy

7.5 Secondary Prevention of Diabetes
Support delivery of the Thurrock Pre-diabetes identification and treatment programme

7.6 ***Improving the capability of Primary Care to Manage Long Term Conditions.*** Develop a Long Term Conditions Performance Score Card for Primary Care that assists and encourages GP practices to improve their identification and management patients with cardio-vascular disease, diabetes, and respiratory disease (in line with Health and Wellbeing Strategy Objective E3).

7.7 ***Prevention of Stroke and other serious Cardio-Vascular Disease***
Commission/implement a programme that improve the identification and treatment of patients with Hypertension in order to prevent more serious cardio-vascular disease and deliver QIPP and ASC savings through demand management

7.8 ***Prevention of Falls in Older People***
Support commissioning/implantation of an Integrated Falls Prevention Programme in conjunction with NHS Thurrock CCG, through the BCF in order to reduce falls in older people, reduce unplanned care admissions as a result of falls and reduce demand on CCG and ASC budgets

7.9 ***Improved Uptake of Cancer Screening***
Significantly improve the uptake of breast, bowel and cervical cancer screening programmes, through a range of social marketing and communications activity, with a focus on deprived communities.

7.10 ***Integrated Healthy Living Centres***
Continue to provide Public Health support and leadership to deliver four new Integrated Healthy Living Centres in Thurrock bringing together services that tackle the wider determinants of health, improve community connectivity and strengthen community resilience, reduce health damaging behaviour and deliver primary prevention programmes, improve and integrate physical and mental health services and reduce depression, deliver world class primary care, integrate health and social care, provide diagnostics locally and bring hospital services into the community

7.11 ***Improve Primary Care in Thurrock***
Provide additional Public Health support and capacity to GP practices in order to assist them to deliver the programmes set out in this Service Plan

7.12 ***Data Observatory***
Establish a web based outward facing Data Observatory for Thurrock containing commissioning intelligence, performance data, and a national evidence base that can be used by all parts of the Council, CCG and third sector, and creates “a single version of the truth”.

7.13 ***Integration of Health and Social Care records at Patient Level***
Establish a data system linking records from primary, secondary, community, mental health and adult social care in line with Objective D2. of the Health and Wellbeing Strategy

7.14 ***Influencing the health and care system***
Activity to work across and influence the health and care system to ensure a focus and shift towards prevention and early intervention – e.g. via Essex Success Regime, partnership working with CCG, Better Care Fund Plan, relationship building with the voluntary and community sector to provide alternatives to traditional services

8. National diabetes prevention programme

8.1 We are currently in a mini-procurement phase. Essex CC are leading on this.

8.2 When a contract has been awarded we are committed to refer 500-600 patients for the intervention.

8.3 Work to construct Systm One queries to help support this work has commenced.