1. The “Health Pyramid”

1.1 The Topic Group held a number of workshop sessions on 26/27 April 2007 from which they agreed to develop their work programme around the following health pyramid, which is reproduced with acknowledgements to Dr. Steve Laitner who presented the concept at the workshop:

```
PUBLIC HEALTH
  (Health Promotion, Vaccination, Screening...)

INTERMEDIATE CARE
  (Home/ NH/ C. Hosp)

INTERFACE
  (CASS/ CATS) and Urgent Care Centre

PRIMARY CARE
  (GP surgery, dentist, optometrists, minor injuries

TRIAGE
  (Assessment of health needs, telephone or “face to face”)

SELF-CARE
  (Home or “Over the Counter” remedies)

PUBLIC HEALTH
  (Health Promotion, Vaccination, Screening...)
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1.2 The following diagram is an illustration of this concept or a “Sore throat”

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Example - “Sore Throat”

PUBLIC HEALTH - healthy eating, exercise, sleep, sensible drinking, smoking prevention, smoking cessation

SELF-CARE – rest, fluids, temperature control, analgesia/ antipyretics,

TRIAGE – severity of symptoms, associated symptoms, medical history, need for face to face assessment

PRIMARY CARE - examination, tests, prescription

INTERFACE – in recurrent sore throat assessment of need for tonsillectomy

INTERMEDIATE CARE - IV antibiotics at home, need for carer support

SECONDARY CARE – surgery
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Dr S Laitner 2007
2. Public Health

2.1 The Group’s investigation began with a presentation on public health issues as part of its series of workshops on 26/27 April 2007. Whilst not part of the DQHC consultation proposals, the Group considered it important to include this aspect of the health service as part of their early deliberations as good health prevention measures will in the long term release more resources to improve other health services within the County.

2.2 The presentation was based on statistics from 2005 and demonstrated that whilst generally the health of Hertfordshire’s residents is generally good and above average compared to other parts of England, there are localities where the instances of certain types of health problems fall below the national average. One example of this is shown in the following graph relating to West Hertfordshire:

2.3 Other examples could be provided to demonstrate the need for public authorities within Hertfordshire to work closely together to tackle the causes of health inequalities. Whilst there is evidence of this, particularly through the Healthy Communities & Older People block of the Local Area Agreement (LAA), it will take time to resolve some of the pockets of ill-health within the County. It is therefore important that systems are in place to provide a co-ordinate use of resources to tackle the treatment of these problems.

2.4 There are also pressures for resources within the health economy caused by the demography of Hertfordshire. An example of this is the proportion of pensioners who remain residents in households in different parts of the county. The first graph on the next page shows that in some districts the proportion is well above average, thus reducing the pressure for beds at an early stage but requiring more intensive and expensive support when eventually taken into social care. In other areas there is a below average percentage of pensioners in households utilising resources which could be used elsewhere in the social care and health services.

2.5 At the same time the second graph on the following page shows an above average level of mortalities from accidents amongst those over 65 and that one the following page of mortalities from fractured femur.
Mortality from Accidents (SMR with 95% CI) in Hertfordshire 2003-05 Pooled, Ages 65+

Source: National Statistics, Compendium of Clinical and Health Indicators 2003 (Final Release 04/05)
2.6 There are a large number of initiatives that could be undertaken to improve the health and general wellbeing of Hertfordshire's residents. Acknowledgement has already been made of the contribution that the Healthy Communities & Older People block of the Local Area Agreement (LAA) will make in establishing targets to achieve this. More information on the LAA can be found on Hertslink:

www.hertslink.org/hertfordshireforward

2.8 Amongst a myriad of possible initiatives, more could be done with schools to help reduce childhood obesity, with district councils to provide and promote access to leisure and sports services etc. The list could be endless but it is important that resources are prioritised

2.9 These examples used in the graphs above and on the previous page simply underline the need for a properly co-ordinated approach to preventative and treatment services as envisaged within both the IIYH and IIYMH strategies. This is important so that resources are targeted in the most effective manner across the whole of the social care and health economies. In this respect the joint appointment by the Health and Adult Care Services of an Assistant Director of Commissioning is welcomed.

Finding 6
The joint appointment by the Health and Adult Care Services of an Assistant Director of Commissioning is a positive move towards ensuring resources are targeted in the most effective manner across the social care and health economies.

2.10 The table on the next page details the underpinning factors, causes of ill health and actions that could be taken to mitigate against these. Members of the Topic Group were reassured during the April 07 workshop that the plans for the future will begin to address some of these issues. One of the determinates for the success of future public health strategies will be the ability to move resources from the acute sector into prevention and primary/community health & social care.
2.11 The Health Scrutiny Committee has an important role to play in monitoring the future development of public health services throughout Hertfordshire and to use it's scrutiny powers to stimulate better partnership across the public and voluntary sectors to achieve this.

2.12 Whilst it was inevitable that the DQHC consultation process would constrain the delivery of all of the HSC’s work streams it is important that its 2008 work programme gives a priority to the previously identified public health work stream. This envisaged a co-ordinated series of locality based topic groups establishing the causes and potential partnership solutions for localised health issues and for their recommendations to be fed into a county-wide strategic scrutiny hearing.

3. General Medical Practice

3.1 GPs inevitably have vital role to play in delivering a successful outcome to both the IIYH and IIYMH strategies. The Topic Group received evidence from the Hertfordshire Local Medical Committee (the organisation which represents GPs) to the effect that they supported the direction of travel of each of these strategies and the concept of reconfiguration. In respect of the latter there was clear support for reconfiguration models that released the maximum amount of resources for re-allocation from the acute to the primary/community sectors.
3.2 The role of GPs in respect of mental health was considered in more detail by the Health Performance & Service Delivery Topic Group. Part of this Group’s work involved consideration of Enhanced Primary Mental Health Services (EPMHS) which are being developed to enable care to be provided by a wider range of practitioners. The HPSD Topic Group visited a number of the pilot GP practices and were impressed by them.

3.3 A full copy of the HPSD Group’s report can be found on www.hertsdirect.org or by request from Elaine Shell at elaine.shell@hertscc.gov.uk; tel 01992 555565.

3.4 At the Topic Group’s meeting on 1 July 2007, Dr Roger Sage gave an outline of the current situation in general practice and drew particular attention to:
- the budget deficit in the health care economy – for example, in the previous year his own practice budget had been cut by 5% and was currently overspent
- the importance of involving the general public in the development of health care services. Dr Sage pointed out that 90% of all health care contact is with GPs, but GPs only get 10% of the health care budget.

3.5 The following issues were noted by the Group:
- The move towards fund-holding practices
- An increase in the number of salaried GPs
- Relationship between budget allocation for primary and secondary care, and the need to move some secondary care services (and budget) into primary care
- Need for a strategy to allow more partnership working with management and nursing staff in secondary care teams
- Need for improved access to diagnostics
- Shift towards practice-based commissioning
- GPs opt-out of ‘out of hours’ cover
- ‘Chose and book’ system for increasing patient choice
- Clinical Assessment teams (see para 3.13 Below)

3.5 3.6 On 21 August 2007 the Chairman of the Topic Group spent a day at a GP practice in St. Albans. A report of this can be found in Appendix 4 but it highlighted;
- The use of the special interest and training of members of the team to provide and develop more services on site.
- Benefits of a team review of special cases including representatives of the secondary care sector
3.7 The potential impact of Practice Based Commissioning (PBC) was raised in paragraph 4 of section 1 of this report in respect of the targeting of resources.

3.8 Both IIYH and IIYMH envisaged an increased role for GPs and at this juncture it is difficult to assess the impact of this. It is however a key issue but to-date their work has not figured high on the HSC’s work programme due to the pressures resulting from the need to scrutinise Financial Recovery Plans and then the DHQC consultation process and decisions.

**Out of hours services**

3.9 Following the provision for GPs to opt out of the Out Of Hours service the way in which this has been provided varies across the County. Some of the services will in future be provided as part of the Urgent Care Centre contract – see paragraph 2 of section 4.

3.10 The Topic Group are concerned that, as far as practicable, there should be equity of provision throughout the County and feel this should form part of the its Access work stream.

**GP Treatment Centres**

3.11 The Topic Group welcome the development of more treatment within GP practises, particularly through the use of the special interest and training of members of local practise teams.

3.12 The post DHQC “Master Plan” should clarify the strategy for developing this concept of localised treatment across the county.

**Clinical Assessment Teams (CATs)**

3.13 In addition to an increased specialisation by GPs, as exampled by the EPMHS referred to in paragraph 3.2 above, there are a number of other developments which will assist in delivering furthering the direction of travel. One of these is the development of CATs.

3.14 CATs are multi-professional primary care services which provide an interface between primary and intermediate/secondary care. They provide for:

- Clinical leadership
- Referral triage
- Specialist assessment

**Finding 8**

Due to the pressures on HSC work load initially by the Financial Recovery Plans and then the DHQC consultation process, the work of GPs has not figured sufficiently highly on the Committee’s work programme.

**Recommendation 5**

Scrutiny of the developing role of GPs should form part of the HSC’s future work programme.

**Finding 9**

As far as practicable there should be equity of provision of Out Of Hours Service across the County.

**Recommendation 6**

Equity of provision of Out Of Hours Service should form part of the Committee’s Access work stream.

**Recommendation 7**

The post DHQC “Master Plan” should clarify the strategy for developing the concept of localised GP Treatment Centres across the county.
• Specialist treatment
• LTC management
• Listing for surgery
• Mechanism to ensure good GMS care
• Commissioning of 2’ care services

3.15 CATs are led by a GP Clinical Leader who is:
• working in partnership with a consultant/specialist
• accountable for the performance of the service and delegated budget holder for the commissioning budget
• accountable to the Practice Based Commissioning Locality Management Group (made up of all general practices in the PCT)

3.16 CATs are intended to deliver the outcomes outlined in the box above and the Topic Group regard this development as one of the indicators that aspects of the strategy are beginning to be delivered.

Anticipated Outcomes from the Clinical Assessment Teams
• Health improvement
• Clinical care pathways
• Referral thresholds
• Treatment thresholds
• Ensuring value for money from 1’ care, education and training
• Enhanced GMS
• Commissioning for locality – PBC LMG

Finding 11
The development of Clinical Assessment Teams (CATs) is an indicator that aspects of the strategy are beginning to be delivered.

4. Pharmacy

4.1 At the Group’s meeting on 1 June 2007, Linda Radford, Community Pharmacist, gave a presentation entitled ‘The Seven Ages of Man’ (see Appendix 7 for the slides in the presentation).

4.2 Members particularly welcomed the increasing provision of confidential consulting rooms within pharmacies and the presentation outlined the extensive role that pharmacists play in the community. For example, offering in-store confidential advice on issues such as smoking cessation, emergency contraception and sexual health.

4.3 Some pharmacy staff train to become ‘Accredited Supplementary Prescribers’. They assist with the management of conditions such as asthma or diabetes and provided services such as advice on travel vaccinations or ‘Pit-stop’ which offers health checks specifically for men.

4.4 Members discussed the prescribing of medicines and the vast amount of waste involved when members of the public were unable to manage their medicines correctly. It was accepted that the Medicine Use Reviews by pharmacists have an important role to play in managing this.

4.5 It was agreed that the direction of travel in making more use of medicines is right and a further example of the IIYH strategy for delivering services closer to the community are beginning to be delivered.

Finding 11
The changes in services provided by pharmacies and in the role of pharmacists are considered to be good; the ‘direction of travel’ is right and a further example of the IIYH strategy for delivering services closer to the community are beginning to be delivered.
pharmacists to advise on minor illnesses and the use of medicines is right and a further example of the IIYH strategy of delivering services closer to the community are beginning to be delivered.

5. Dentistry

5.1 On the 1 June 2007 there was also a presentation from Dr Sue Gregory, Consultant in Dental Public Health, entitled ‘The New Dental Contract - 12 months on’ (see Appendix 8 for the slides).

5.2 The presentation outlined the duties of the PCTs to provide or secure primary dental services (see slide opposite). The overall objectives established by the PCTs are detailed on the diagram on the following page.

5.3 These new duties were effective from April 2006 when budgets were devolved on an historic spend basis, albeit with an additional £250m investment nationally. This underlined a developing view amongst members of the Topic Group that the majority of health resources in Hertfordshire are currently allocated on an historical rather than needs assessment basis. Also that it will take time to redress this imbalance.

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**Primary Dental Services (2003 Act)**

- PCT has a duty to provide or secure primary dental services to the extent it considers reasonable through:
  - GDS contracts;
  - PDS contracts; or
  - provides them itself

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**Local commissioning, national framework**

- From April 2006, PCTs responsible for commissioning primary care dental services within national framework of:
  - Contract regulations (GDS + PDS)
  - New system of patient charges
  - 3-year investment guarantee
  - NICE guidelines (recall intervals)
  - Oral health plan, including fluoridation
  - Devolution of budgets to PCTs from April 2006, based on historic GDS/PDS spend + £250m extra investment
5.4 The presentation also explained the practice-based budget allocation and the system of three charging bands and ‘unit of activity’ measures, which make up the ways in which dentist are paid for the amount of work they carry out.

5.5 There was discussion on concerns about deficits in practice budgets. The Patient Charge revenue did not meet the deficit. There was a high demand for NHS dental services, but there had been a trend for dentists to move towards private practice.

5.6 Dr Gregory suggested that it was very positive that the public had an improved awareness of oral health, but they also expect a wider range of complex dental work, plus there is a vastly increased demand for cosmetic dentistry. All of this puts pressure on what the budget, devolved from the PCT, could support.

5.7 Sole practitioner dental surgeries were

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Overall objectives

How local commissioning helps, both in the short term …

- Stabilise investment at PCT level
- Sustain dentists’ commitment to NHS (off the ‘treadmill’ + 3-year income guarantee)
- Promote less intervention & more preventive approach
- Facilitate access improvements (if NICE guidelines followed)
- Influence over where new practices establish
- Stronger local relationship with NHS dentists
- Commissioning to meet oral health needs of population
- Commissioning to more explicitly address access

Finding 12

The current allocation of resources for dental services is undertaken on an historic spend basis and is further evidence that Hertfordshire’s health resources are allocated on an historic spend rather than on a needs assessment basis.

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Units of dental activity in respect of banded courses of treatment

<table>
<thead>
<tr>
<th>Type of course of treatment</th>
<th>Units of dental activity provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1 course of treatment (excluding urgent treatment)</td>
<td>1.0</td>
</tr>
<tr>
<td>Band 1 course of treatment (urgent treatment only)</td>
<td>1.2</td>
</tr>
<tr>
<td>Band 2 course of treatment</td>
<td>3.0</td>
</tr>
<tr>
<td>Band 3 course of treatment</td>
<td>12.0</td>
</tr>
</tbody>
</table>

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Number of dentists and practices by PCT in June AND DECEMBER 2005

<table>
<thead>
<tr>
<th>PCT</th>
<th>Number of Dentists</th>
<th>Number of Practices</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dacorum</td>
<td>84</td>
<td>86</td>
<td>148,000</td>
</tr>
<tr>
<td>Hertsmere</td>
<td>68</td>
<td>70</td>
<td>89,300</td>
</tr>
<tr>
<td>North Herts &amp; Stew</td>
<td>97</td>
<td>99</td>
<td>196,000</td>
</tr>
<tr>
<td>RBBS</td>
<td>43</td>
<td>47</td>
<td>78,843</td>
</tr>
<tr>
<td>SE Hertfordshire</td>
<td>96</td>
<td>95</td>
<td>175,000</td>
</tr>
<tr>
<td>St.Albans &amp; Harp</td>
<td>100</td>
<td>100</td>
<td>131,400</td>
</tr>
<tr>
<td>Watford &amp;3 Rivers</td>
<td>107</td>
<td>114</td>
<td>178,000</td>
</tr>
<tr>
<td>Welwyn Hatfield</td>
<td>87</td>
<td>87</td>
<td>101,000</td>
</tr>
</tbody>
</table>
struggling; there were initiatives for dentists to go into ‘super-surgeries’ but this comes with problems associated with the cost of larger premises.

5.8 A new contract came into force in April 2006 and it was suggested that there was no evidence to suggest that this had resulted in reduction of NHS dentists within Hertfordshire. *(see table at the bottom right of the previous page).* Members were not convinced in respect of this and agreed to undertake further scrutiny of this by visiting an NHS practise.

5.9 The visit took place on 9 October 2007 to a dental practice in Hitchin which is contracted to provide primarily a service to NHS patients. It demonstrated how the PCTs can commission services to fulfil their duties as outlined in paragraph 5.2 above. It is not clear why Hitchin have this facility and other areas in the County, believed to have equivalent demand, have not. However, members were encouraged to feel that the NHS were looking at adopting a similar process in other areas of Hertfordshire

**Finding 13**
The visit to the Hitchin NHS dentists demonstrated how well services can be provided but are concerned about disparity of service across the County.

**Recommendation 8**
Equity of access to NHS Dentists should form part of the Committee’s Access work stream

**Recommendation 9**
The scrutiny of optical and audiology services should form part of a future work programme for the Health Scrutiny Committee

6. **Optical & Audiology Services**

6.1 Time constraints did not permit the Topic Group to review these aspects of NHS provision but this should be considered as part of the future work programmes for the HSC.