NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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Friday 28 March 2014 10:00 a.m.
Camden Town Hall, Judd Street,
London, WC1H 9JE

Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Peter Brayshaw and John Bryant (Vice-Chair) (L.B.Camden), Alev Cazimoglu and Anne Marie Pearce (L.B.Enfield), Gideon Bull (Chair) and Dave Winskill (L.B.Haringey), Jean Kaseki and Martin Klute (L.B.Islington),

Support Officers: Andrew Charlwood, Linda Leith, Robert Mack and Harley Collins

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members of the Committee are invited to identify any disclosable pecuniary or prejudicial interests relevant to items on the agenda. A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting at which the matter is considered:

a) must disclose the interest at the start of the meeting or when the interest becomes apparent; and
b) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in their borough's Register of Members' Interests or the subject of a pending disclosure must notify their Monitoring Officer of the interest within 28 days of the disclosure.

3. URGENT BUSINESS

4. MINUTES (PAGES 1 - 12)

To approve the minutes of the meeting of 7 February 2013.

5. THE WHITTINGTON HOSPITAL - TRANSFORMATION PLANS

To report on transformation plans for the Whittington Hospital.

6. PRIMARY CARE - FUNDING

To report on;

- GP funding, including an explanation of the process for how this is determined;
- Funding allocations for each borough.

7. PRIMARY CARE - CASE FOR CHANGE (PAGES 13 - 76)

To consider proposals for changes to Primary Care services including the public engagement process.

8. CANCER AND CARDIOVASCULAR SERVICES - UPDATE (PAGES 77 - 90)

To receive an update on changes to cancer and cardiovascular services in north and east London.

9. MOORFIELD EYE HOPITAL; PROPOSALS FOR RE-LOCATION (PAGES 91 - 102)

To approve a joint formal response to the recent engagement process regarding the proposed re-location of Moorfields Eye Hospital.

10. MEETING OF BARNET, ENFIELD AND HARINGEY MEMBERS

To report back on the outcome of a meeting of Barnet, Enfield and Haringey Members of the JHOSC that took place on 24 March regarding A&E performance issues at Barnet and Chase Farm and North Middlesex hospitals.

11. WORK PLAN AND DATES FOR FUTURE MEETINGS (PAGES 103 - 104)

MINUTES OF THE MEETING OF THE NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY, 7TH FEBRUARY, 2014

MEMBERS: Councillors Alev Cazimoglu and Anne-Marie Pearce (LB Enfield), Alison Cornelius, Barry Rawlings and Graham Old (LB Barnet), Peter Brayshaw and John Bryant (Vice Chair) (LB Camden), Gideon Bull (Chair) and Dave Winskill (LB Haringey), Jean Kaseki and Martin Klute (LB Islington)

Officers: Linda Leith, Jane Juby

Also Attending: Dr Tim Peachey (CEx, B&CF), Professor Stephen Powis (Medical Director, RFH), Diana Mohar (NMUH), Fiona Smith (B&CF), Kim Fleming (Director of Planning, RFH), Kevin Howell (Director of Environment, NMUH), Julie Lowe (CEx, NMUH), Deborah Sanders (Director of Nursing, RFH), Wendy Wallace (CEx, C&IFT), George Howard (Islington CCG and Islington Council), Maria Kane (CEx, BEH MHT), Andrew Wright (Director of Strategic Development, BEH-MHT), Liz Wise (Chief Officer, Enfield CCG), Dr Deborah Turbitt (Deputy Regional Director for Health Protection, London), David Sloman (CEx, RFH)

1. WELCOME AND APOLOGIES

No apologies for absence received.

2. DECLARATIONS OF INTEREST

Cllr Cornelius declared a personal interest as an assistant chaplain at Barnet Hospital.

3. URGENT BUSINESS

Cllr Klute requested that NHS England attend a future meeting to explain their proposal not to consult nationally on the privatisation of the commissioning support units. .

Following complaints, it was important that each local authority should ensure that agendas for JHOSC meetings are on their websites.

4. MINUTES

The Minutes of the meeting 29 November 2013 were **APPROVED** subject to the following:

- That Cllrs Cazimoglu and Bryant be noted as present;

- That the statistics for overseas visitors to A&E and maternity services requested at page 6 were circulated.

5. ACQUISITION OF BARNET AND CHASE FARM HOSPITALS BY THE ROYAL FREE

David Sloman, Chief Executive, Kim Fleming, Direct of Planning, Deborah Sanders, Director of Nursing and Professor Stephen Powis, Medical Director, Royal Free NHS Foundation Trust gave a presentation the main points of which are summarised as follows:

- In September 2012 Barnet and Chase Farm Hospitals decided to choose the Royal Free as its preferred partner to achieve Foundation Trust status;
- The focus was on patient and economic benefit;
- The Strategic Health Authority agreed in November 2012;
- In August 2013 the acquisition was given the go ahead by the competition regulator;
- The Business Case was submitted in January 2014 to the Trust Development Authority;
- The Monitor's three-month assessment of five-year plan is underway;
- The target date for acquisition is 1 July 2014;
- The final decision will be taken in May at the Royal Free's Council of Governors;
- Between now and July residents will be informed and consulted;
- The vision and guiding principles were to offer excellent care and patient experience, excellent expertise through world class research and teaching, excellent value for money and a strong organisation with more depth and resilience;
- Existing strategies would be adhered to and wherever possible, the aim would be to deliver care close to patients' homes.
- The Royal Free would deliver a wide range of local and specialist services.

The following questions were then taken:

Q: Will there be the services in primary care available to replace those currently being offered through hospitals? What will the boundary lines be?

A: One of our other key principles is to work with the CCG and other partners to plan what will be provided in the community; working in partnership is essential. We have in fact planned for a loss of income to the Trust due to patient funding being directed into community provision. We are working with CCGs and GPs to work out a treatment partnership and we are confident we will get this right. For example, we are already moving the treatment of kidney patients out of the Royal Free to sites closer to where people live. We want to remove the confusion and fragmentation of secondary care level.

Q: Is there a standing stakeholder reference group? Patient engagement is key as many people are anxious and worried their services may change and need to see the detail of what is going to happen to feel reassured.

A: We have already engaged with lots of stakeholders but your point regarding a reference group is well taken and we will take this away **ACTION: David Sloman**.

Q: When The Royal Free NHS Foundation Trust acquires Barnet & Chase Farm does this mean it will have Foundation Trust status?

A: Yes.

Q: What assurances can you give that no land sales at the Chase Farm site will take place until Barnet & Chase Farm has Foundation Trust status (any sale of land prior to this will mean the money raised is not ring-fenced for investment back into the site but will go to the Treasury)? Can you give an assurance that there are no discussions, negotiations or valuations currently being undertaken which indicate that you are looking at the sale of land on the Chase Farm site.

A: Dr Tim Peachey (Interim Chief Executive, Barnet & Chase Farm Hospital NHS Trust) stated in response that there was no plan to divest of any land on the Chase Farm site before the (acquisition) transaction was completed. There was no plan to put any land on the market. He also added, in response to an enquiry from a Member, that the sale of land at Elmbank would be used to pay back the debt already incurred for building work at the Barnet Hospital site.

David Sloman also added that there was a commitment that any sale of land at Chase Farm site would be invested in services for Enfield residents.

It was subsequently stated that the Foundation Trust always looked to see how it could put its assets to best use, for example the building at Coppetts Wood had not been in use for a significant number of years and therefore was being sold for reinvestment.

It was requested that details of the Foundation Trust's investment programmes for the next 5 years be brought to the June meeting. David Sloman stated that he was happy to bring this detail to the June meeting, but could not commit to the level of granularity available at that time. **ACTION: David Sloman.**

It was also noted that if the acquisition proceeded, then there would be no change to the configuration of services provided on existing sites, as set out in the BEH Clinical Strategy. The acquisition aimed to improve patient experience and access and provide more financial

depth and resilience. There was, additionally, always a premium on patient safety.

Deborah Sanders, Royal Free, added that the acquisition would also provide greater security and career opportunities for staff, which would improve staff engagement and consequently, patient experience. An increase in scale would also allow better training opportunities.

A Member commented that, although the specialist centres referred to earlier were welcomed, the success of these would be dependent on the right levels of primary and community care being developed. Residents wanted to see evidence of this in place before any services were removed.

A further question was taken as follows:

Q: A Member asked if we had the sites to be treated locally, and would this be in primary care with transfer of responsibility and funding?
A: The Trust has worked closely with CCG partners. The Business Case takes account of the loss of funding. The CEx agreed that the new model of care was the right one, with integrated care pathways.

Q: What will be the level of investment after the acquisition for research and teaching?
A: There is currently, within a total £550m turnover, around £35m-£50m invested in teaching, and several millions invested in research. Investment will be strengthened after the acquisition but it is difficult to give figures at the moment.

6. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY – IMPLEMENTATION

Liz Wise, Chief Officer Enfield CCG, gave the following update on the implementation of the BEH Clinical Strategy:

- The Strategy's aim was to improve quality of care, provide a more senior doctor presence, increase maternity provision, make A&Es specialist emergency centres, create a dedicated planned care hospital at Chase Farm and help to provide a sustainable hospital and medical workforce.
- Maternity changes had been completed to plan on 25 November and emergency, paediatric and planned care changes were implemented on 9 December.
- The programme was now consequently in closedown.
- Urgent Care Boards had been set up to monitor post-implementation. These would review activity flows, final costs,

benefits realisation and process. The Boards were also helping to manage current winter demands.

- Early impact assessments: B&CF/NMU first to be compliant with new clinical workforce standards, improved physical environment, recruitment of 200 additional staff at North Middlesex Hospital, improved staff morale and reduction in delayed discharge.
- The Urgent Care Centres were now up and running with the North Middlesex UCC extending its opening hours to 15 hours a day.

The following questions were then taken:

Q: A Haringey resident stated that the review group involved with the Strategy had expressed a wish for the lessons learned to be published – it's disappointing that this has not happened.

A: We are keen to look at these.

Q: Patient experience has not really been mentioned. At the last Health & Wellbeing Scrutiny Panel we received a presentation from the London Ambulance Service where it was noted that there were ambulances queuing at hospitals and handover and journey times were up. How are these being monitored?

A: Every winter is challenging and this winter has been no different despite the mild weather. This is impacting the whole of the NHS system which in turn is affecting us. We have as much A&E capacity as we had before. Performance has gone up and down but we are constantly tracking it across the system. Intelligent conveyancing (where ambulances are directed in a certain pattern to prevent queuing) is an issue and is being looked at.

A Member stated at this point that greater transparency from the CCG would be welcomed; if there were issues or problems then Councillors should be informed.

Q: Funding has been made available from the Government to help prevent people visiting A&Es. Is enough being offered to people at home to stop them presenting to an A&E in the first place? Are you confident enough is being done in this respect?

A: There is always more we can do. Such preventative work requires a lot of upfront investment. All CCGs do look at the most vulnerable residents in this respect and this is why we are trying to put as much care as possible closer to home. Integrated care programmes like this do take a while to build up. The CCG is developing a 2-5 year plan; which the JHOSC may wish to see at a future meeting.

Q: There are 20% more ambulances being called than expected; this is a sizeable number and is a good indicator of need in the population – is there any analysis of the reasons for this?

A: We are collecting this information. We also need to look at what happens to patients subsequent to them being taken to hospital by ambulance – do they go home or are they admitted? Is there a link with any particular GP practice and what are the reasons? There is evidence available so far to suggest that certain care homes have been using an increased number of ambulances; and we need to understand the reasons for this and ensure ambulances are not being used as 'alternative transport' for elderly patients. In general, only 35% of people transported to hospital by ambulance are subsequently admitted at NMH.

An Enfield resident stated that ambulances were queuing outside hospitals and were also having longer journeys.

This was confirmed by another resident; who also mentioned that demand for ambulances appeared to be highest at 8am and 9pm and suggested this may coincide with carers visiting elderly residents.

It was **AGREED** that the London Ambulance Service be invited to attend the next meeting **ACTION: Secretary**

It was **AGREED** that the spend levels between primary and secondary care across the five boroughs would be an item on a future JHOSC agenda.

7. HOSPITAL FOOD

Dr Tim Peachey gave a brief explanation of meal provision at Barnet & Chase Farm Hospitals as follows:

- Catering was sub-contracted to a company called Medirest, through a PFI.
- Meals were cooked and prepared individually for each patient under the 'Steamplicity' system.
- Meals were chosen by the patient no more than 3 hours before serving and a change of meal option could be accommodated up to 30 minutes beforehand.
- A menu was also available 24 hours a day for emergency admittance.
- The cost per patient per day for meals was £7.10.
- Satisfaction ratings across Barnet & Chase Farm Hospitals was high, although it was slightly lower at Chase Farm than at Barnet; this may be linked to the overall environment/ambience in which meals were taken.
- Menus were available in multiple languages, including braille.

The following questions were then taken:

Q: Can you explain why the cost per patient at North Middlesex Hospital is £11, for the same catering system?
A: This may be due to how costs are measured; staff costs associated with serving/clearing away may have been included, for example.

Kevin Howell, Director of Environment at North Middlesex Hospital, confirmed that this was the case.

A Member raised the issue that diabetic patients had been served sugary food/desserts at the North Middlesex Hospital – this was noted and the matter would be followed up **ACTION: Kevin Howell.**

Q: Is there a wheat free option at B&CF Hospitals?
A: Wheat free products are identified on menus with a logo, and there is an option provided at every meal.

Q: How can you explain the differences nationally in food spend in hospitals?
A: This may be due to the level of wastage and, as referred to previously, how costs are measured. Barnet & Chase Farm Hospitals have a very low level of wastage due to the fact that food is prepared less than 3 hours before service and the amount ordered is the amount prepared.

Q: Has the food offer changed at Barnet & Chase Farm Hospitals over the last few years?
A: The current contractor has been in place for several years – the menus would have certainly changed but the basic offering would therefore be the same.

Deborah Sanders outlined the arrangements for the Royal Free Hospital:

- A cook/chill system was used to prepare meals.
- Nursing staff took an active part in helping patients select their meals and portion sizes.
- Focus groups helped taste and rate food.
- Homemade soups were being offered which were made on site from local ingredients.
- Salads were also offered, prepared on site which reduced packaging volumes.
- The breakfast offering was being reviewed.

It was acknowledged that the message generally that good nutrition was the key to good recovery was now well embedded in hospitals in the UK.

It was **AGREED** that an update on the food offering from the Whittington and UCL Hospitals should be requested **ACTION: Secretary.**

Q: Is there a requirement for the payment of minimum wage to contracted workers?
A: Maria Kane responded that the B&CF MHT was a Living Wage employer. She added that the Trust used a cook/chill system and provided additional food options such as a smoothie group and Sunday roast clubs. A community meeting every 2 weeks was held to review the food offering. It was a continuing challenge for the MHT to encourage and motivate patients to eat well. The spend per head per patient was £10.19.

Q: Does the CQC undertake hospital food inspections?
A: Yes, they do. The CQC inspectors will watch a meal service and taste the food. They will also monitor how people are supported to eat and drink.

Wendy Wallace, CEx of the Camden and Islington FT added that they also used a cook/chill system, which provided more menu choice (this was felt particularly important where the majority of patients were long term). A cooked breakfast had now been introduced on a Sunday.

The question was asked as to whether any patient groups walked around hospitals to get direct feedback from patients and who was asked for their feedback, since elderly and vulnerable patients could often 'gloss over' any problems. It was noted visiting relatives and friends should also be asked for their feedback to mitigate this.

MHTs were asked how patients with eating disorders were treated at meal times. It was noted that this depended very much on an individual's issues but for example, a patient may eat with a member of staff and/or have a personalised eating plan which may include added nutritional supplements. The environment in which a person with an eating disorder would take their meals was also considered.

8. FUNDING FOR MENTAL HEALTH SERVICES

Wendy Wallace, CEx Camden and Islington Foundation Trust, Maria Kane, Chief Executive Barnet, Enfield & Haringey Mental Health NHS Trust, and Liz Wise, Chief Officer, Enfield CCG, gave presentations, the main points of which were as follows:

- The BEH MHT continues its focus on improving services for patients;
- The Trust had consistently met its operational and financial performance targets for the last 5 years;
- There was a clear long term strategy to integrate mental and physical health services and reduce the need for patients with

both mental and physical health conditions from being admitted to hospital wherever possible;

- Due to major increases in the numbers and acuity of patients, the Trust faced a very difficult situation in continuing to provide safe services, with no additional funding available.
- Services were consequently under increasing pressure, particularly inpatient services.
- Parity of esteem issues were acknowledged around the funding of mental health services;
- In addition to the current level of CCG investment into the BEH MHT; it also spent c. £4m in 2013/14 to date on private placements in order to accommodate the increased demand for inpatient admissions.
- The Trust was working with the CCG to agree the best way forward. A jointly commissioned project with Mental Health Strategies was underway to benchmark current levels of investment, assess financial viability and provide options to align service provision to funding levels. A final report is due on 14 March.

The following questions were then taken:

Q: Are Recovery Houses now being used to relieve pressure for beds on the Trust's hospital wards?

A: The Recovery House model was to be used preventatively; however they have needed to be used as a step down measure. Of the 7 beds available, 3 are currently taken up by people of no fixed abode. There is an increasing need for mental health services in the community and it is becoming increasingly difficult to meet this need.

Q: Has the closure of mental health beds over the last few years contributed to the problem?

A: No, there are just more people with mental health needs who require admission; this may be due to the current economic climate and people finding it difficult to cope.

A Member requested more information on the total spend across the 5 boroughs on mental health to enable Members to lobby for increased funding. **ACTION: Liz Wise.**

Q: Who determined the configuration of the BEH MHT? Why have 3 boroughs been grouped together?

A: Many MHTs are in fact larger than this; it reflects the fact that there were 3 borough community health services that merged when the PCTs were formed.

Q: Is the closure of St Ann's on the agenda?

A: BEH-MHT is progressing its plans to redevelop St Ann's Hospital as there is a need improve the quality of the current

wards and therefore the Trust would need to consider the sale of parts of this site not currently used for investment in improvements on the part of the site to be retained for NHS use.

Wendy Wallace, CEx of the Camden & Islington FT commented that their funding was based on block contracts; there was therefore no facility to respond to changes in demand.

C&I FT was, however, significantly ahead of other acute services in preventative work and had been reducing the numbers of beds required largely successfully for a number of years.

The question was asked of MHTs if they had any problems of intensive occupancy associated with delayed discharge.

C&I FT responded that their housing pathways were very good and that their delayed discharge figure is 1%, which may be the lowest in the country and that they are very connected with the local authorities in their area and have been integrated with social care services for 20 years. BEH MHT responded that this year had seen significant pressures due to increasing demand.

It was agreed that there was an argument in principle that the formula for calculating mental health funding should be based on need. It was **AGREED** that a letter from the JHOSC be sent to Norman Lamb. It was also **AGREED** that further detail on the 'mental health weighted population' should be provided as it may assist in the case for funding **ACTION: Committee Secretary.**

Cllr Kaseki declared an interest as a Governor of the MHT.

A request was made to rearrange the meeting on 17 March in order to receive the Mental Health Strategies report due on 14 March **ACTION: Chair**

The following further questions were then taken:

Q: In austerity, what is the strategy for MHTs to tackle poverty in mental health service users?
A: MHTs do try and work to get patients into employment, which is the main factor in tackling poverty in mental health service users.

Q: Can the BEH MHT work with Haringey Council to unblock housing stock to release the Recovery House beds?
A: It isn't always the Council's responsibility to house a patient, there is also a significant demand for housing stock in Haringey and issues such as the payment of benefits sometimes take a while to resolve, which again causes delay in discharge. We have a responsibility to make sure patients have somewhere

safe to go, so cannot discharge them until we are sure that they do.

9. PUBLIC HEALTH ENGLAND – ENGAGEMENT PLANS

Deborah Turbitt, Deputy Director Health Protection, Public Health England (London), gave a presentation, the main points of which were as follows:

- Public Health England was a new organisation, created in April 2013 as part of the overall transformation of the NHS.
- 5 main priorities for 13/14 had been set, with 2 supporting priorities.
- PHE was now starting to engage with health economies. It's primary purpose was to provide evidence based professional, scientific and delivery expertise and advice, ensuring effective arrangements were in place locally and nationally for preparing for and responding to health protection concerns and supporting local authorities and CCGs by providing evidence, knowledge and advice on local health needs.
- PHE's overall main mission was to protect and improve health and to address health inequalities.

The following questions were then taken:

Q: Where does the Public Health England budget for mental health sit?
A: One of our top 5 priorities does include mental health and wellbeing – there is a workstream for this. Public Health England does have a mental health strategy for London. From April of this year Londoners will also be able to access an app which will give help and advice on mental health issues and accessing services.

Q: Is there a Public Health lead for mental health – we do need to develop a more preventative and robust approach?
A: The Lead would be Paul Plant, who is Deputy Director for Health Improvement.

Q: Public Health allocations across London are very different. Is this going to be looked at?
A: Yes, it is being looked at. Allocations were previously based on PCT spend. Work is going on at a national level to look at a fairer funding system. My understanding is that, consequently, there will be a further adjustment.

Q: What proportion of local authority Public Health funding is for the local authority to allocate and what is mandatory spend/prescribed by bodies such as yourselves?

A: The allocation to local authorities is primarily for local authorities to allocate, save for, as you know, certain mandatory areas of spend. Your Director of Public Health would be able to advise on the proportions of each within your own local authority.

Q: What level of involvement do you have in gathering health intelligence for local authorities?
A: We have Knowledge and Intelligence Teams in Public Health England who will gather intelligence for local authorities, there is a team for London. The team can provide detailed borough profiles and can also provide bespoke information for a particular need.

Q: In 2016 councils will have greater freedom over their public health spending; how much flexibility will there be?
A: If it can be justified that it is in the interests of public health, and a benefit can be demonstrated, it will be for local authorities to decide how the money is spent. You will, however, need to account for any such spend to Public Health England.

10. JHOSC REVIEW

The recommendations:

- that the current arrangements, Terms of Reference and procedures for the JHOSC be maintained subject to further periodic review;
- that a date be agreed for the first meeting of the JHOSC after the Local Government elections;

were **AGREED.**

11. WORK PLAN AND DATES FOR FUTURE MEETINGS

The date of the next meeting was noted as 28 March 2014.

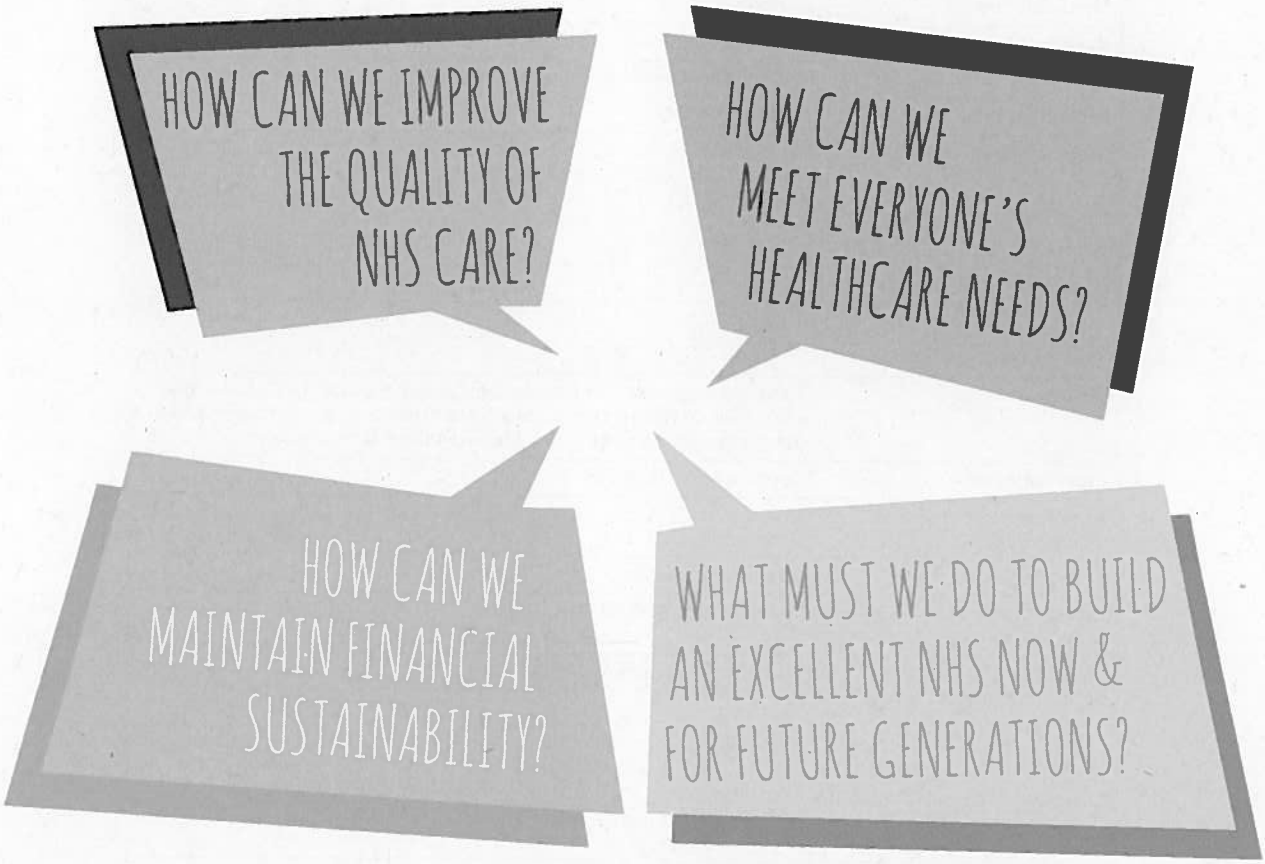
The items on the forward agenda were noted and **AGREED.**

It was also requested that the London Ambulance Service be invited to attend this meeting, or if this was not possible, the next thereafter **ACTION: Secretary.**

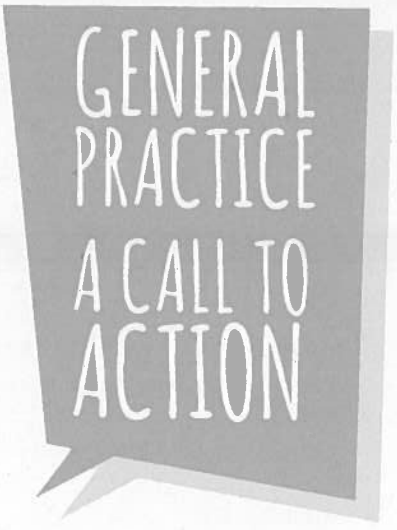
The meeting ended at 1.15pm.

NHS England

Transforming primary care in London



London



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Document Status

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Report Sponsors: Dr Clare Gerada, Chair of London's Primary Care Clinical Board
Simon Weldon, Regional Director of Operations and Delivery, NHS England (London Region)

Report Author: Jemma Gilbert, Regional Head of Primary Care, NHS England (London Region)

November 2013

NHS England

Contents

1. Foreword

The NHS is unique because of general practice.

Health and care services provided by GPs and practice nurses are the cornerstone of the NHS – 90 per cent of patient contact with the NHS takes place in general practice. High quality general practice provides a holistic approach to our care, from preventing illness and diagnosing problems, to treating diseases and managing long term conditions. GPs don't just provide care themselves, they also help their patients to navigate the system and access the care they need in other settings. GPs represent a single coordinator of care for people from birth through to the end of their life.

General practice's achievements should be celebrated.

Today general practice undertakes 90 per cent of NHS activity for 7.5 per cent of the cost, seeing more than 320million patients per year.

But the model of general practice that has served Londoners well in the past is now under unprecedented strain. There are significant challenges that must be addressed.

Population growth, widening health inequalities and complexity are driving up demand and the general practice is struggling to respond effectively to rising health needs. London faces a

significant financial challenge. General practice finances are also declining in real terms, exacerbating their inability to invest in service improvements. Yet, acute reconfigurations across London hinge heavily upon the ability to increase the capacity and capability of primary care.

This is a call to action for all stakeholders in London to work together so that general practice is able to adapt to meet these challenges.

It is a call to action for general practice providers themselves to work with us to set a bold ambition for service development, training and education.

We need to celebrate what general practice does well and retain what works, but we also need to see through significant changes to how general practice is organised, how services are delivered and how the workforce will develop.

Tweaking at the edges will not be an option. London needs solutions that will sustain primary care for 50 years. Solutions that safeguard the core purpose of general practice whilst improving care coordination, access and providing more proactive care.

It is important at the outset to build a solid case for change, which this document seeks to do, but we know the conversation is already moving forward and many people working in general practice are already discussing inspiring futures.

This call to action is launched at the Primary Care Futures Summit – the first of many collaborative meetings – in which stakeholders from across the capital will co-design options for transforming general practice services.

Solutions may differ for different communities but this case is unanimous – doing nothing is not an option.

Dr Andy Mitchell
Regional Medical Director, NHS England (London Region)

Caroline Alexander
Regional Chief Nurse, NHS England (London Region)

Dr Clare Gerada
Chair of London's Primary Care Clinical Board

2. What we are trying to achieve with this document

This document sets the scene for a conversation we would like to have with all London health partners and the public on the growing urgency for transforming general practice services in London. Our conversation is being conducted as part of a national engagement exercise, the *Call to Action* that is continuing up to April 2014. *London – A Call to Action* was published in October and provides a backdrop to this focused look at general practice. Londoners will be asked to discuss the challenges facing general practice in London today – some of which may be common nationally – but some unique to this capital city. Many Clinical Commissioning Groups (CCGs) are already conducting local engagement work with their stakeholders and we hope that this document will be a useful resource to supplement those discussions. It will also be used within NHS England and across London level organisations to obtain a consensus view on the case for change in order to develop the strategic direction and galvanise a collective effort and action on this important priority.

The document draws on a wide collection of research and evidence. We are grateful to the many stakeholders who have had input to the development of this document, which we are now opening up for discussion and review. The analysis that has been undertaken paints a compelling picture; doing nothing is not an option.

Important note on the definition of primary care: *This report focuses on general practice improvement challenges. The term 'primary care' is highly relevant on the basis that the transformation of general practices requires a look at its connectivity to, and has implications for, primary care based urgent care services, community services and wider care delivered in the community. NHS England will be publishing a further set of national Call to Action documents that cover dental, ophthalmic and community pharmacy services.*

NHS England

3. The importance of primary care

Primary care, and in particular care delivered by general practitioners and practice nurses, has been the cornerstone of the healthcare system since the inception of the National Health Service (NHS) in 1948. Good quality primary care is considered an essential feature of all cost-effective healthcare systems delivering improved outcomes at lower cost and with higher patient satisfaction.[1] General practice is often quoted as providing the majority of care in the NHS whilst utilising only 9 per cent of the budget. In the NHS in England, more than 300 million consultations take place in general practice per year, which represents 90 per cent of all NHS contacts.[2]

The primary care system in the UK performs highly when compared with other international systems and London contains many fine examples of general practice delivery at its best.[3]

What is primary care for?

In 2007, a prominent primary care academic, Barbara Starfield, described primary care as:

> *"The provision of first contact, person-focused, ongoing care over time that meets the health-related needs of people, referring only those too uncommon to maintain competence, and coordinates care when people receive services at other levels of care."*[4]

Primary care provides universal and comprehensive access for all. It provides a holistic approach to an individual's care, diagnoses and manages disease, prevents illness and protects health by promoting healthy behaviours, having a whole population focus. It is the first element of the continuing healthcare process and supports patients to navigate across multiple care providers and settings.

1. Keynote address of Dr Margaret Chan at an International Seminar on Primary Health Care in 2007. WHO
2. QResearch and the Health and Social Care Information Centre (2012) Trends in consultation rates in general practice 1995/6 to 2008/9. QResearch
3. The Commonwealth Fund (2013) Improving the Quality of Primary Care: An International Comparison Perspective
4. Starfield B (2008) The importance of primary health care in health systems. Qatar-EMRO Primary Health Care Conference.

What primary care represents to Londoners

The general practice registered list establishes a primary care 'home' for patients, carers and their families and represents the potential for a close, direct relationship with a single coordinator of their care right from their birth through to the end of life.

We already know from our public engagement work that people in London want a service that provides timely and convenient access to care. Those with more complex physical and mental health needs want a service that provides GP-patient continuity, is seamlessly coordinated and supports them to stay well. Evidence supporting the efficacy of relationship continuity is set out in a later chapter of this document.

Maintaining the integrity of primary care's core purpose

General practice is under strain and bearing the brunt of pressures to meet increasing and changing health needs. Whilst change is necessary it is important to recognise the things about general practice that should be preserved and which, if eroded, would compromise the quality and safety of care patients receive.

An important commitment will be to maintain the **integrity of the core purpose of general practice**.[5]

The core purpose of general practice is becoming increasingly compromised within the current constrained model. Three characteristics are needed for general practice to thrive and deliver the care that patients need and deserve:

1. **Coordinated care** – providing patient-centred, coordinated care and GP-patient continuity
2. **Accessible care** – providing a responsive, timely and accessible service that responds to different patient preferences and access needs
3. **Proactive care** – supporting the health and wellness of the population and keeping people healthy

Whilst these three areas do not represent the totality of general practice work, they provide helpful themes for service redesign that can apply equally to practice-based care, home care and end-of-life care. Cross-cutting design principles for general practice services include the need to provide safe, patient-centred, high quality care.

Many models and configurations of services will emerge in response to the challenges general practice currently faces. **Tweaking at the edges will not be an option – London needs solutions that will sustain primary care for the next 50 years**. Changing the divisions between primary and secondary care that were developed at the birth of the NHS will also be key. Primary care has a leading role to play in the development and delivery of integrated care systems across London. Primary and community care practitioners bring generalist expertise to the design of integrated care to be responsive to multifaceted care needs, and not designed around single conditions or a specialism.

5. Londonwide LMCs (2013) *Securing the Future of General Practice in London*

NHS England

4. Summary case for change

General practice in England is a mature model with a world reputation for excellence, ranking highly for access, coordination, electronic health records, performance data and patient satisfaction. Yet the model, which has been broadly stable for 60 years, is now under unprecedented strain, due to rising demand, higher expectations, and a tighter financial settlement. There is time for primary care to move to a new model of service that can meet the changed needs of Londoners for the next fifty years or more, before the challenges facing today's model become insurmountable.

	The issue	Headline evidence (Referenced throughout this document)	Potential impact if unmanaged	What needs to happen
Population	**London's population growth and complexity are placing unprecedented levels of demand on general practice and the current service is struggling to respond effectively to rising health needs.**	• Projections suggest that London's population will grow by 13 per cent by 2031. • There are more than 2 million children and young people under the age of 18 in London. The average age of 37 is young when compared to the UK as a whole (40 years of age). • The number of over 65 year olds is set to increase by 19 per cent by 2020. This age group are typically the most significant users of health services. • Life expectancy between wards in London boroughs vary significantly. Within Westminster there is a 17 year difference in life expectancy for the male population. • London faces substantial pressures from increasing prevalence of long-term conditions and complex co-morbidity. The number of people living with multiple long-term conditions is expected to rise by a third over the next ten years. • London is celebrated as a richly multicultural capital. Of the top 30 boroughs in England with the highest rankings of ethnicity, 26 are in London. • More than 100 languages are spoken in London and more than 300,000 people living in London don't speak English. • London accounts for 37 per cent of the nation's short-term residents. • In some parts of London approximately 30 per cent of the registered list is subject to annual turnover from high population mobility. • Average number of appointments per patient in general practice has risen from 3.6 to 5.5 between 1995 and the most recent measure in 2008.	• Rising demand • More complex care needs • More tailored interventions for diverse groups • Consultations more complex and longer time needed • Continuity of care more difficult to achieve • Quality targets and patient satisfaction scores more difficult to attain	London needs urgent action to tackle health inequalities. General practice will need to adapt to rising levels of demand, proactively preventing ill health and coordinating care for people living with complex health needs in challenging social circumstances.

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	The issue	Headline evidence (Referenced throughout this document)	Potential impact if unmanaged	What needs to happen
Economic	**London faces a significant financial challenge. Practice finances are declining in real terms, exacerbating their inability to invest in service improvements. Delivering smaller pump-prime investment in primary care initiatives has the potential to release greater cost efficiencies overtime.**	• London's NHS needs to save an estimated £4billion between 2015 and 2020. This equates to approximately 8 per cent of annual budgets each year. • Rapid population growth has led to an underestimate of resources for many London councils and CCGs. • Funding growth in general practice has been relatively flat with a real terms decline in investment in the last two years. • Per capita payments to practices vary significantly. • There is no link between practice income and needs, investment, services or outcomes. • Investment in primary care transformation will deliver cost savings elsewhere. • Improving access and care coordination has the potential to decrease A&E usage and hospital admissions. • Primary care delivers 90 per cent of NHS activity for 7.5 per cent of the budget. The RCGP estimate that it requires 10 per cent and that a year of care by a GP costs 1/10th of a day's stay in hospital.	• Cuts in staffing • Cuts in services • Lack of time and resource for innovation and improvement • Growing care quality gap • Reduced access • Low workforce morale	London needs to commission for a general practice service that is delivered by sustainable and financially effective organisations. London needs to deliver an economic analysis that identifies the cost efficiencies that can be achieved by investment in building primary care capacity and capability.

	The issue	Headline evidence (Referenced throughout this document)	Potential impact if unmanaged	What needs to happen
Service Changes	**London CCGs are leading ambitious proposals to reconfigure local services to improve care that hinge heavily upon the ability to increase the capacity and capability of primary care services.**	• There are pressures to reconfigure acute services across London. Some of the most financially challenged NHS trusts in the country are in London. • Service reconfiguration proposals include a reduction in the number of hospitals providing full A&E services, acute inpatient medical, surgical and paediatric care, and consultant-led maternity services, and the concentration of planned surgery. • The main reason given by ambulatory patients attending A&Es across London is inability to access an appointment from their own GP. • Piloting of the NHS 111 service has further exposed gaps in access to general practice in London. • Providing consistent 24/7 care in primary care is seen as one of the key ways to reduce A&E demand. • Contracts for unscheduled primary care activity span multiple providers (for A&E front door, Urgent Care Centres, Walk-in Centres and Out of Hours) in multiple settings making a confusing system for patients to navigate. • Reconfigurations are reliant on developing more integrated care services, increasing capacity and capability in primary and community care settings.	• Increased demand for services • Increased requirement for care integration • Improved 24/7 care coordination required • Urgent need to improve access to general practice	London needs to be bold in its ambition in order to deliver the capacity and capability shift required for primary care services.

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	The issue	Headline evidence (Referenced throughout this document)	Potential impact if unmanaged	What needs to happen
Service improvement	**Across the country, there are significant unexplained variations between practices for key aspects of diagnosis and treatment. Reducing variation has the potential to save lives and enable people to live longer. London practices face greater challenges than most in delivering high measures of quality and experience.**	• London practices lag behind the rest of the country in measures of quality and patient satisfaction. • Demographic factors present more complex challenges for practices making measures of performance more difficult to achieve. • However, some practices in deprived boroughs achieve excellent clinical outcomes and patient satisfaction. • Variation in the proportion of outlying ('review identified') practices by CCG ranged from 0-21.3 per cent in London (in 2011/12) as measured by the GP Outcome Standards. • Approximately 70 per cent of practices exceed thresholds for the standards on severe mental illness review. • Cancer referrals in line with best practice are lower in London than the rest of England with late diagnosis being a key factor in poorer cancer survival rates. • 23 of the lowest 25 boroughs for breast screening coverage are in London. • The ratio of expected to reported prevalence of COPD varies from an inter borough average of 0.36 to 1.47. • Exception reporting levels vary across London boroughs. It is estimated that levels exceeding 12 per cent represent a gap in care delivery.	• Unmet population health needs • Variations in clinical practice, quality and outcomes • Increased burden of disease e.g. number of years lived with a disability	London needs to improve core standards of care and tackle unwarranted variation in quality to improve the safety and clinical effectiveness of care delivered to all Londoners. CCGs in London need to work with health and wellbeing boards and local authorities to tackle the wider determinants of health.

	The issue	Headline evidence (Referenced throughout this document)	Potential impact if unmanaged	What needs to happen
Coordinated Care	**Patients with long term conditions account for more than 50 per cent of GP appointments and consume more than 75 per cent of the total health and social care spend. Improved care coordination has been shown to deliver better health outcomes, more satisfied patients and at a lower cost, vital for people living with multiple complex conditions.**	• Londoners report that they are less able to see their preferred GP than in other parts of England. • GPs in the UK are more dissatisfied with the time they are able to spend with each patient. • A large percentage of the population live with complex (often co-morbid conditions). • Approximately 70 per cent of health and social care spend is attributed to the top 20 per cent of people with the highest levels of care need. • People with long-term conditions account for more than 50 per cent of all general practice appointments, 65 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days. • Rates of emergency admissions for children for chronic conditions such as diabetes, epilepsy and asthma show a threefold to fivefold variation across London boroughs. • London hospitals have higher use of emergency bed days for the frail elderly than the rest of the country. In 2012, seven of the top ten areas nationally with the highest emergency bed use were in London. • Half of all people with dementia never receive a diagnosis – just 31 per cent of the capital's GPs believe they have received sufficient basic and post-qualification training to diagnose and manage dementia. • Older people with dementia occupy 20 per cent of acute hospital beds across England but 70 per cent of these may be medically fit to be discharged. • Nationally, 70 per cent of patients want to die at home but 58 per cent die in hospital. London has the five worst performing local authorities nationally in terms of deaths in hospital. The proportion of deaths in hospital following an admission in the last week of life from care homes is higher in London than in other regions. • Short consultation times and constraints on multidisciplinary team working are not meeting the needs of these patients.	• Patients with increasingly complex care needs • Consultations more complex and longer time needed • Continuity of care more difficult to achieve • General practice teams frustrated by limits of care they are able to provide • Services not sufficiently patient centred or responsive to diverse needs	London needs a primary care service that can provide greater continuity of care, more time with patients who need it, case management, multidisciplinary working and care planning in partnership with other parts of the health system.

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	The issue	Headline evidence (Referenced throughout this document)	Potential impact if unmanaged	What needs to happen
Accessible Care	**Patients in London find access more challenging than in the rest of England. Access impacts on patient experience and the quality of care they receive and also matters to practices whose workloads can become unmanageable if access is not managed in a systematic way. If patients find it hard to access their general practice then their diagnosis and treatment may be delayed, or they may choose to go to A&E because it is open and available.**	• London's patients report that access to many GP practices does not meet their reasonable needs. • Patients are often unable to see a GP of choice when they need continuity of care, access any GP quickly when they have an urgent issue or see a GP conveniently without having to take time away from work. • Across all of London there is significant variation in access. In four London boroughs satisfaction is low across all five access measures: ▪ Rapid access ▪ Seeing a GP of choice ▪ Getting through on the phone ▪ Booking ahead ▪ Opening hours • Less than half of London's patients are able to see a GP by the next working day. • Many practices are not open outside of normal working hours and many still close for a half-day midweek. • Of the bottom 30 boroughs in England for seeing a GP of choice 22 are from London. • A third of patients would like to use the Internet to book appointments and request prescriptions but only 1 per cent report that they are able to do so. • Patient-reported satisfaction with access to general practice is associated with lower emergency admission rates for ambulatory care sensitive conditions.	• More patients attending A&E with primary care conditions • Diagnosis and treatment may be delayed • Patients are less able to manage their long term condition • There is increased potential for unnecessary emergency admissions • Patients have to take time off work in order to access their general practice	London needs to respond to these challenges by shaping and developing new models for access that deliver convenient and reliable unscheduled care as well as coordinated and high quality continuity of care to a population with diverse needs.

	The issue	Headline evidence (Referenced throughout this document)	Potential impact if unmanaged	What needs to happen
Proactive Care	**Stark health inequalities exist across London. Many London boroughs fall below the England average on key preventative measures. Health promotion and primary prevention by general practice working in partnership with others will be key to reducing morbidity, premature mortality, health inequalities, and the future burden of disease in the capital.**	• Self-care and offering peer support to manage long-term conditions could reduce the cost of delivering healthcare by approximately 7 per cent through decreasing A&E attendances, reducing hospital admissions, reducing length of stay and decreasing patient attendances. • Putting this into practice would save the NHS an estimated £4.4 billion across England. • London has the highest levels of childhood obesity on national comparators and 40 per cent of Londoners are predicted to be obese by 2035. • London compares poorly for physical activity in adults (10 per cent compared with 11.5 per cent nationally). • Rates of teenage pregnancy are higher in London (40.9 per 1,000 compared with 38.1 nationally). • Infectious diseases are a special challenge in London, given its demographic profile with high rates of tuberculosis and sexually transmitted infections. • London's population is more transient than the rest of the country. • London has the highest number of rough sleepers in England. Homeless people are 40 times more likely to not be registered with a GP. • London has a poorer performance in childhood immunisations compared with national averages. • Flu vaccination rates for under-65 high-risk groups range from 35.3 per cent to 61.5 per cent between London boroughs. • 22 of the 25 boroughs with the lowest breast screening rates nationally are in London, and rates of cervical screening are also low.	• Additional workload associated with complex population and overreliance on medical intervention. • Unmet patient need due to gaps in registration or poor service uptake • Greater burden of disease • Poorer health outcomes • Reduce QOF performance and reward • More expert capability required for e.g. delivering care to the homeless	London needs a more proactive approach targeting high-risk groups to improve the uptake of preventative services and to encourage them to present early. London needs a primary care service that can systematically enable patients to self-care, provide behavioural change support and/or referring to those who can assist with improving health and wellness for all. Primary care needs to take action to overcome demographic challenges to improve levels of immunisation, diagnosis and screening in order to protect the health of Londoners.

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	The issue	Headline evidence (Referenced throughout this document)	Potential impact if unmanaged	What needs to happen
Infrastructure	**Most practices in London remain relatively small, and could benefit from shared economies of scale. London has an especially high number of single-handers and GPs nearing retirement as well as a significant practice nurse shortage. The use of other primary care roles such as physicians assistants and health trainers is patchy. Existing digital health opportunities are not being well utilised. London has a higher than average proportion of smaller general practice premises, mainly in converted residential housing or older, purpose-built, health centres.**	• Across London new models of provision are emerging offering new opportunities to integrate and enhance care for patients. There is a trend towards a greater degree of scale through practice networks, mergers, federations and other means. • There is a GP shortage. Nationally 16,000 more GPs will be needed than are currently available by 2021. • Almost 16 per cent of London GPs are over 60 years old, compared with 10 per cent nationally. • The percentage of GPs over 60 is typically higher in areas where there are many single handers – these also tend to be areas of greater deprivation. • London has a significant nurse shortage. • London has a higher percentage of salaried and locum GP workforce than other parts of the country. • In 2011, 43 per cent of all doctors in England were female – in primary care there will be more female GPs than male by 2017. This may increase the demand for flexible, part-time and salaried posts. • It is likely that patient contacts conducted through a digital health environment will exceed face to face contacts in the future. • Across London only a small percentage of practices are utilising their current digital capability: ▪ access their records (3 per cent of practices); ▪ cancel or book appointments on line (40 per cent of practices); and ▪ order repeat prescriptions on line (40 per cent of practices). • A thorough diagnostic of one London region found 30 per cent of practices to be operating from substandard premises – the proportion elsewhere is likely to be similar.	• Insufficient clinical staff available • Dropping engagement in clinical commissioning • Isolated practitioners • Reduced staff morale • Lack of career progression opportunities • De-skilling of staff and inability to flex capacity to work in new ways • Small inflexible buildings with limited physical space to extend ways of working • IT not being utilised as effectively as it could • Patients dissatisfied by inability to contact the practice through digital channels	London needs a primary care service that has the capacity and capability to provide the best care possible in a modern environment that enables multidisciplinary working and training, and in which the use of technology is maximised to better support patient care.

5. Change leadership for primary care

"WITH GENERAL PRACTICE ON A TREADMILL OF DEMAND, TRAPPED IN OFTEN OUTMODED MODELS OF PROVISION, POLICY MAKERS NEED TO SHAPE AND FUND AN ENVIRONMENT THAT ENCOURAGES GPS AND THEIR TEAMS TO PLAN A DIFFERENT FUTURE."[6]

Dr Judith Smith, Nuffield Trust (2013)

This quotation identifies the need to enable provider teams to take responsibility for change in primary care. Contract managers spend much of their time focused on tackling poor performance and as we have seen with the recent debate on A&E pressures, it is all too easy to apply blame to general practice for failures in whole system delivery. Engaging providers in change will require a more comprehensive and sympathetic diagnosis of the challenges facing general practice to rebuild trust and motivate action.

A review of variation in general practice outcomes shows us that the majority of general practices in London deliver well and most providers are responsive to the service specification and quality standards that commissioners have set over time. That said, there is wide recognition that the smaller size of general practices in London is a challenge for multi-disciplinary working and the fragmentation of other primary and secondary care providers is not facilitating patient-centred care. Perverse incentives and contractual barriers act as obstacles to change and do not deliver the most safe, effective and high quality care for patients. Service improvement and innovation is constrained in environments where there is insufficient time and space to develop and invest in new ways of working. Commissioners must work with providers to balance incentives towards providing better patient care and removing barriers to change.

6. Smith J (2013) Back to First Principles: Primary Care for the Future. Nuffield Trust

There have been many attempts to resolve the challenges of the capital's health care system – the *Tomlinson Report* (1992) sowed the seeds for Local Implementation Zones (LIZs) across London to manage resources and lead the development of primary care. This was followed by the *Tumberg Report* (1998), reviews by the King's Fund (1992 and 1997) and, most recently, *Healthcare for London* (2007). These reports concluded that effective political, clinical and managerial leadership and a commitment to working together was required at all levels, across both commissioners and providers. The success of the changes to London's stroke services has shown how coordinated action, led by clinicians, can deliver significant improvements. London's NHS needs to replicate this type of exemplary effort in the context of primary care and develop ambitious plans to transform patient care.

Change in primary care requires a 'Call to Action' for **all** stakeholders to work together to enable general practice to unlock its potential across the capital.

There is widespread support and impetus for transforming services. NHS England's London Region, the London Clinical Commissioning Council and London's Education and Training Boards (LETBs) have all identified developing primary care as a top priority. These challenges have been recognised by the Mayor of London who recently announced an independent, clinically-led 'Health Commission' to examine issues about how health improvement and the healthcare system can best operate in the future. In 2013, the Royal College of General Practitioners published a bold ambition for 2022 and this was later followed by the Londonwide LMCs document *Securing the Future of General Practice in London*.[7,8]

Change in primary care in London should be provider driven and clinically led. A Clinical Board reporting to the London Clinical Senate and chaired by Dr Clare Gerada, Immediate Past Chair of the Royal College of General Practitioners and practicing London GP, will oversee the transformation work. This Board will be building a network of clinical change leaders who will support transformation work in local areas across the capital.

The RCGP's vision for general practice in 2022:

- Accessible, high-quality, comprehensive healthcare services available for all communities
- A good in and out of hours care experience for patients, carers and families
- Patients and carers routinely sharing decisions and participating as partners
- An expanded, skilled, resilient and adaptable general practice workforce
- Investment in suitable community based premises for delivering care, teaching, training and research
- Coordination and collaboration across boundaries, with less fragmentation of care
- Reduced health inequalities and increased community self-sufficiency
- Greater use of information and technology to improve health and care
- Improved understanding and management of inappropriate variability in quality
- More community-led research, development and quality improvement

7. Royal College of General Practitioners (2013) The 2022 GP: A Vision for General Practice in the future NHS. RCGP
8. Londonwide LMCs (2013) Securing the Future of General Practice in London

6. Why change is necessary

There are many perspectives on why change is necessary but there is overwhelming agreement from stakeholders that transforming primary care is one of the greatest and most complex improvement challenges facing London's health system today.

Evidence shows that more practices have been reporting unprecedented levels of demand for care in recent years. GPs in the UK report a much lower level of satisfaction with the time they are able to spend with their patients.[9] The 2012 NHS reforms place GPs at the centre of clinical commissioning, increasing demands on GP time and especially practice partners. Many practices are reporting that the pace and intensity of workload has increased whilst investment has declined in real terms. An RCGP poll of its members in 2013 revealed that 80 per cent said that they now have insufficient resources to provide high quality patient care. Nearly half (47 per cent) revealed that they had to cut back on the range of services they provide for their patients with 39 per cent cutting staff.[10] New staff roles (e.g. GPNs, PA, HCAs, nurse practitioners) remain unfilled across London. Many GPs are approaching retirement. Many are not prepared for commissioning, population health, working as part of a multi-disciplinary team, management or leadership. GP training was extended in 2011 from the shortest in the world, at three years, to four years in recognition that the next generation of trainees will require these skills. In London, the current business model for many practices is based around small organisations, working independently. The greatest potential for primary care could be reached by enabling general practice to do more collectively, to invest in and strengthen the workforce, to provide ringfenced time and expertise for service development and to integrate and coordinate care in a way that is patient-centred. The shift of care to out-of-hospital settings is a significant opportunity for general practice. However their ability to maximise these changes is compromised by a fragmented and variable GP provider landscape, top-down performance indicators and targets, competition rules and potential conflicts of interest.

The RCGP opinion poll demonstrates that many general practices across London are under immense strain.[11] Socio-economic changes and growing population health needs are particularly acute across the capital.

9. International GP Opinion Survey (2012) Commonwealth Fund International Survey of Primary Care Doctors. The Commonwealth Fund
10. GP Opinion Survey (2013) Royal College of General Practitioners: Perceptions of Resourcing among GPs. ComRes
11. GP Opinion Survey (2013) Royal College of General Practitioners: Perceptions of Resourcing among GPs. ComRes

NHS England

GPs	Patients	CCG members	Acute clinicians
"We are dealing with **unprecedented levels of demand**"	"**A&E is faster** than my GP service"	"There are significant variations in **healthcare resource consumption**"	"I see the same patients **readmitted in a worse condition** because their **post discharge care** is not good enough"
"I'm worried about the **financial sustainability** of my practice"	"I wouldn't know who to contact **in the evenings and at weekends**"	"We're **concerned about the quality** of care in that practice and need NHS England to step in"	"I am not confident discharging patients back into the community so they are in hospital **longer**"
"Patient **expectations are out of kilter** with what's achievable"	"I **can't get through** on the phone"	"We need to strengthen primary care if we want to **stop actute activity from spiraling**"	"There is too much **variation in standards** of primary care"
"The **contract is over prescriptive** and drives the wrong behaviours"	"At the most convenient times of the day **my surgery's doors are closed**"		

Commissioners	Taxpayers	Practice nurses	Politicians
"There is a **weak link** between pay and quality"	"GPs are **taking money away** from patient care"	"I'm employed by a family and **have no say** in the business"	"GPs need to **recognise the changes** that are coming and adapt"
"You have the **best and worst** delivery in one place"	"Where does the money go? **Facilities are not modern enough**. The service feels old fashioned"	"My **skills could be better** used in prevention"	"The **system is different**, the landscape is different"
"I am sucked into **dealing with failures** rather than working with the majority"		"I have **few opportunities** to develop, lead others or interact with my peers"	"Primary care should be **taking the pressure off** the rest of the system"
"I have national contracts with independent providers that have **no exit strategy**"		"There **aren't enough** new nurses coming into general practice"	

Foundation, acute and mental health trust boards are undergoing reconfigurations in order to deliver more sustainable and financially effective services and primary care must not be left behind. We begin this case for change with a review of the rising pressures that are making the status quo increasingly untenable.

Population challenges

London's population growth and complexity are placing unprecedented levels of demand on general practice and the current service is struggling to respond effectively to rising health needs. This demand converts into increased consultation activity, the requirement for longer consultations and multi-professional intervention and increased unscheduled activity. General practice is doing its utmost to meet these needs but the pressure cannot be sustained and GPs across the capital are urging action now to ensure their patients' needs continue to be met in the future.

Demographics

The profile of London's population is very different to the rest of England. It is younger, more transient, more ethnically diverse and growing at a faster rate than any other region in England due to increased births (an additional 7,000 a year since 2008), reducing mortality

12. GLA Intelligence Updates 2011 Census results: London's boroughs' population by age and sex (2012) and GLA Intelligence Update GLA 2012 Round Population Projections (2013).

and a continuing trend of net domestic and international migration into the area.[12] There are more than 2 million children and young people under the age of 18 in London.[13] With an average age of 37, London is young when compared to the UK as a whole (40 years of age),[14] however the most significant increase in the population will be seen in the capital's over 65 year olds. This age group is due to increase by 19 per cent by 2020[15] and over 65 year olds are typically the most significant users of health services.

London has high levels of both international and internal population migration and accounts for 37 per cent of the nation's short-term residents.[11] Over 200,000 people move to, and leave, London each year within the UK. As a result, list churn is a major issue for general practice in London. It increases workload, disrupts continuity of care and negatively impacts patient safety, care quality and clinical outcomes. In some parts of London, such as Newham, list turnover can be as high as 30 per cent of patients registered.

It is, unsurprisingly, difficult to find robust figures on the unregistered population in London. Subtracting registered from resident populations is not considered a suitable proxy in a city where so much of the unregistered population are homeless or migrant and do not appear in census figures. This population is likely to have much higher health needs than the resident population and could account for a significant number of inpatient and outpatient attendances. Securing greater uptake of primary care services by this population could improve activity and cost.

London is richly diverse compared with other UK cities. In rankings of ethnic diversity indices, 26 of the top 30 local authorities were in London in the 2011 census. Recent census data showed that there are over 100 languages spoken in London, more than 300,000 people living in London can't speak English and nearly 1.7m people don't have English as their first language. This makes the patient-clinician consultation more complex and reduces uptake of screening and immunisation programmes.

These population trends may also be one reason why the overall patient average satisfaction with a London GP surgery is 81 per cent compared with the national average of 88 per cent. It is important to recognise that variation in patient population will be accompanied by differing needs and expectations and therefore different levels of satisfaction with the delivered service. For example, an elderly patient with a long term condition and co-morbid illnesses is unlikely to have the same requirements as a working female patient in their 30s. That said there are many practices in the most diverse boroughs of London that have demonstrated it is possible to achieve the highest levels of patient satisfaction.

London has the highest average income but is also the most polarised in the country, with people in the top 10 per cent of households earning around five and a half times more than those in the bottom 10 per cent.[16] On the whole, people in the more deprived boroughs in London have poorer health. However, it is a characteristic of many London boroughs that poverty, affluence and associated health inequalities exist side by side. In 2007, these health inequalities were starkly illustrated by the average life expectancy reducing by a year of life for every tube stop passed from Central London going east, and this mortality gap has continued to widen in recent years. Between London boroughs there are life expectancy gaps of 9.1 years for men and 8.7 for women, and healthy life expectancy gaps of 11 years for men and 10.5 for women. Within boroughs differences can be bigger, for instance the difference between men in the tenth of the population with the worst and the tenth with the best life expectancy in Westminster is 17 years.[17] A recent study into the health impact of the economic downturn predicted that health inequalities would further widen.[18]

13. National Census (2011) Office for National Statistics
14. GLA Focus on London (2010) *Population and Migration*
15. Office for National Statistics (2012) Interim 2011-based subnational population projections for England
16. Indices of Deprivation, 2010
17. Institute of Health Equity (2012) The impact of the economic downturn and policy changes on health inequalities in London
18. INWL Public Health Intelligence (2012-13). *Slope Index of Inequality Briefing. Joint Strategic Needs Assessment (JSNA) for the geographic area covered by the London Borough of Hammersmith & Fulham, the Royal Borough of Kensington & Chelsea, and Westminster City Council.*

Health

The primary care system in London faces substantial challenges from the increasing number of patients with long-term conditions. The number of people living with multiple long-term conditions is expected to rise from 1.9 million in 2008 to 2.9 million by 2018 costing the NHS and social care an additional £5 billion.[19] The association between socio-economic status and prevalence of individual chronic diseases is well established. It is now recognised that most of those with a long-term condition are multi-morbid and have co-existing mental health disorders, particularly depression, being more prevalent in people with increasing numbers of physical disorders.[17] A recent study found that more than half of people with multi-morbidity and nearly two-thirds of people with physical and mental morbidity were younger than 65 years. Although age has the strongest association with multi-morbidity, this study found substantial excess of multi-morbidity in young and middle-aged adults living in the most deprived areas who had the same prevalence of multimorbidity as people aged 10-15 years older living in the most affluent areas.[20,21] London has more than one quarter of its 'lower super output areas' in the most deprived quintile in England. In London, the number of people with a long-term condition is estimated at 1.5million.[22]

England lags behind Europe in the level of healthcare provided for children and in recent years key reports have highlighted deficiencies in the quality of services for children in London. Despite a high-level of spending on children's services per capita in London, problems include:

- The highest rates of childhood obesity in the UK.
- One of the highest rates of teenagers having unwanted pregnancies in the UK.
- Only 32 per cent of London schools achieved 'healthy school' status in 2005 – significantly lower than the national average.
- Significantly lower rates of children immunised with MMR (measles, mumps and rubella) before their second birthday, compared with the rest of the country.
- In some areas, the infant mortality rate is significantly higher than the national average.
- London also falls behind the national average in terms of child poverty, the proportion of low weight babies and the prevalence of measles case placing an additional pressure on GP services.

Economic challenges

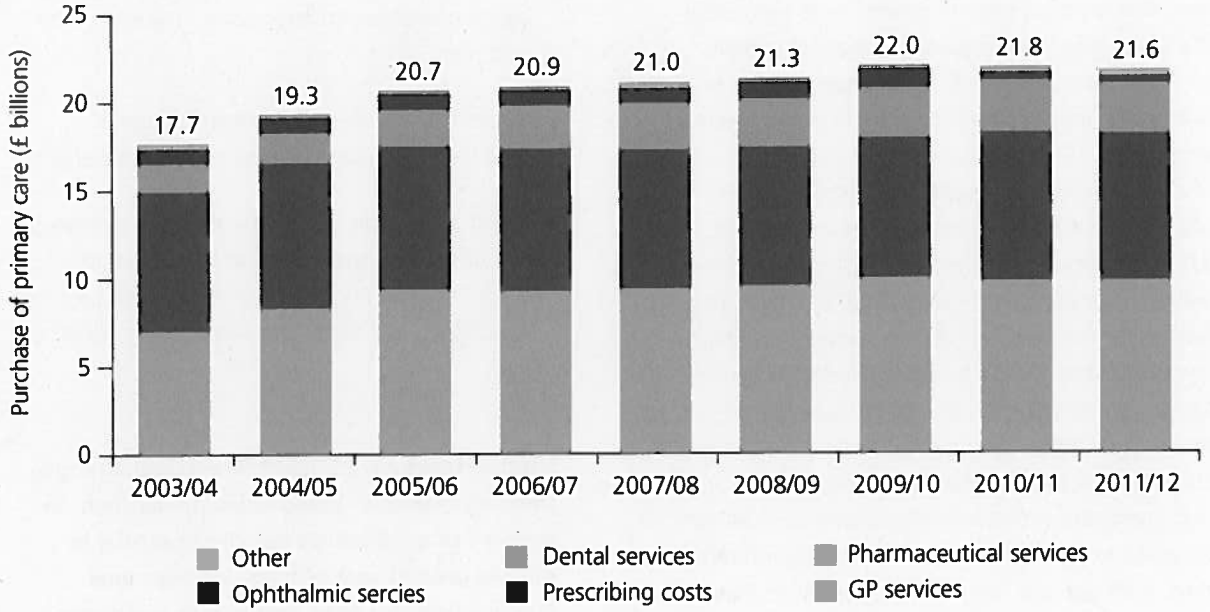
London faces a significant financial challenge. Delivering smaller pump-prime investment in primary care initiatives has the potential to release greater cost efficiencies over time. Practice finances have declined in real terms, exacerbating their inability to invest in service improvements and causing some to fold. London needs a general practice service that is delivered by sustainable and financially effective organisations.

NHS funding is expected to remain flat in real terms over the next decade and with a forecast 4 per cent annual growth in healthcare demand (10 per cent for specialised services) the NHS is facing a funding gap of £30 billion by 2020. If London is to continue to bridge its estimated share of the national funding gap in future as it has done to date we will need to save an estimated £4 billion between 2015 and 2020. If shared equally over the next five years this equates to £0.8 billion of London's £10.1 billion annual London CCG budget, or approximately 8 per cent each year.

In addition the, unique characteristics of London are not being captured in national funding allocations, which in turn are slow to respond to population change and the consequences on service demand. Population growth particularly, means that resources are significantly underestimated for many London councils and CCGs.

19. The King's Fund. The Health and Social Care System in 2025 – A view of the future.
20. Marmot M. (2005) Social determinants of health inequalities. The Lancet
21. Barnett k, Mercer S, Michael N, Graham W, Sally W, Bruce G (2012) Epidemiology of multimorbidity and implications for health care, research, and medical education. The Lancet
22. Estimate of LTC prevalence taken numerator used in QOF calculations

Figure 1: Investment in primary care 2003/04 to 2011/12



(Nuffield Trust and Kings Fund 2013)

The provision of a primary care 'home' for every resident, and corresponding accountability of a GP as the first point of call for most healthcare provision, gives the NHS the opportunity to deliver the best possible outcomes at the lowest possible cost.[23] Relatively smaller investments and shift of resources to develop primary care capacity and capability could have a correspondingly large impact in reducing acute activity and overall cost to the health service.[24] In the face of a £4billion funding gap in London, transferring resources to primary care will need to be matched with ambitious changes in the configuration of services and improved integration.

Whilst there have been incremental uplifts to general practice funding over time, funding growth has been relatively flat in recent years.[25]

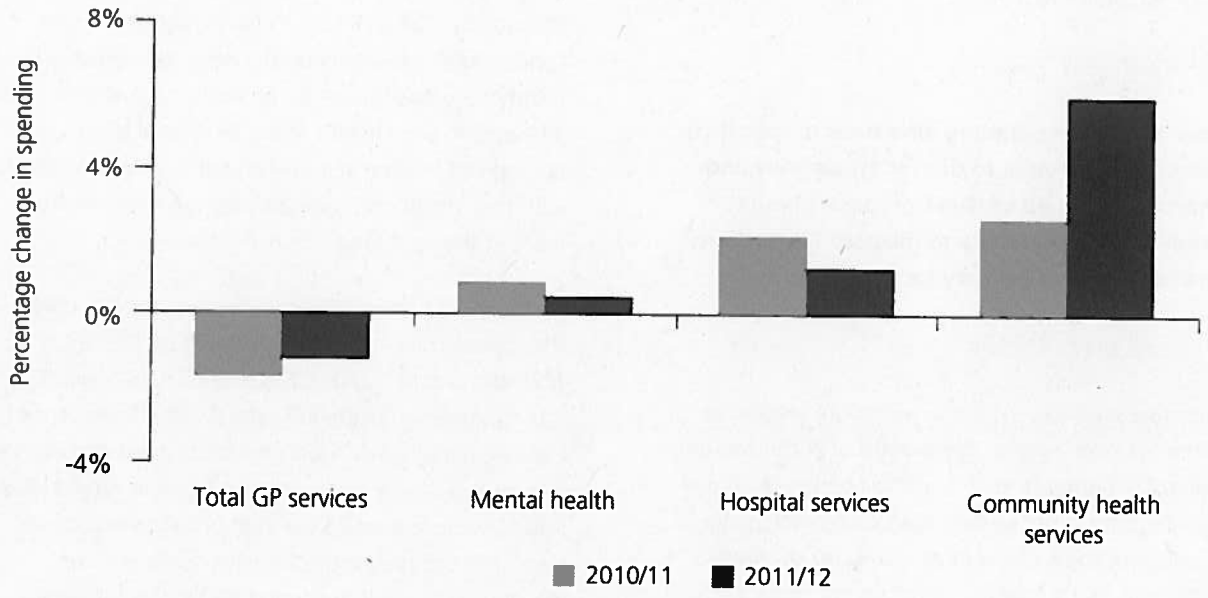
Analysis by the Nuffield Trust (2012) indicated that there was a real terms decline in investment into general practice from 2010-2012. This compared with other care settings suggests that any limited investment available for improvement is still tipped heavily in favour of other non-GP services.[26]

London practices are feeling this financial squeeze – for relatively smaller business units managing a tighter bottom line the effect is amplified. NHS England commissioners have confirmed that a small number of London practices merged or changed ownership in 2012/13 for financial reasons alone. Even relatively large practices with 10,000+ list sizes are anxious about financial sustainability. There is a risk that with a reduced budget, some practices are doing less with less. 37 per cent of GPs polled by the RCGP opinion said they had made cuts to staff.[27] Without investment in service redesign and improvement, the impact could be a net reduction in quality, safety, access and patient satisfaction with care.

There is a need to end the piecemeal reward of enhanced services from general practice – a process that for any small enterprise adds to the financial uncertainty and inability to plan effectively for the future. Service developments need to be appropriately contracted for and funded with opportunities to tailor these to local population needs where required.

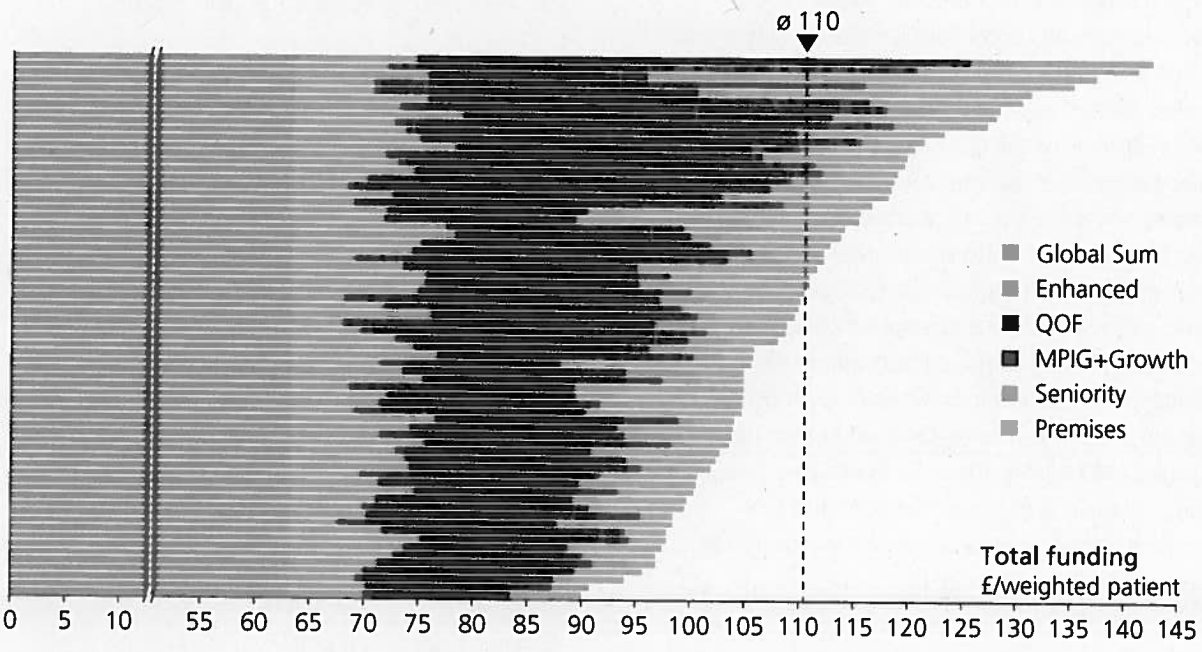
23. Hill S (2013) Transforming London's Primary Care. McKinsey & Company
24. Is there a study to demonstrate this?
25. Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R, Walsh N (2013) Securing the Future of General Practice: New Models of Primary Care. The King's Fund and Nuffield Trust
26. Charlesworth A (2013) Trends in Health Spending and Productivity. Nuffield Trust
27. GP Opinion Survey (2013) Royal College of General Practitioners: Perceptions of Resourcing among GPs. ComRes

Figure 2: Percentage changes in spending by type of care 2010-2013



Nuffield Trust (2013)

Figure 3: Sources of funding for all practice in a sample London CCG



(McKinsey, 2009)

Variations in funding levels for general practice need to be addressed and resources distributed based on population health need and rewarding outcomes. There continues to be wide differentials in funding between neighbouring practices.

Investment to develop primary care is urgently needed. The vision of transformed general practice must be clarified quickly in order to model the financial cost of development required alongside the expected

improvements in health outcomes and cost reductions elsewhere in the system.

Service changes

London CCGs are leading ambitious proposals to reconfigure services to deliver efficiencies and improved care. All of these proposals hinge heavily upon the ability to increase the capacity and capability of primary care services.

Acute reconfigurations

There are pressures to reconfigure acute services in London. Constraints on the availability of clinical staff will make it difficult to achieve the London Quality Standards for acute services without service change. In addition, some of the most financially challenged NHS trusts in the country are in London. Service reconfigurations are at different stages in each London area. These reconfiguration proposals include a reduction in the number of hospitals providing full A&E services, acute inpatients medical, surgical and paediatric care, and consultant-led maternity services, and the concentration of planned surgery. Across London, there would be a reduction of 6 full 24-hour A&E units when all the reconfiguration proposals already agreed are implemented. Following several independent reviews by the Secretary of State, North West London has plans to concentrate acute services at five major acute hospital sites: Hillingdon, St Mary's, Charing Cross, Chelsea & Westminster and West Middlesex. Charing Cross, Ealing, Hammersmith and Central Middlesex hospitals will be redeveloped as local hospitals with Charing Cross and Ealing having changed A&E services. Chase Farm's A&E services will change at the end of November 2013 and King George Hospital's services are currently expected to change in the summer of 2015.

NHS 111

Throughout 2012/13 NHS 111 was mobilised across London as a two-year pilot of a new, free-to-use telephone based service for accessing urgent care. NHS 111 aims to offer health advice or referral to an appropriate healthcare provider within a single contact, with the ambition to navigate patients to the 'right place at the right time'.

Four NHS 111 providers were commissioned to cover the capital; three existing GP out-of-hours (OOH) providers and NHS Direct. Since April 2013 London 111 has received c480,000 calls. Around 9 per cent of calls are immediately transferred to London Ambulance service and 6 per cent of callers advised to attend local A&E/ UCCs. Around 25 per cent of callers require self care advice or have more complex needs and are transferred to speak to a nurse within the 111 service. However, the majority of callers, 49 per cent, are identified as needing to speak to or see a GP, and as most calls occur in out-of-hour periods, callers are transferred electronically to GP OOH services.

Learning from 111 pilots has provided evidence that patients experience difficulties gaining access to their general practice. This manifests in over a third of all callers who are advised to see their own GP in-hours, rejecting this advice and requesting an alternative service, usually this is an appointment at a local urgent care or walk-in centre.[28] However, in North West London, links with 111 and local GP practices means callers are offered and accept same day appointment slots with their GP practice.[29]

Referrals from 111 to community nursing services including rapid response services are low. Less than 0.1 per cent of all 111 referrals are transferred to community services. There are some notable examples of higher referral rates.[30] A review of 111 and London community services is underway to understand why referral rates are low and identify solutions to increase

28. Analysis of London 111 call volume for April, May and June 2013 shows 11 per cent of calls to 111 (42,000) where the callers registered GP was the most appropriate service that the patient was then referred to. Over one third (150,000) of callers rejected the option of their GP practice and instead opted for an alternative service matching their requirements.
29. 41 GP practices in Westminster, Kensington and Chelsea offer a morning and afternoon urgent access slot for 111 to book patients in
30. Wandsworth CCG integrated their community service 'single point of contact' (SPOC) within their NHS 111 service, creating referral routes from 111 to 14 community services including rapid response nursing services, DN service, falls, OT and Physio services. Westminster, Hammersmith and Fulham and KC CCGs created an additional electronic referral platform to community services increasing referral rate to DNs to 6 per cent.

appropriate referrals from vulnerable older callers or callers already registered with community services.

A high number of Londoners aged 18-55[31] call 111 on weekdays between 17:00–22:00 peaking at 19:30, possibly having finished their working day and seeking health advice. Alternative health advice channels such as online health and symptom checkers could be made more widely available to reduce this peak in demand. It is important that existing online resources, e.g. NHSD Health and Symptom Checker, are retained and utilised as additional 111 access channels.

NHS 111 has in-built technical links and data transmission connections between each NHS 111 and GP OOH providers. This supports transmission of electronic referral and booking-in systems and includes transmitting clinical outcome messages between four NHS 111 providers, 12 GP OOH providers, numerous urgent care centres and hundreds of GP practices. Most GP systems however have been slow to adopt the required technical standards to receive the electronic messages.

GP Out of Hours (OOH)

GP OOH services provide primary care to patients who need to be seen quickly when their general practice is closed. Since 2004 practices have been able to opt out of providing OOH care and responsibility for commissioning these services has been transferred to local commissioning organisations. Stand alone GP OOH services are often based within large walk-in or urgent care centres, where face-to-face care can be provided at an accessible location.

There is limited information available on the performance of these service providers and no data regarding correlations with A&E attendance. The Urgent and Emergency Care Clinical Audit Toolkit states that all GP OOH services are to be routinely monitored.[32] A Department of Health study in 2010 found that most GP OOH services work effectively to deliver a high standard of care to patients who need urgent care when their GP practices are closed.

However, there are variations in the standard of care provided and with a lack of performance information available, commissioners are not always able to hold providers to account effectively.[33]

Data included in a study by the Primary Care Foundation (2010) shows large differences between geographic areas in how quickly patients can access face-to-face care through GP OOH. In many areas, all emergency patients calling their OOH service are seen face-to-face within one hour; however in at least four areas, the local providers were only able to comply with this standard in 60 per cent of cases. In an investigation into OOH provider, which had been delivering a poor standard of care, many of the issues were attributed to the local commissioners' lack of ability to challenge services and enforce standards of care.[34,35]

NHS 111 provides a preliminary clinical assessment of callers symptoms and triages patients to the most appropriate service. The pilot of NHS 111 services in London has provided the following insights:

1. The NHS 111 service has reduced GP OOH demand by between 5 and 15 per cent but the concentration of GP OOH contacts requiring a face-to-face assessment as opposed to a phone consultation has increased by 7 per cent. The proportion of home visits required has not noticeably changed. This means the activity profile for GP OOH has shifted as a result of implementing 111 and the corresponding commissioning and contracting arrangements should also be reviewed.

2. The NHS 111 system identifies the timeframe within which the GP OOH service should consult with each patient. Delays in the GP OOH response can result in patients calling back to NHS 111 for a status update. 15 per cent of NHS 111 calls relate to patients who have been unable to get a call back from their GP OOH provider within the set timeframe. This suggests that there may be an inherent capacity problem in GP OOH services that requires further investigation.

31. Average weekday 111 call volume for 18-55 year old peaks at c2, 800 calls per day between 17:00-22:00 hours over 6 month period (January – June 2013)
32. Royal College of General Practitioners, Royal College of Paediatrics and Child Health and the College of Emergency Medicine (2010) Urgent and Emergency Care Clinical Audit Toolkit

3. NHS 111 provides an initial clinical triage using NHS pathways to decide whether a face-to-face or telephone consult is required by the GP. The GP OOH service should in theory be able to make a direct face-to-face booking. However, during the pilot some GP OOH providers reassessed all referrals and generated different dispositions for patients. A large-scale clinical audit on whether this was appropriate will be initiated as part of the NHS 111 learning programme. Reassessment of patients is not considered good practice. It is better to streamline the process for patients and standardise the system, reducing patient confusion and additional GP/triage cost and risk.

4. Special Patient Notes (SPNs) detail important clinical or social (e.g. child protection) data on high risk, vulnerable patients with complex needs. These SPNs are shared between GP in-hours and GP OOH providers and a new IT platform has been created to make them visible to NHS 111. Uptake of the new SPN electronic template has been varied and the pilot has exposed inconsistencies in the quality of SPN completion. A recent audit of London's use of SPNs for over 75 year olds showed a decrease the likelihood of an emergency ambulance or referral to A&E by 50 per cent. It has also showed that patients were 50 per cent more likely to require a 'speak to GP' rather than a 'see GP' outcome.

5. NHS 111 pilots would like to see greater uptake of a feedback loop created for GP OOH providers and other healthcare professionals to enable system improvements.

6. Patients undergo a triage by NHS 111 of approximately 10 minutes before transfer to GP OOH, which may be unnecessarily long and patients find this frustrating, particularly when they have minor problems. In addition, the routing of patients to NHS 111 providers out of their area and lack of interoperable IT systems across NHS 111 providers can lead to heightened frustration for patients prior to accessing the GP OOH service. If patients call back to NHS 111 with a change of symptoms they may find they are talking to a different provider who cannot access detail from their original triage.

Urgent care walk-in services

Urgent care walk-in services were developed to have a 'see and treat' approach to less serious yet immediate illness or injury.[36] This approach was set up to address the problems associated with demand management and treatment waiting times in A&E.[37]

Urgent care services are highly fragmented and generate confusion among patients. Currently, urgent care walk-in services across England range from large integrated care services that encompass a 24/7 urgent care centre, GP services in hours and OOH, emergency dental, rapid response nursing teams and radiology services to a minor injuries unit that has variable access to essential healthcare professionals and diagnostics, and may not be available out-of-hours. Numerous names are given to these facilities and there is significant variation in the care offered between them for different conditions and for patients of different age groups, and within services of the same name, across different geographies. This can be in respect of the services provided, clinical staffing, opening hours, protocols or overall quality of care.

New quality standards for urgent care services have been devised to support a more standardised approach. CCGs are taking account of these standards and developing commissioning strategies for urgent care services in future. These will need to take into account new opportunities afforded by a transformed general practice landscape – increasingly integrated and more accessible with greater potential to directly provide and share unscheduled care services across practice networks 24/7.

Integrated care systems

A common theme in reconfiguration proposals for London is the aspiration to develop more integrated care and to deliver more care in primary and

33. Colin-Thome et al (2010) General Practice Out-of-Hours Services: Project to consider and assess current arrangements, Department of Health
34. Primary Care Foundation (2011) Out of Hours Services Benchmark
35. Stern, R (2010) Improving out-of-hours care; GP Commissioning in association with NHS Alliance

community settings. London's health and social care commissioners and providers recognise the need to move away from organisationally imposed boundaries and work together to provide more coordinated care for their population. The approaches adopted across London have varied significantly in scale from single borough level initiative to multi-borough or whole systems. Different populations have been targeted, a range of models piloted, and there is no unified consensus on the pace required for implementation. It is widely accepted that coordinated care can take many forms and there is no one model that should be universally adopted; however there is sufficient evidence to demonstrate that there are a number of key ingredients (e.g. risk stratification, care planning, case management) which impact on the ability to commission and provide joined up care. These key ingredients provide significant opportunity for London's health and social care system to respond to the needs of the population they are serving. There has been a movement away from developing services purely along speciality/disease specific lines towards a generalist service that responds in a more holistic way to multi-morbidity.

The largest scale integrated care system in London covers the North West boroughs and has evolved over many years. The North West London Integrated Care Pilot is designed to improve the coordination of care for people over 75 years of age, and adults living with diabetes. The establishment of professional multi-disciplinary teams has had an important role in facilitating collaborative working and nurturing a sense of shared objectives in patient care. As of June 2013, 220 multi-disciplinary case conferences were held across the three inner North West London boroughs, discussing over 1600 people and the care they need[38], with 37,000 individual care plans produced[39]. The pilot has been able to demonstrate increased staff commitment and motivation as a result of the new ways of working. 77 per cent of GPs felt that they had improved patient care, 69 per cent of patients felt they had increased involvement in decision making facilitated by care planning. There are however still barriers to overcome. GPs commented that participating in multidisciplinary team meetings was difficult due to the time commitment. This demonstrates that finding the most effective ways to deliver care coordination is a continually evolving effort.

In summary

The mounting pressures detailed here support what practices are telling us. This is clearly a defining moment in the history of primary care in London. General practice is operating in an increasingly harsh environment with many practices already in crisis or recognising that the situation is not sustainable. **No action is not an option.**

1. **London's population growth and complexity are placing unprecedented levels of demand on general practice and the current service is struggling to respond effectively to rising health needs.** London needs urgent action to tackle health inequalities. General practice will need to adapt to rising levels of demand, proactively preventing ill health and coordinating care for people living with complex health needs in challenging social circumstances.

2. **London faces a significant financial challenge. Delivering smaller pump-prime investment in primary care initiatives has the potential to release greater cost efficiencies overtime. Practice finances are declining in real terms, exacerbating their inability to invest in service improvements and causing some to fold.** London needs a general practice service that is delivered by sustainable and financially effective organisations.

3. London CCGs are leading ambitious proposals to reconfigure local services to improve care that hinge heavily upon the ability to increase the capacity and capability of primary care services. London needs to be bold in its ambition in order to deliver the capacity shift required for primary care services.

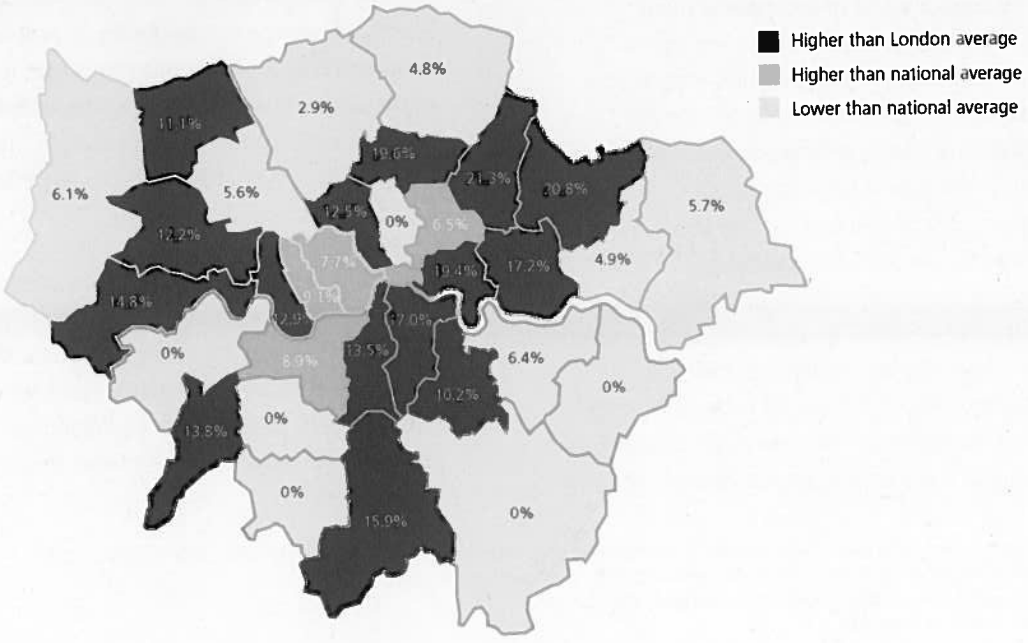
36. Royal College of General Practitioners (2011) Guidance for commissioning integrated urgent and emergency care. A 'whole' system approach. RCGP
37. Primary Care Foundation (2010) Primary Care and Emergency Departments. Primary Care Foundation
38. NWL – NHS England, Whole System Learning Event, Slide pack, 20th June 2013
39. NWL Pioneer Application, June 2013

7. How Londoners' needs are being met

London's unique population presents a significant challenge to delivering outcomes at a comparable level to the rest of England. Some comparisons are included in this section to highlight the greater scale of London's improvement challenge.

The map below demonstrates that quality of care provided by general practice varies across London (as measured by the GP Outcome Standards) and London practices appear more frequently in the 'review identified' category compared to the rest of England. Variation in the proportion of outlying ('review

Figure 4: Percentage outlying practices by CCG for high-level indicators of good quality care. London GP Outcome Standards (2011/12)



NHS England

Figure 5: Percentage breast screening coverage (less than 3 years) of women aged 53-60, England PCTs 2011

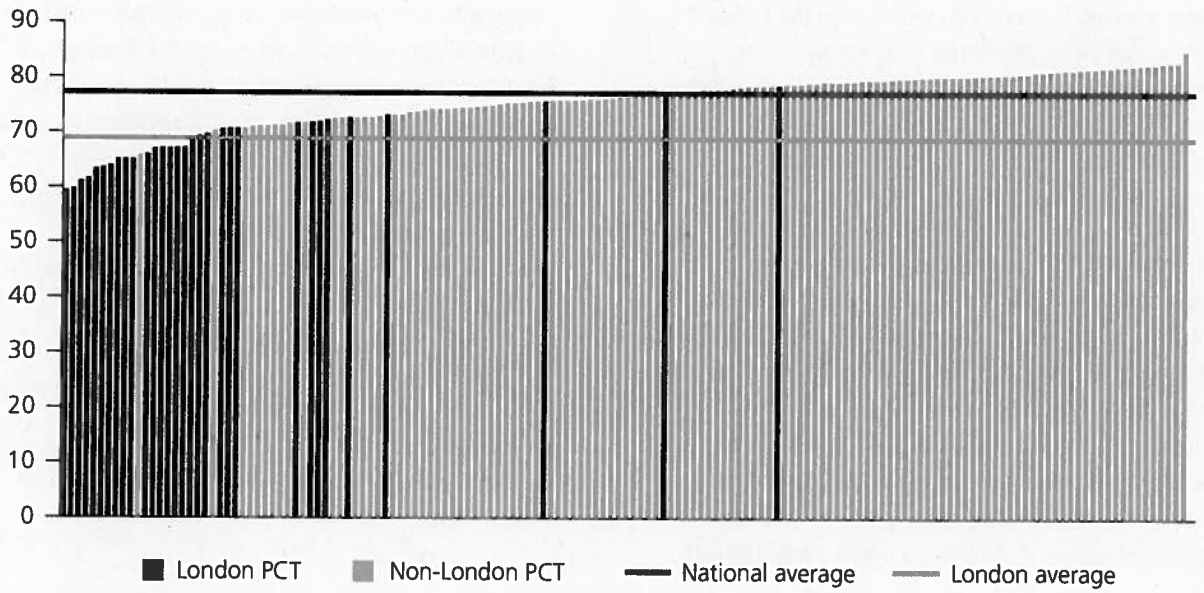
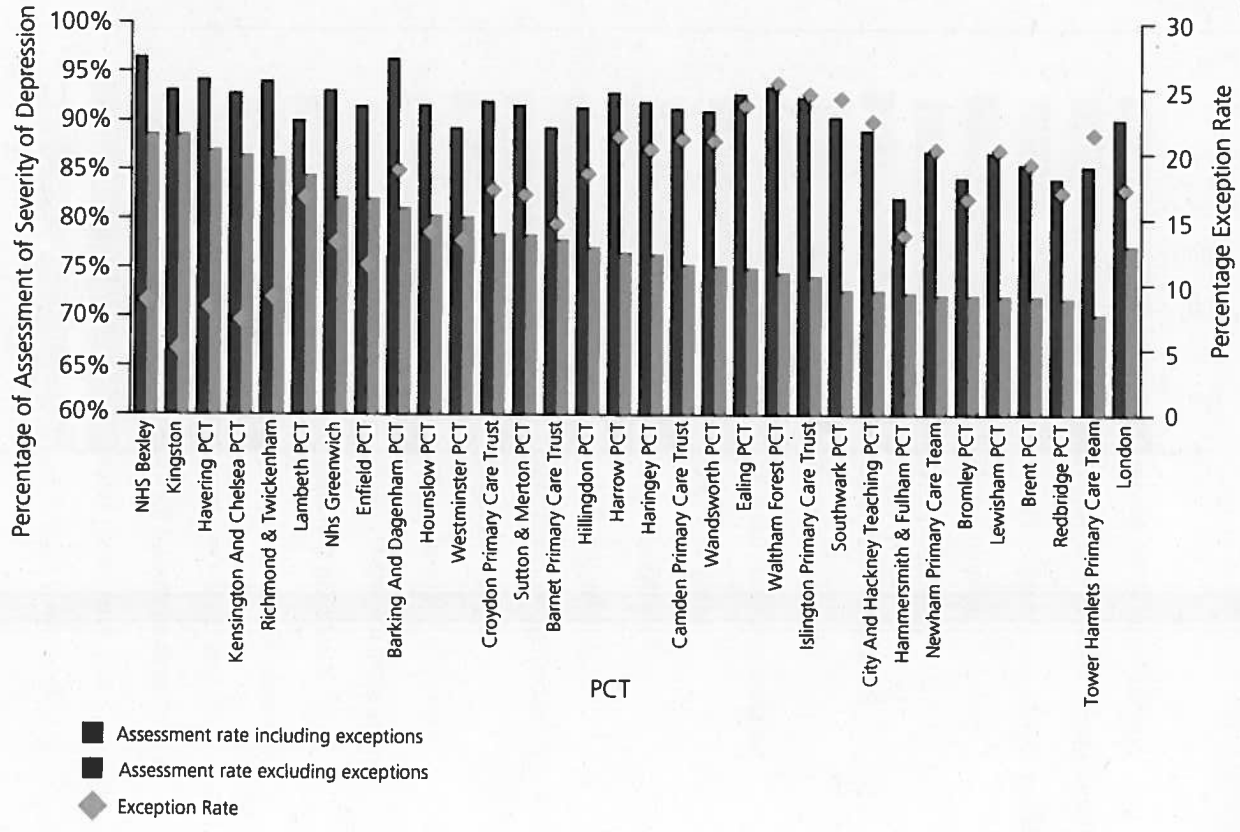


Figure 6: Impact of 'exceptions' on rates of assessment of depression severity by London PCT



QOF 2011/12

identified) practices by CCG ranged from 0-21.3 per cent in London (2011/12).

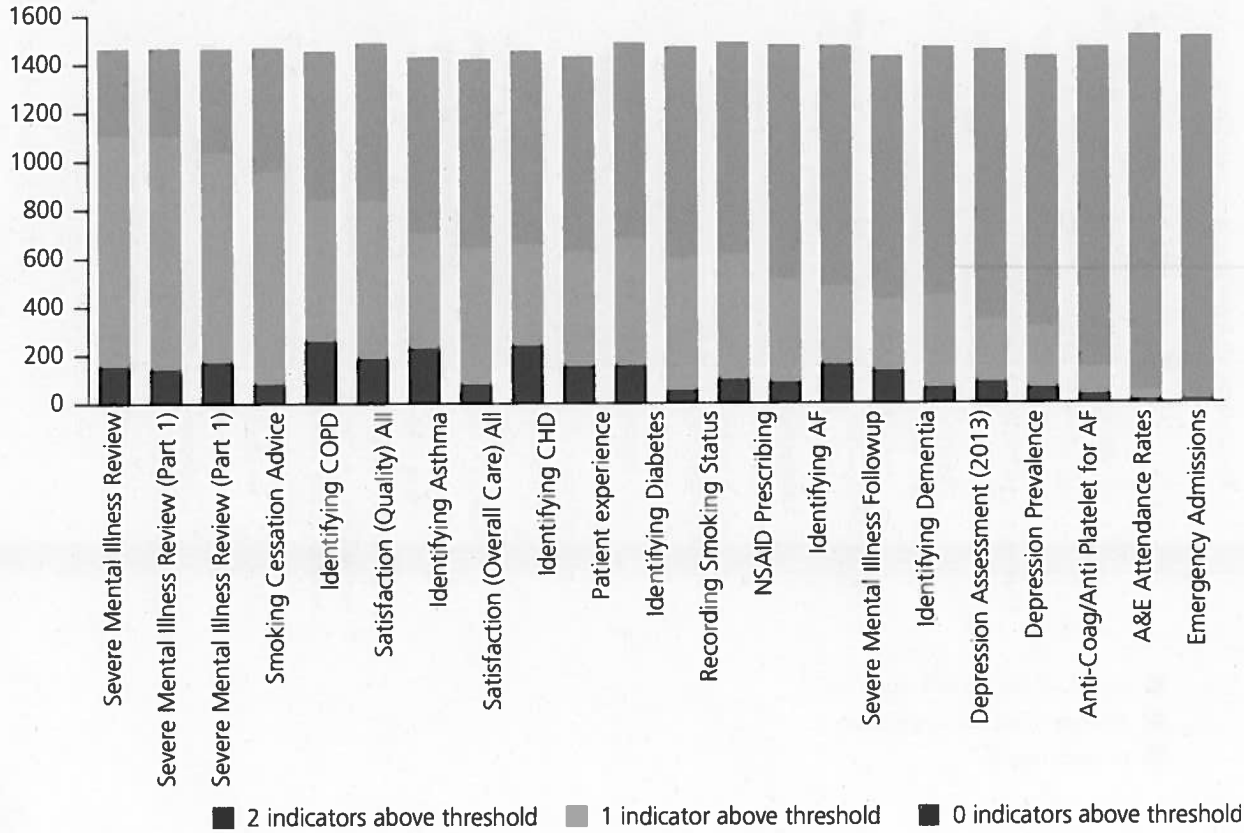
Many London boroughs do worse than the England average on key indicators of ill-health prevention, including childhood immunisations and flu vaccination, and breast and cervical screening. However, some more deprived boroughs have the highest immunisation rates in London.

Evidence suggests that many Londoners have undiagnosed and untreated conditions, for example the ratio of expected to reported prevalence of chronic obstructive pulmonary disorder varies from an inter-borough average of 0.36 to 1.47. Cancer referrals in line with best practice are lower in London than the rest of England with late diagnosis being a key factor in poorer cancer survival rates in the UK. Improving uptake of cancer screening is a major challenge for London, for example, 23 of the lowest 25 borough areas for breast screening coverage are in London.

The health inequality challenge is exacerbated by high exception reporting levels across London boroughs. It is estimated that exception levels greater than 12 per cent represent a gap in care for those patients in areas of high deprivation and corresponding high health need. The graph below shows the marked difference in exception rates between London boroughs for patients who were asked to attend the practice for an assessment of depression.

Analysis of the GP Outcome Standards indicators identifies where London practices are most likely to require review. Severe mental illness features prominently – a significant concern given London has an elevated prevalence of mental ill-health.

Figure 7: Number of London practices with 0,1 or 2 GPOS indicator thresholds exceeding triggering a review



London GP Outcome Standards (2011/12)

Several London boroughs are in the highest quintile for prescribing of anti-diabetic items; nationally there is no correlation between spending on insulin and non-insulin anti-diabetic drugs and the percentage of people with diabetes with controlled blood sugar. London spends less overall on prescribing and pharmaceuticals than other regions of England. This could be related to higher levels of undiagnosed disease, reflecting the population issues faced by London practices. It is also possible that London's investment in prescribing advice is having a positive impact on reducing inappropriate prescribing. Further investigation of differences in prescribing rates and expenditure is needed and effective support to ensure that prescribing is in line with best practice.

In terms of patient experience, general practice in London has always struggled to reach a national average. The 'London population effect' on patient surveys is described on page 19. However, comparisons made between London practices show stark outliers for overall patient experience. We need to do better for these patients.

Since April 2013, a single NHS England complaints team has been handling complaints for general practice and specialised services. Given the number of general practice providers in London, the largest proportion (82 per cent) relate to general practice. Learning to date has been that improvements could be made in the ways that general practice invites and responds to complaints with a high proportion of complaints related to clinical treatment (24 per cent) and communications/attitude (27 per cent). The NHS England complaints team is keen to work with the profession and regulators to reduce the volume of complaints in London, improve the handling process and ensure services are improved in response to patient feedback.

North West London and North East London, in particular seem to have a high rate of complaints compared with other regions of the country (Fig 10). This needs to be more fully understood and the NHS England complaints team is keen to work with the profession and regulators to reduce the volume and help address recurring themes.

Figure 8: Number of London practices by overall patient satisfaction score

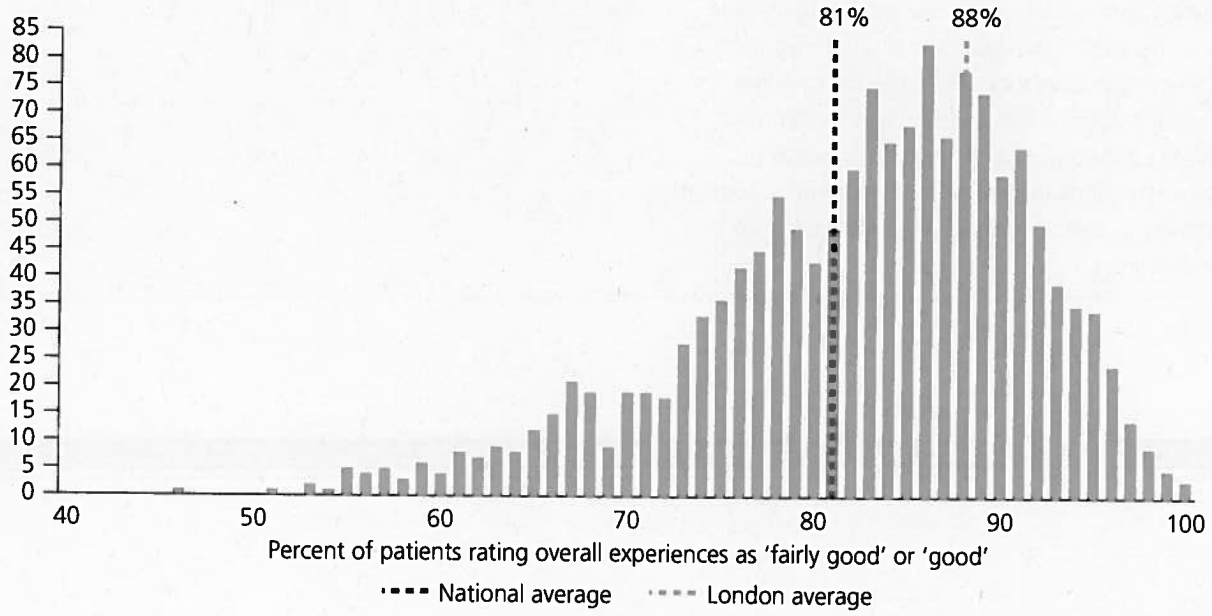
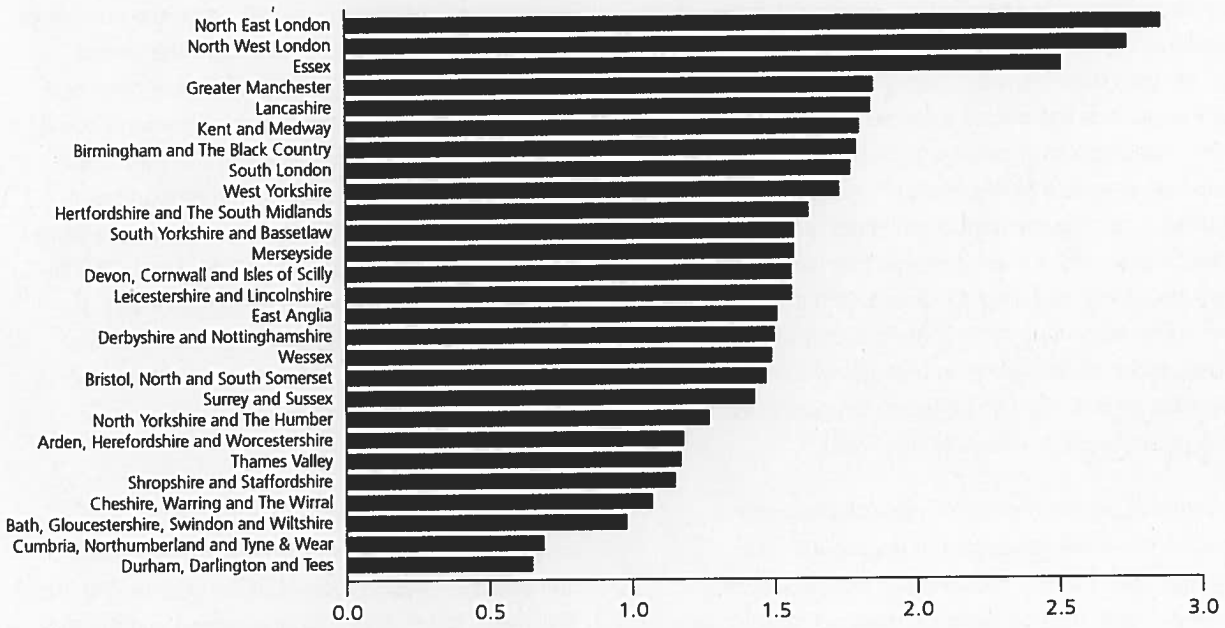


Figure 9: Complaints per 10,000 population



Variations in performance will always exist. They represent an opportunity for improving population health and must be examined to inform continuous improvement activities. There is no doubt that population demographic factors underpin much of this variation and present more complex situations for some practices. However, practices and networks across London have shown it is possible to deliver excellent outcomes in a diverse urban environment. Providers and commissioners investing time and resources to engage effectively in service improvement is the key to delivering improved patient experience and outcomes.

NHS England

8. How general practice services need to adapt

Coordinated care

"MY CARE IS PLANNED WITH PEOPLE WHO WORK TOGETHER TO UNDERSTAND ME AND MY CARER(S), PUT ME IN CONTROL, CO-ORDINATE AND DELIVER SERVICES TO ACHIEVE MY BEST OUTCOMES."

National Voices, Narrative for Integrated Care, 2012

A large proportion of the population live with complex (often co-morbid) conditions. People with long-term conditions account for more than 50 per cent of all general practice appointments, 65 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days.[40] These patients are most frequently in contact with multiple parts of the health and social care system and consume circa 75 per cent of the overall health and social care spend in England.[41] Primary care can play a key role in preventing illness and premature death through the effective care management of people with chronic conditions.

Much of the population use health and social care services infrequently to respond to immediate and short-term issues or concerns. However there is a cohort of the population including those with multiple long-term conditions, older people, those with dementia, and people at the end of their lives who are frequent users of services from multiple providers of care, are at greater risk of adverse outcomes such as unplanned hospital admissions, and who may therefore benefit from additional preventative and co-ordinated care. Analysis from North West London demonstrates that this group is approximately 20 per cent of the population and as the highest users of health and social care services they consume approximately 75 per cent of all resources. These costs will continue to rise in line with a growing population and consequent increases in demand.

40. Nigel M, Sue R, Isabel H, Karet B (2011) Care Planning: Improving the lives of people with long term conditions. Royal College of General Practitioners
41. Department of Health (2011) Ten things you need to know about long term conditions

Frail elderly in focus:

- The over 65s are projected to rise by 34 per cent (300,000) to 1.17 million, the over 80s projected to rise by 40 per cent (100,000) to 350,000, and the over 90s are expected to almost double to 96,000.
- The minority ethnic population in London aged 80+ is projected to almost triple, comprising about a quarter of the over-80 population by 2031.
- Once in hospital, vulnerable patients are at increased risk from unfamiliar and confusing environments, infection and the potential loss of day-to-day functionality. Long-term care frequently follows as the decline experienced while in hospital means returning home is often viewed as not being an option for the frail elderly.
- In London there are higher levels of intensive home help for the frail elderly than the national average but the rate varies across boroughs between 25 per cent and 48 per cent (24 boroughs are above the national average, but 9 fall below).
- Older people account for 68 per cent of all emergency bed days in the NHS. London hospitals have higher use of emergency bed days for this age group than the rest of the country. In 2012, seven of the top ten areas nationally with the highest emergency bed use were in London.

Dementia sufferers in focus:

- There are around 65,000 Londoners with dementia; this is forecast to rise by 16 per cent to 2021 and by 32 per cent to 2031.
- Half of all people with dementia never receive a diagnosis – just 31 per cent of the capital's GPs believe they have received sufficient basic and post-qualification training to diagnose and manage dementia.
- Earlier diagnosis and treatment can be critical in delaying the onset of dementia.
- Carers and other family members of people with dementia are often older and frail themselves, with high levels of depression, physical illness, and a diminished quality of life.
- London is struggling to meet the needs of older black and minority ethnic Londoners who have dementia.
- Older people with dementia occupy 20 per cent of acute hospital beds across England but 70 per cent of these may be medically fit to be discharged.
- 80 per cent of people living in care homes have dementia or severe memory problems.
- The estimated cost of dementia to the English economy is about £20 billion p.a. This is set to increase to over £27 billion by 2018.
- Delaying the onset of dementia by 5 years would reduce deaths directly attributable to dementia by 30,000 a year.

Rising demand for End of Life Care (EoLC):

- Nationally, 70 per cent of patients want to die at home but 58 per cent die in hospital (18 per cent die at home, 17 per cent die at care homes, 4 per cent die in hospices and 3 per cent die elsewhere).
- EoLC provision in London fails to meet the wishes of patients.
- There are approximately 500,000 deaths in England every year. This is forecast to rise by 16.5 per cent to 590,000 in 2030.
- The percentage of deaths among those aged 85 forecast to rise from 32 per cent 2003 to 44 per cent in 2030.
- London has the five worst performing local authorities nationally in terms of deaths in hospital (Ealing, Enfield, Redbridge, Newham, and Waltham Forest).

- The proportion of deaths in hospital following an admission in the last week of life from care homes is higher in London than in other regions.
- 78 per cent of people are admitted to hospital in their last year of life.
- 30 per cent of people use some form of local authority funded social care in the last year of life.
- London has more deaths in hospital following emergency admission (this is the most expensive form of EoLC).
- The inpatient cost of EoLC is £3,065.50 per person, compared with £2107.50 for EoLC in the community and less for home.

Variation in general practice quality, and a fragmented health and social care system, contribute significantly to wide variations in patient outcomes and experience.

A number of integrated care systems are being established across the capital to improve care coordination and primary care is seen as a fundamental player in this effort to:

- Provide care that is focused on people, not a care pathway or setting.
- Support people to manage their own conditions and be supported at home and in the community.
- Coordinate patient care.
- Provide care that is local where possible and central where necessary.

Continuity of care

There is increasing evidence that continuity of care by GPs will deliver better health outcomes, more satisfied patients and at a lower cost, vital for people living with multiple complex conditions.[42] For a number of reasons, patients find it difficult to get the relationship continuity they would like with their GP. Patient satisfaction with seeing a named GP is lower in London than elsewhere in England. Where a patient sees the same GP regularly they are more likely to trust their GP's advice, agree with decisions about their care and adhere to any treatment.[43] When we consider the challenges of supporting vulnerable older people it is clear that a trusted clinician who knows them and their care history is especially important.

In order to be an effective delivery partner in integrated care, general practices across London will need to provide a more consistent service offer that is patient-centred and tailored for people living with multiple complex conditions. Practices will need to adopt new ways of working with patients, and a range of public, private and voluntary sector providers. Patients with complex needs will require more multi-professional input and longer consultations. Integrated care systems will need to be generalist in their design in order to provide a holistic response to patients. Primary care practitioners will need enhanced training to adapt to the new ways of working and new skillsets required. The ability to work across organisation boundaries will require interoperable IT systems and shared patient records.

Londoners are particularly dissatisfied with their ability to see a GP of choice and being able to choose a GP closely correlates with the perceived helpfulness of the support given to manage their long-term condition.

42. Paddison C, Sunders C, Abel G, Payne R, Roland M (2012) Why do patients with multimorbidity report worse primary care experiences? Cambridge Centre for Health Services Research
43. Hill A and Freeman G (2011) Promoting Continuity of Care in General Practice. Royal College of General Practitioners

Management of long-term conditions in London

- London has a lower rate of emergency admissions for ambulatory care sensitive conditions than the national average (428 per 100,000 compared with 426 per 100,000 nationally); however, there is a four fold variation between London boroughs (from 223 to 857).
- Rates of emergency admissions in children for chronic conditions such as diabetes, epilepsy and asthma are also lower in London than the England average, although they show a threefold to fivefold variation across London boroughs.
- There is growing evidence that patient-reported good access to general practice is associated with lower emergency admission rates for ambulatory care sensitive conditions.
- Although London's performance on some clinical quality indicators (eg cholesterol control among patients with coronary heart disease or blood pressure control among stroke patients) is similar to the national average, there are variations of up to 10 per cent within London, with some areas that cover relatively deprived populations (e.g. Newham) outperforming more affluent areas.
- The National Diabetes Audit found that only 54 per cent of people with diabetes in England received all nine care processes. Among old PCT areas in London the range was from 31 per cent to 63 per cent. Again, some deprived areas in East London had the highest rates.
- Breast cancer survival rates show no statistically significant differences between London PCTs. For lung cancer, survival rates show a socio-economic gradient, with Westminster and Richmond and Twickenham having higher rates than more deprived parts of London (Hillingdon, Waltham Forest and Redbridge).
- Compared with the England average (29 per cent), London had a higher percentage (35 per cent) of households receiving intensive home care, although there is wide intra-London variation (from 25 per cent to 48 per cent).

Extract from General Practice in London: Supporting Improvements in Quality (2012) The King's Fund and Imperial College London.

Figure 10: Number of practices by patient satisfaction score for seeing a preferred doctor. GP Patient survey 2011/12

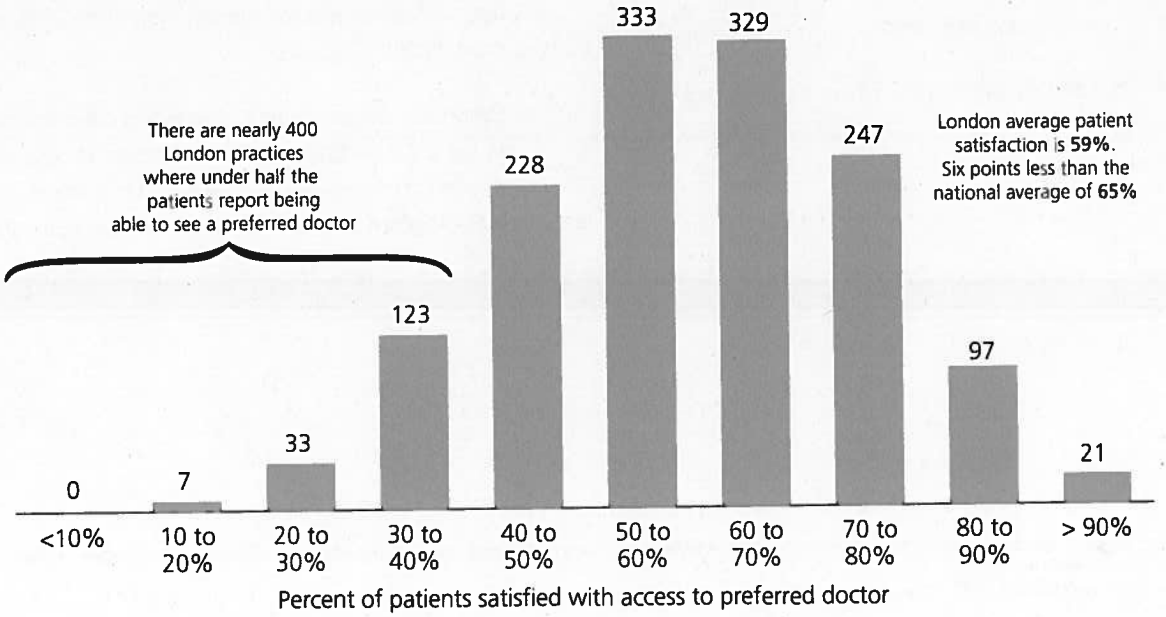
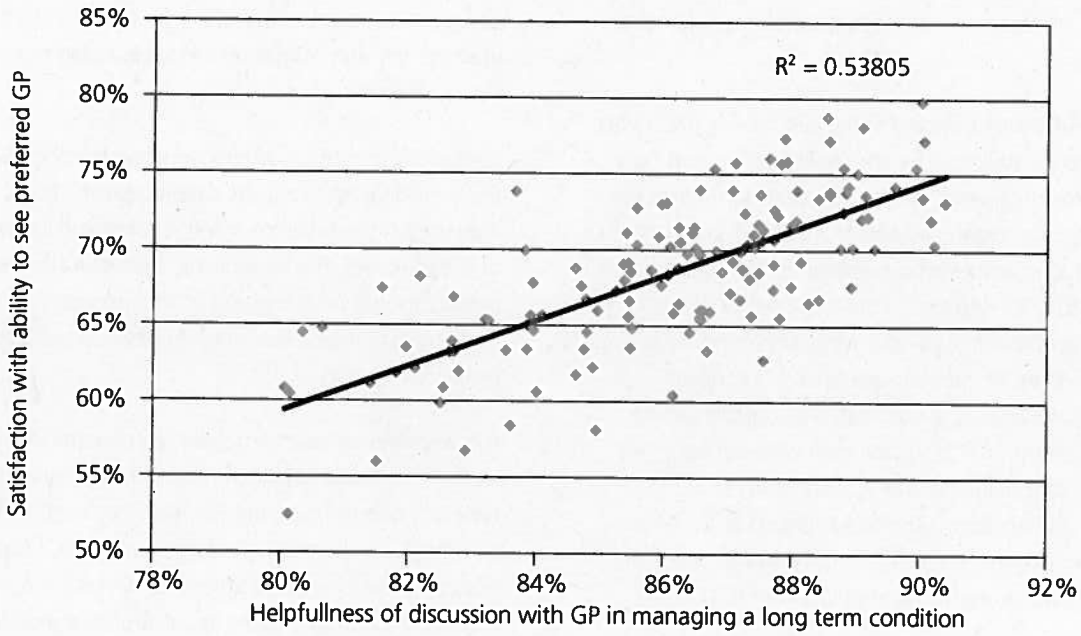


Figure 11: Satisfaction with access to preferred doctor 'v' helpfulness of discussion with GP in managing LTCs



GP Patient Survey (2011/12)

A recent Department of Health evaluation of integrated care pilots in England found that although integration did lead to better processes, the patient themselves did not generally feel that this had translated into an overall improvement in their experience and care continuity had actually declined.[44]

Continuity of care is important clinically as well as financially and plays a major role in reducing hospital admissions as well as improving quality of care.[45] A study examining the impact of continuity found that a 1 per cent increase in the proportion of patients able to see a particular doctor was associated with a reduction of 7.6 elective admissions per year in the average sized practice and 3.1 elective admissions per year. This equates to considerable cost savings across a whole practice of £20,000 per year for a 1 per cent increase in continuity at a saving of £2,641 per hospital admission.[46]

Different models of service delivery can improve continuity for example, in 2013, a London surgery with a 20,000+ patient list, proved it was possible to improve GP-patient continuity by grouping clinicians into 'care teams' and introducing a 'triage desk' to undertake all routine tests. Continuity of care improved threefold in the early stages of this pilot.[47]

Risk stratification

The entire population does not require or need an integrated system of care to meet their needs. To identify those individuals who would most benefit from a coordinated care package the system needs to risk assess patients. Risk stratification is using information on people's past interaction with health and social care to predict those who need more coordinated support. Risk stratification systems are now in widespread operation across London. For example across Southwark and Lambeth an innovative software tool (called Population Health Management & Clinical Checking) is being used across all practices to identify people at higher risk of emergency admission to hospital in the next 12 months. It uses information

44. Ernst and Young, RAND Europe and the University of Cambridge (2012) National evaluation of the Department of Health's integrated care pilots. Department of Health
45. Royal College of General Practitioners (2013) Patients, Doctors and the NHS in 2022; Compendium of Evidence. RCGP
46. Chauhan M, Bankart JM, LabeitA and Baker R (2012) Characteristics of general practices associates with numbers of elective admissions. Journal of Public Health.
47. Kentish Town Care Continuity Pilot. London GP Innovation Fund (2011-13) Evaluation in process – reporting in November 2013.

about the number of times a patient has visited their GP, their diagnoses, and any unplanned visits to hospital, to determine the likelihood of needing extra support.

In 2013/14 a new Directed Enhanced Service (DES) was offered to GP practices for the identification and case management of patients who are seriously ill or at risk of emergency hospital admission. The DES provides payment to practices who risk stratify the registered list in order to tailor services to meet the needs of an increasing number of people living with complex co-morbidities. The requirements of this contract included provision of a nominated lead professional responsible for providing case management for patients, care planning and working with a multidisciplinary team. The DES is priced at £0.74 per registered patient or £5,175 for an average sized GP practice (with a registered population of 6,911).

Risk stratification is not yet applied systematically across London with many high-risk patients not yet identified, resulting in a lack of proactive and coordinated care. Identifying high-risk individuals in London has to be a priority.

Care planning

Care planning is a means of supporting people to understand and confidently manage their own condition, as well as supporting them to manage the inevitable consequences of living with a long-term condition.[48]

For those individuals identified as high risk, there is a clear need to provide care plans developed and delivered with the patient, to identify shared goals and how to achieve them, as well as aligning primary, community and social care around localities serving the same population of patients.

Care planning is an example of putting self-management support into practice in a systematic way as part of routine care for people with long-term conditions.[49] Patients tell us that they want us to do more to support their own self-care. 95 per cent of people with diabetes are seen annually in general practice, yet only 50 per cent discuss a plan to manage their diabetes.[50]

Care plans should be developed in partnership with the individual receiving the care (co-production), drawing on the skills, knowledge, time and expertise of service users. The relationship between clinician and patient should be a meeting of two experts, challenging the perception of service users as passive recipients of care.

A care planning approach in which patients, health professionals and carers work collaboratively and review outcomes on a regular basis has been shown to be effective in improving patient outcomes.[51] Care planning however takes time to undertake the needs assessment and to engage in collaborative working – this can only be sustainably be achieved by transforming services to deliver greater capacity and integrate team working.

To support this and enable care plans to remain current, easily accessible, and to meet the needs of the individual, local systems need to utilise developed and emerging technological solutions. Whilst many systems are in development, there are examples of where technology has been used to enable patients and those delivering their care to electronically share a care plan.

The use of care planning and its application remain inconsistent across London. Whilst many systems are using care planning as an important approach in providing co-ordinated care for an individual, the role of the patient in developing and owning these has been largely absent.

Longer consultation times and case management

The general practice delivery model remains largely focused on face-to-face contact between the GP or

48. Royal College of General Practitioners (2013) Patients, Doctors and the NHS in 2022: Compendium of Evidence. RCGP
49. Nigel M, Sue R, Isabel H, Karet B (2011) Care Planning: Improving the lives of people with long term conditions. Royal College of General Practitioners
50. Health Care Commission (2007) Managing diabetes: Improving services for people with diabetes.
51. Mercer SW et al (2007) More time for complex consultations in a high deprivation practice is associated with increased patient enablement. British Journal of General Practice

practice nurse and the patient. The standard appointment time continues to be 10 minutes, which presents a challenge when dealing with a cohort of patients that will have multiple problems to discuss. In future a greater proportion of patient contacts are likely to be carried out through non-face to face digital channels. A *Cochrane Review* in England found evidence that at least 50 per cent of calls can be handled by telephone advice alone (ranging from 25.5 per cent to 72.2 per cent). This is seen as being key to releasing capacity to provide more bespoke services for the patients whose requirements are greatest.

A fundamental building block for integrated care is the creation of integrated or multi-disciplinary teams comprising all the professionals and clinicians involved with providing care for a specific group of individuals.[52]

These multi-disciplinary, integrated care teams should provide a more effective patient experience through integrated case management, a mechanism for delivery of personalised care plans. Case management forms part of a wider programme of care including primary care, primary prevention, and coordinated community care.

Whilst it remains difficult to explicitly attribute specific benefits to a particular intervention, there is evidence that case management has had a positive impact on service utilisation (length of stay and admission to long term care), health outcomes (quality of life, independence, functionality, and general wellbeing), and improving patient satisfaction.[53]

A service prototyped in the US included the creation of 'care-team huddles' to plan patient visits, distribute tasks and troubleshoot problems. Patients in the most at-risk cohort could bypass other access systems to connect directly with their care teams. These expanded care teams include practice nurses, medical assistants, community nurses and clinical pharmacists. The clinical evidence supporting this prototype was compelling with 29 per cent reduction in A&E attendances and 6 per cent fewer hospitalisations.[54] Two years in, service evaluation showed cost savings, higher patient satisfaction and reduced burnout of practitioners.

Solutions cannot be directly supplanted from other health systems that are very different to our own, but can act as inspiration for developing solutions that will work in the local context. General practices and CCGs in London will need to look at models in London, the UK and internationally to understand how the model of care needs to adapt to support better care coordination.

Appointment scheduling

National estimates suggest that people with long-term conditions account for more than 50 per cent of all general practice appointments.[55] The proportion of 'complex' workload for general practice may be even higher than this with just 20-30 per cent of the patients on a GP's list utilising 65 per cent of the available appointments.

A study of 25 practices in Tower Hamlets showed that all practices had a similar attendance pattern. 70 per cent – 80 per cent of patients attend between 0-4 times a year with 30-50 per cent of these attending 0 times. 20-25 per cent attended 5-12 times a year and the remaining 2-5 per cent of patients came more than 12 times a year. The bulk of patients (70-80 per cent) who attended 0-4 times a year used only a third of all the appointments available. Those who attended between 5-12 times used 40 per cent of all appointments at all practices. The highest attenders (more than 12 times a year) used about 25 per cent of all appointments despite being only 2-5 per cent of the patients on a registered list.

There is an opportunity to improve the coordination of treatment by simply reviewing the frequency of visits patients are making to practices. The study in Tower Hamlets found that in some cases people with co-morbidities, on different disease registers, were being recalled several times a year for assessments of each condition separately. Integrated care requires a person centred and holistic service, but quality frameworks

52. Making integrated care happen at scale and pace, The King's Fund, March 2013
53. Case Management. What is it and how it can best be implemented, The King's Fund, November 2011
54. Robert R et al (2010) The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers. Health Affairs
55. Nigel M, Sue R, Isabel H, Karet B (2011) Care Planning: Improving the lives of people with long term conditions. Royal College of General Practitioners

such as QOF and NICE are separated into discrete conditions.

Improving clinical effectiveness

It should be possible to provide a more 'one stop service' for people with multi-morbidity, whilst improving their clinical outcomes and complying with care processes recommended by the National Institute of Clinical Excellence.

Medicines management

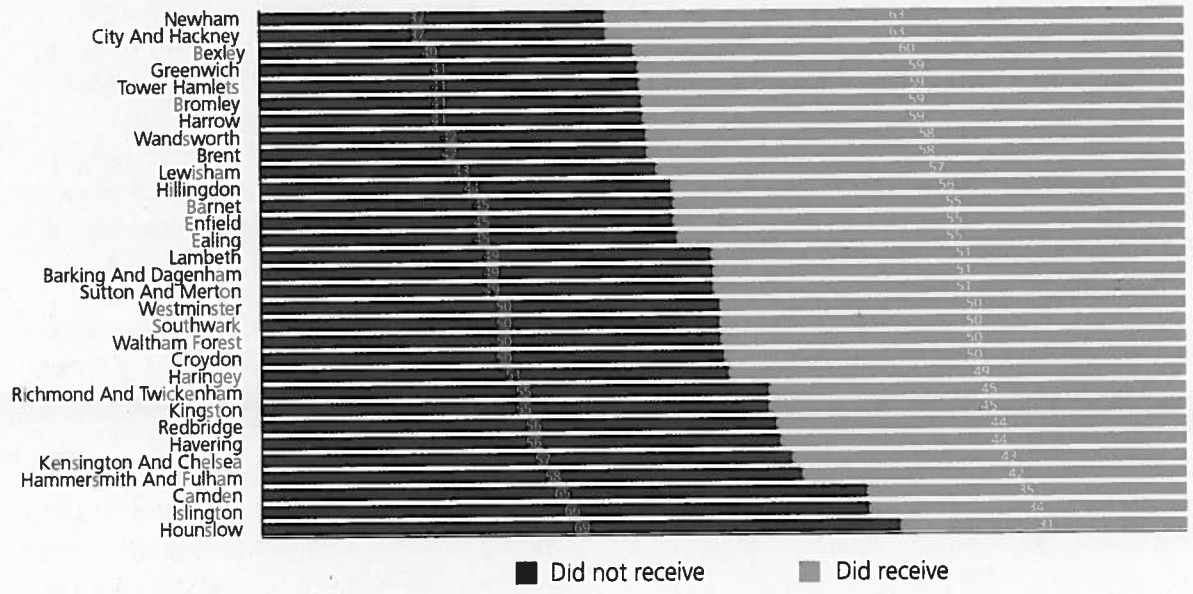
Poly-pharmacy, the simultaneous use of multiple drugs, is associated with adverse drug reactions, medication errors, and increased risk of hospitalisation. When the number of concurrently used drugs totals five or more (major poly-pharmacy), a significant risk may be present. Multiple drug use in older patients is associated with overall worsening physical and psychological health.[56]

Given that life expectancy is increasing, and multi-morbidity is more common in older patients, the problem of poly-pharmacy is likely to become worse.

Medicines cost the NHS in excess of £10 billion annually, with the total cost and number of prescriptions steadily rising; the majority of prescribing occurs in general practice. Given this investment, together with the shift of chronic disease management to primary care, GPs need to ensure their prescribing is effective in maximising health gains while minimising risks to patients.[57]

Regular and thorough **medication review** is an essential intervention for addressing the risks associated with poly-pharmacy. It is important to assess whether patients are receiving therapeutic benefit from their medicines, whether there is ongoing clinical need, and whether potential benefits are outweighed by risks and side effects. Wherever possible, patients' views should be ascertained; they should be fully involved in decisions about their medicines; the rationale behind any medication changes should be explained; and any concerns should be addressed. Reviews should be specifically arranged, rather than rushed impromptu additions to the end of a 10 minute consultation.

Figure 12: Percentage of patients with diabetes receiving all 9 care processes recommended by NICE 2010/11



Kings Fund and Imperial College 2012

56. Kadam U (2011) Potential health impacts of multiple drug prescribing for older people: a case-control study. British Journal of General Practice
57. Payne R (2011) Polypharmacy: one of the greatest prescribing challenges in general practice. British Journal of General Practice

Managing patients with poly-pharmacy can be time consuming, with complex cases requiring careful balancing of competing clinical priorities and conflicting guidelines. Where GPs do not feel they have the time to undertake a thorough medication review, they need to consider alternative approaches such as employing a clinical pharmacist or working more closely with their local community pharmacist. £9.38million is invested in funding medication usage reviews (MURs) through community pharmacies across London but the take-up across London varies significantly by borough with £165k spent on MURs in Kingston in 2012/13 compared to £446k in Newham.

Accessible care

Accessible care for all patients, irrespective of their lifestyle and needs, is key to the health of our diverse population. Good access means different things to different patients – providing frequent continuous care support for those who need it and convenient, responsive, timely care for those who seek it.

More patients are living longer with chronic conditions and need to be supported to live healthier, independent lives. They require more frequent access to continuity and better coordinated and planned services in the community, often from multi-disciplinary teams. Working age adults consult less frequently but require access that allows them to engage with services in the morning, evenings or at weekends. Some practices in London are pioneering remote consultation through email, phone or video-consultation, allowing people to be seen and treated without taking time off work. Those who require an urgent response such as parents with children need to know that they can easily contact their practice and speak to a clinician at least as quickly as they would be able to at A&E.

Although there are examples of excellent services at some practices, many London patients report that access to general practice does not meet their reasonable needs. On average patients in London are less satisfied with access to general practice than elsewhere in England across a range of access metrics. There is also significant variation in accessible services from practice to practice and limited scope for patients to register elsewhere.

Good access to general practice has the potential to reduce the over reliance on hospitals, building capacity in the community where it can be delivered faster, better and cheaper. Effective management of access in primary care has the potential to reduce some A&E attendances and emergency hospital admissions. Diagnosis and treatment will be less likely to be delayed and patients won't need to take time off work to see their GP or go to A&E to in order to be seen outside of working hours. Some practices need to be more flexible and responsive in making contact with patients with different needs. Access solutions need to be safe, practical and save the patient's time.

Access also impacts on patient experience and the quality of care they receive, and also matters to practices whose workloads can become unmanageable if access is not managed in a systematic way.[58] Many practices report increasingly struggling with rising patient demand and expectations.

Patient satisfaction across London

The GP Patient Survey collects patient satisfaction with:

- Seeing a GP of choice
- 48 hour access
- Booking appointments ahead (at least three days)
- Getting through on the phone
- Opening hours

The GP patient survey 2011/12 shows that patients across London are less satisfied with several aspects of access than elsewhere in England. Fig 13 shows red boroughs as those with patient satisfaction below the London average, amber above the London average

58. Stern R and Clay H (2009) Urgent Care – A Practical Guide to Transforming Same Day Care in General Practice. Primary Care Foundation

Figure 13: London practices by patient satisfaction score ranked against London and national averages

	Seeing GP of choice	Seeing GP fairly quickly (within 48 hours)	Booking ahead	Getting through on the phone	Opening hours
Haringey PCT	61%	70%	65%	63%	73%
Newham PCT	57%	76%	65%	59%	77%
Brent PCT	61%	75%	64%	62%	73%
Barnet PCT	64%	78%	66%	57%	72%
Camden PCT	69%	75%	69%	61%	73%
Ealing PCT	61%	75%	66%	63%	72%
Redbridge PCT	66%	75%	65%	54%	77%
Waltham Forest PCT	62%	73%	65%	61%	76%
Islington PCT	62%	73%	68%	64%	72%
Lewisham PCT	60%	76%	65%	64%	77%
Hounslow PCT	65%	72%	68%	61%	74%
Bexley Care Trust	64%	74%	66%	62%	76%
Enfield PCT	64%	75%	66%	62%	76%
Hammersmith and Fulham PCT	64%	73%	70%	62%	76%
London average	64%	76%	69%	64%	76%
Harrow PCT	62%	81%	68%	62%	76%
Sutton and Merton PCT	65%	80%	68%	62%	76%
Southwark PCT	61%	75%	71%	67%	77%
City and Hackney Teaching PCT	63%	76%	70%	67%	77%
Tower Hamlets PCT	61%	73%	72%	67%	81%
Wandsworth PCT	64%	76%	69%	67%	78%
Havering PCT	68%	72%	74%	64%	75%
Croydon PCT	64%	74%	73%	69%	76%
Lambeth PCT	62%	79%	69%	68%	78%
Bromley PCT	68%	77%	72%	65%	74%
Hillingdon PCT	67%	75%	71%	68%	75%
Greenwich PCT	65%	76%	72%	67%	76%
Richmond and Twickenham PCT	65%	78%	74%	71%	72%
Westminster PCT	69%	72%	72%	72%	75%
Kingston PCT	65%	84%	69%	67%	78%
English average	70%	80%	70%	67%	78%
Barking and Dagenham PCT	64%	78%	73%	74%	82%
Kensington and Chelsea PCT	70%	80%	75%	75%	78%

GP Patient Survey January–September 2012

Green = above the England average

Amber = above the London average

Red = below the England and London averages

and green above the English average. Very few boroughs score above the English average for any of these criteria but it is noticeable that London's patients are significantly less satisfied with their ability to see a GP of choice, '48 hour' access and opening times. The four London boroughs of Haringey, Brent, Ealing and Islington are 'red' across all criteria. None of the boroughs are 'green' across all criteria.

Furthermore there is significant variation within each borough with patients receiving highly variable access to general practice depending on which practice they are registered, with often with limited scope for moving to a practice which better meets their needs.

Urgent/unscheduled care

The GP Survey 2012 shows that less than half of patients in London are seen by the next working day. Phone lines are extremely busy first thing in the morning and same day appointments run out quickly. Many patients are asked to try again to get an appointment by calling back the following day.

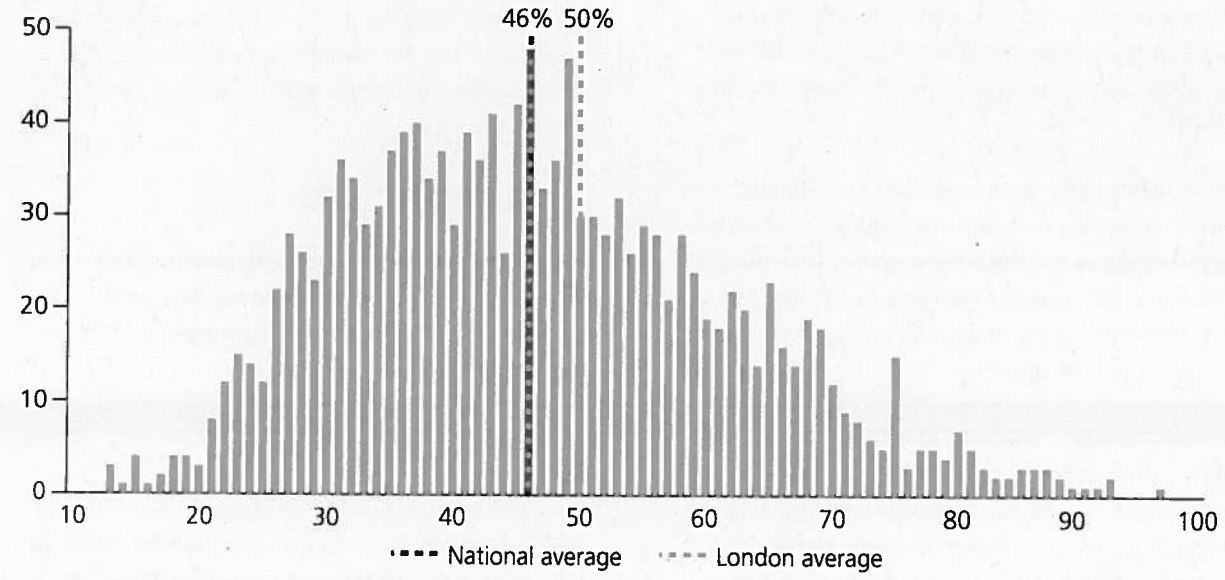
Some practices open on Saturdays, early mornings or evenings but often with a limited number of appointments most of which are pre-bookable. Many practices continue to be open 'office' hours, some continue to close for periods during the day, are only open Monday to Friday and are closed on either Wednesday or Thursday afternoons.

This contrasts with A&E which is open 24/7 and where patients know they can be seen within 4 hours.

Patients who cannot access their practice because it is closed or they are unable to get an appointment are more likely to attend Walk-in centres, Urgent care centres or A&E with primary care issues. The Primary Care Foundation has found that the proportion of A&E cases that could be classified as primary care is between 10 and 30 per cent.[59]

Fig 15 shows that A&E attendances rise as patient satisfaction with GP access and with their practice in general declines.

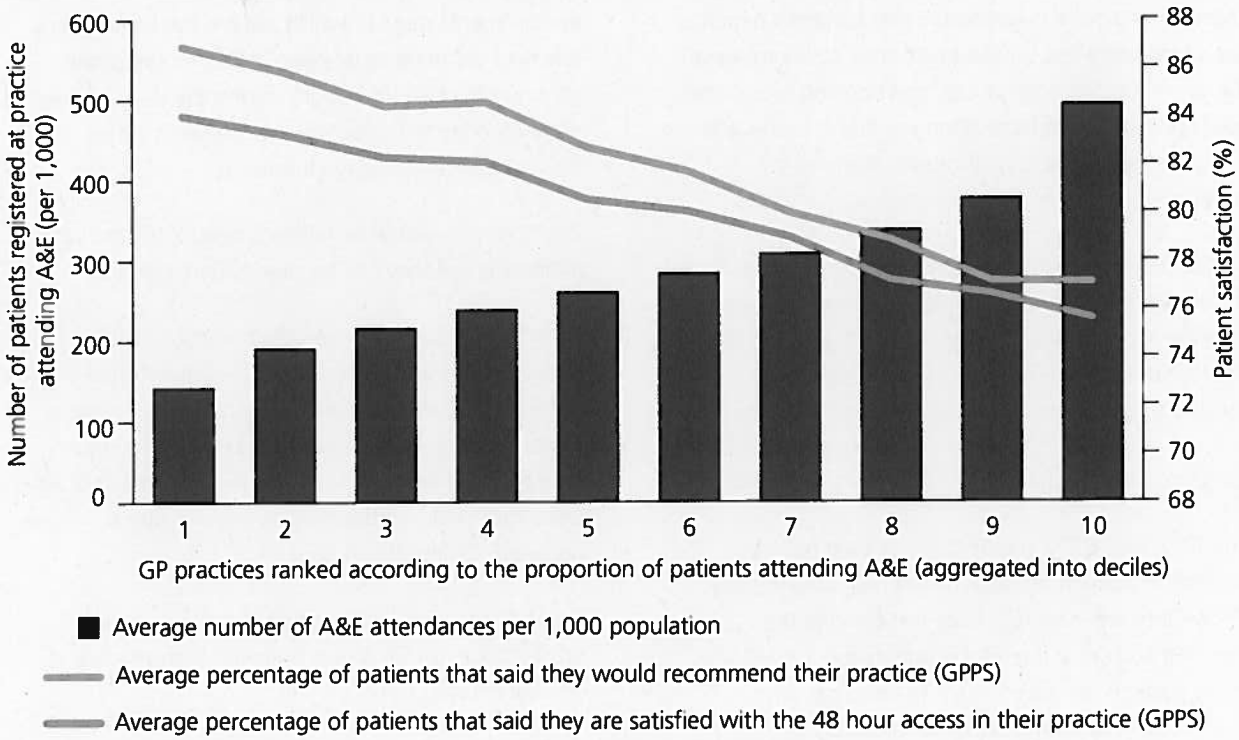
Figure 14: Number of London practices by patient satisfaction score for rapid access to a GP/nurse



GP Patient Survey (2011/2012)

59. Stern R and Clay H (2012) The 7 Myths of Urgent Care. Primary Care Foundation

Figure 15: Relationship between A&E attendances and results from the 2011-12 GP Survey



Ease of contact

Getting through to their practice on the phone is a problem for many patients. Appointments often run out early in the day and once appointments have run out patients are often asked to call back the following day rather than be given an appointment at the time of their call.

Consequently patients can call repeatedly without getting an appointment and then return to the back of the phone queue the following morning. Potentially a patient may not be able to get an appointment for some time without the practice being aware or monitoring repeat callers.

The vast majority of practices have the facility to offer patients internet functionality to book or cancel appointments, view medical records and order repeat prescriptions online. However although as many as a third of patients would like to be able to book online only around 1 per cent of patients do.[60]

There is scope to widen the use of IT in order to make general practice more accessible. The use of telephone consultations is not universal and there are other possibilities to make access more convenient to patients including the facility to contact clinicians by email or 'skype'. New technology initiatives need to be communicated more effectively to support better take-up.

Seeing a preferred doctor

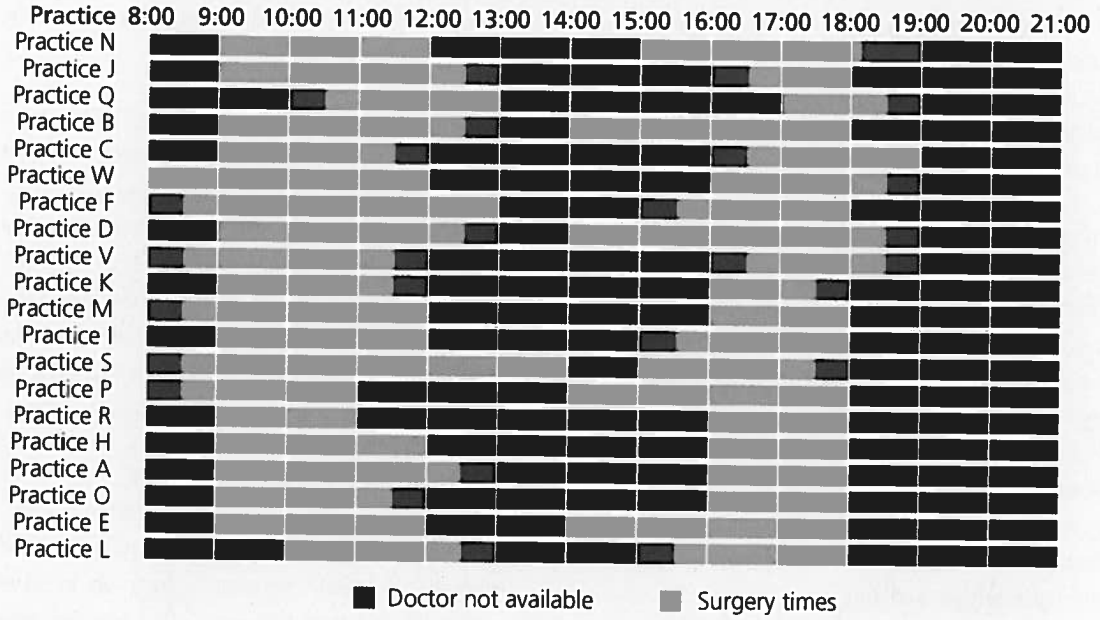
Access to a preferred doctor and corresponding relevance to long term condition management is covered in the main section on Continuity of care (see page 35).

Range of opening times

Most practices continue to be open Monday to Friday 4.5 days a week. Many patients do not have access to their general practice outside of working hours and as a result need to take time off in order to see a GP or

60. GP Patient Survey 2011/12

Figure 16: GP availability on a typical Monday for the 20 lowest ranking practices for patient satisfaction with access in one London borough



McKinsey analysis

practice nurse. The GP Patient Survey showed that a majority of people who were dissatisfied with opening hours said it was because surgeries were not open on Saturdays (median 44 per cent), with a high number also saying that surgeries are not open enough in the evenings (31 per cent). Smaller proportions of people said surgeries were not open early enough in the morning or around lunchtime (when many practices still close for periods during the working day).

Offering greater opening time and appointment flexibility is important. Where the logistics of staffing receptions and clinics over extended opening periods proves difficult joint solutions may be required across practice networks.

Proactive care

General practice has an important role to play in keeping people healthy. Health promotion and ill-health prevention by general practice working in partnership with others is key to reducing morbidity, premature mortality, health inequalities, and the future burden of disease in the capital.

Increasing the focus on health and wellbeing will require a clear definition of what is in scope for general practice and other community based partners delivering prevention and outreach programmes.

In 2010, the King's Fund published a paper that described the role of general practice and health promotion activities as:[61]

- **Primary prevention** – comprising activities designed to reduce the instances of an illness in the population and this to reduce (as far as possible) the risk of new cases appearing, and to reduce their duration.
- **Secondary prevention** – comprising activities aimed at detecting and treating pre-symptomatic disease

61. Boyce T, Peckham S, Hann A and Trenholm S (2010) A pro-active approach. Health Promotion and Ill-Health Prevention. King's Fund

- **Tertiary prevention** – comprising activities aimed at reducing the incidence of chronic incapacity or recurrences in a population, and thus to reduce the functional consequences of an illness, including therapy, rehabilitation techniques or interventions designed to help the patient to return to educational, family, professional, social and cultural life.

London has the highest levels of childhood obesity (11.1 per cent compared with 9.4 per cent nationally) and a quarter of adult Londoners are obese. London compares poorly for physical activity in adults (10 per cent compared with 11.5 per cent nationally). Rates of teenage pregnancy are higher in London (40.9 per 1,000 compared with 38.1 nationally). Many London boroughs are doing worse than the England average on key preventative measures. London has a poorer performance in childhood immunisations compared with national averages. London has marginally lower flu vaccination rates for under-65 high-risk groups than the national average (48.3 per cent compared with 50 per cent nationally); however, within London the variation ranged from 35.3 per cent to 61.5 per cent between London areas. 23 of the 25 boroughs with the lowest breast screening rates nationally are in London, and rates of cervical screening are also low. Infectious diseases are a special challenge in London, given its demographic profile with high rates of tuberculosis and sexually transmitted infections.[62]

General practice, with its registered list of patients has untapped potential to engage in a more proactive approach to improving the health and wellbeing of the local population. A recent report commissioned by the National Association for Primary Care argues that general practice is well placed to improve population health because it is: i) the most accessed part of the health system; ii) it holds a registered list for a defined population in an immediate locality; and, iii) generalists deliver care to people with a full understanding of their social context.[63]

Developing a more proactive primary care system will require a re-balancing between the current focus on the patient clinical agenda and the need for more community orientated engagement on lifestyle and health and wellbeing issues.

A more proactive primary care system will need to address the distribution of health across the whole population. GPs and primary care teams are in a unique position to promote health and wellbeing of patients and the registered population. Profiling populations and using predictive modelling to identify those at risk of illness and deteriorating health will allow earlier intervention, particularly for those people who are registered and not attending regularly.

The general practice list of registered patients has been described as a basic tool for a population health approach.[64] The list provides access to patients who live within a specific geographic location. In urban areas such as London, there is often overlap between the GP catchment area and the geographical location and this provides an opportunity for GP practices to collaborate with each other in order to effectively target a particular community.

One interesting point about London is that the population appears to be relatively more transient than the rest of the country and therefore this presents the London GP with a challenge of managing a significantly mobile population group. Another challenge that primary care faces is the minority group of unregistered patients, which may include asylum seekers and the vulnerable homeless. This is important given that the health needs in this group of people are often extremely significant and they have some of the worst health problems in society.

A study conducted by Crisis, the UK homelessness charity[65], found that homeless people were 40 times less likely to be registered with a GP than members of the public. Four out of five (81 per cent) of GPs interviewed believe that it is more difficult for a

62. Dixon A, Nick G, Raleigh V, Michael S, Hong T, Nick G, Anna D, Thompson J, Millett C (2012) General Practice in London: Supporting Improvements in Quality. The King's Fund and Imperial College London.
63. Thorlby R (2013) Reclaiming a population health perspective: Future challenges for primary care. Nuffield Trust
64. Ashton J (2011) 'Developing a community orientedhealth and wellbeing service for Cumbria, through clinical commissioning –personal reflections', *London Journal of Primary Care.*
65. http://www.crisis.org.uk/data/files/document_library/policy_reports/gp_mediabrief.pdf

homeless person to register thereby making A&E the main service that homeless people turn to. In fact, they are over four times more likely to turn to A&E when they can't speak to a doctor than members of the general public. Given that the cost of a visit to A&E is significantly higher than a visit to a GP, this has significant cost implications for the NHS. Although it is understandably difficult to monitor the number of homeless rough sleepers in London, Crisis estimates that 6437 people slept rough at some point during 2012/13 with 53 per cent of them being non-UK nationals. London has the highest proportion of recorded rough sleepers of anywhere in England.

A recent study estimated that empowering patients to self-care and offering peer support to manage long-term conditions could reduce the cost of delivering healthcare by approximately 7 per cent through decreasing A&E attendances, reducing hospital admissions, reducing length of stay and decreasing patient attendances.[66] Putting this into practice would save the NHS an estimated £4.4 billion across England.

Building capacity and capability for proactive care

With general practices across London already under pressure, delivering proactive care interventions can seem like an additional burden with some people believing that it increases demand and pressures on the practice. However, those practices that have embraced the value of proactive care and put in place services to better support health and wellbeing disagree. They argue that rather than increasing pressure proactive care is a good way of keeping people well; it helps to meet the health needs of patients more effectively, often without requiring additional GP time; it has a wider system impact to reduce costs; and it improves clinical outcomes.

The Cabinet Office behavioural insights team has found that GPs are best placed to provide behavioural change considerations to patients or refer to those that can help.[67] This places further expectations on patient consultations to combine clinical expertise with patient-driven goals of wellbeing and connect to interventions that change behaviour and build networks of support.[68] The London Deanery in 2010 established a Health Coaching Techniques course for trainee GPs. Those trainees that took part in its first year reported a shift in mindset and attitude as well as more confidence and tools to support patients with long term conditions. The patients found the coaching beneficial and there were dramatic changes in the patients' conditions in the short term. Demonstrable benefits included weight loss, smoking cessation and improvements in medication adherence. The pilot study demonstrated that investing in health coaching has the potential to improve clinical outcomes.[69]

Proactive care interventions need not always rely on GP time. The Royal College of Nursing's Community Nursing & General Practice Nursing Advisory Group has developed a vision for nursing that highlights the unique contribution the profession makes to improving the health of the population. Nurses are in a key position to contribute to optimising the health of the practice population across a range of care settings including the patient's home.[70] An increasing number of practices are working with a wider health team of district nurses, practice nurses, health care assistants, health advocates and psychological wellbeing practitioners trained in cognitive behavioural therapy to provide comprehensive care. All general practices in London would like to be in a position to draw on these resources to widen their care offer.

A series of publications in 2013 from Nesta, PPL and the Innovation Unit are researching the rise of 'People Powered Health' solutions and clarifying the business case for proactive care to support further prototyping of targeted interventions.

66. People powered health (2013) The business case for people powered health. Nesta, Public Partnership Limited and the Innovation Unit.
67. Applying behavioural insight to health. Cabinet Office Behavioural insights team
68. People powered health (2013) The business case for people powered health. Nesta, Public Partnership Limited and the Innovation Unit.
69. London Deanery, Training GP trainees in health coaching – feasibility and impacts
70. Royal College of Nursing (2013) Vision for Community Nursing & General Practice Nursing

The People Powered Approach[71] advocates changing three vital components of the current system:

1 **Changing consultations** to create purposeful, structured conversations that combine clinical expertise with patient-driven goals of well-being and which connect interventions that change behaviour and build networks for support.

- **Consultations** that are flexible, collaborative and have alternative structures, including group consultations, built according to what is most useful to the patient.
- **Self-management support** through care planning and shared decision-making.
- **Social prescribing:** a system of collaborative referral and prescription that incorporates social models of support in local communities, such as peer support groups.

2 **Commissioning new services** that provide 'more than medicine' to complement clinical care by supporting long term behaviour change, improving well-being and building social networks of support. Services are co-designed to configure and commission services around patient needs.

- **Peer support groups** where patients and service users with shared experience and goals come together to offer each other support and advice.
- **Platforms** such as timebanks that facilitate the exchange of time and skills between people.
- **Coaching, mentoring and buddying** from professionals or peers offering structured support to help a patient build knowledge, skills and confidence. This includes health trainers and navigators who guide and support individuals to make healthy lifestyle choices.

3 **Co-designing pathways** between patients and professionals to focus on long-term outcomes, recovery and prevention. These pathways include services commissioned from a range of providers including the voluntary and community sector.

- **Integrated care** through collaboratives, partnerships and alliances that ensure care is joined-up from the service user's perspective across health, care and voluntary providers.
- **Self-directed support** and personal health budgets that allow service users to choose, with support, the solutions they need – increasing choice, control and personalisation.
- **Collaborative commissioning** focused on outcomes, including patient reported outcomes, and involving a wide range of people in commissioning, designing and delivering services.

Partnership with London's Health and Wellbeing Boards and public health

Increasing the focus on health and wellbeing and primary prevention will require practices to work with their CCGs and Health and Wellbeing Boards locally to coordinate and harness available resources across health and social care and draw in resources available in the wider local communities.

In partnership with local authorities through health and wellbeing boards, CCGs will play a pivotal role in driving local improvement in health and care and reducing health inequalities. Member practices will contribute in the development of Joint Strategic Needs Assessments and joint health and wellbeing strategies.

CCGs will need to work with Public Health colleagues together with Academic Health Science Networks to promote further research on the effectiveness of primary prevention.

71. People Powered Health (2013) The Business Case for People Powered Health. Nesta, PPL & Innovation Unit

In summary

The opportunities for improvement are vast but the investment, capacity and capability available to support these is currently insufficient. There are many examples of best practice that can be cited and a great deal of evidence is now available regarding interventions and innovations that work. Deploying these innovations consistently across the capital for the benefit of all Londoners will require a significant change in the way services are developed and delivered. If London's general practice is to maximize its potential in delivering care that is coordinated, accessible and proactive, then describing that service model clearly, costing it, and providing compelling evidence demonstrating its impact on the wider system, will be an important first step.

- **Across the country, there are significant unexplained variations between practices for key aspects of diagnosis and treatment. This variable, often unsatisfactory care leads to more people being ill, dying early, and being hospitalised. London practices face greater challenges than most in delivering high measures of quality and experience.** London needs to improve core standards of care and tackle unwarranted variation in quality to improve the safety and clinical effectiveness of care delivered to all Londoners. CCGs in London need to work with health and wellbeing boards and local authorities to tackle the wider determinants of health.

- **Patients in London are less able to see their preferred GP. Patients with long-term conditions account for more than 50 per cent of GP appointments and consume more than 75 per cent of the total health and social care spend. Continuity of care by GPs will deliver better health outcomes, more satisfied patients and at a lower cost, vital for people living with multiple complex conditions.** London needs a general practice service that can provide greater continuity of care, case management, multidisciplinary working and care planning in partnership with other parts of the health system.

- **Patients in London find access more challenging than in the rest of England. Accessibility of services impacts on patient experience and the quality of care. It also matters to practices whose workloads can become unmanageable if access is not managed in a systematic way. If patients find it hard to access their general practice then their diagnosis and treatment may be delayed, or they may elect to go to A&E because it is open and available.** London needs to respond to these challenges by shaping and developing new models for access that deliver convenient and reliable unscheduled care as well as coordinated and high quality continuity of care to a population with diverse needs.

- **Stark health inequalities exist across London. Many London boroughs are not performing as well as the England average on key preventative measures. Health promotion and primary prevention by general practice working in partnership with others will be key to reducing morbidity, premature mortality, health inequalities and the future burden of disease in the capital.** London needs to proactively target high-risk groups to improve the uptake of preventative services and encourage them to present early. London needs a primary care service that can systematically enable patients to self-care, provide behavioural change support and/or refer patients to those who can assist with improving health and wellbeing. Primary care needs to take action to improve levels of immunisation, diagnosis and screening in order to protect the health of Londoners.

9. How general practice infrastructure needs to adapt

London practices face a significant challenge as a result of infrastructure shortfalls. Infrastructure can enable or inhibit service improvement. Taking control of infrastructure shortfalls is often a shared responsibility and not always within an individual practice's gift to resolve, for example, the shortfall in newly qualified practice nurses across London. In the new commissioning system, improving infrastructure relies on complex partnerships between multiple agencies that are regional, national and local. Clarifying roles, responsibilities and opportunities across multiple partner agencies will be vital to deliver a step change improvement in general practice infrastructure across the capital.

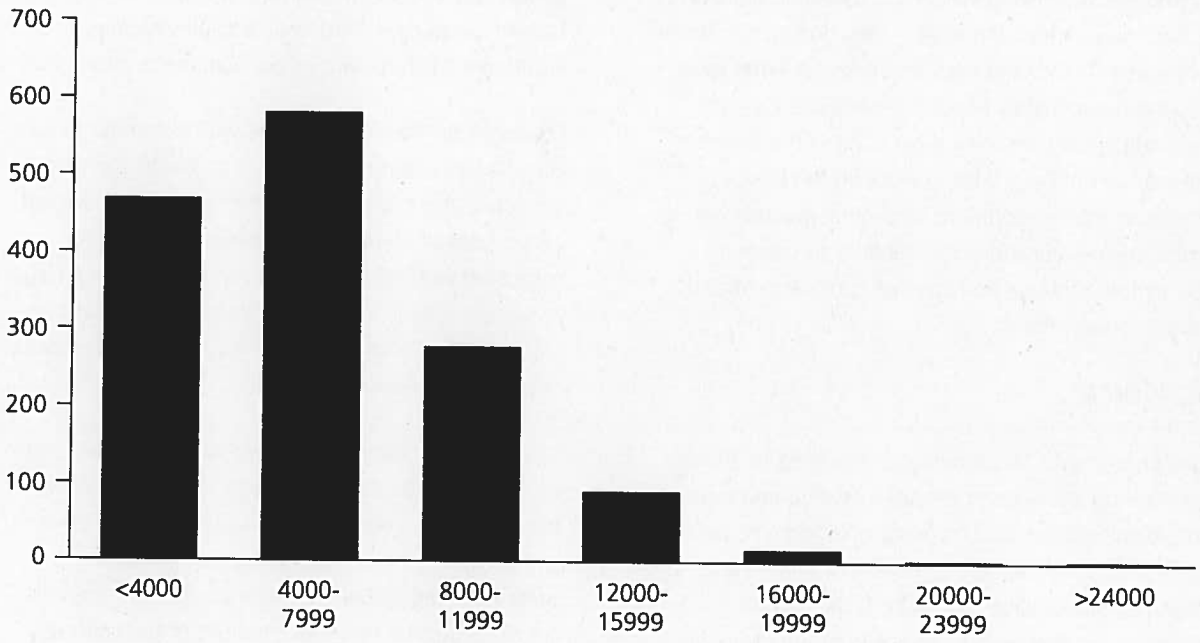
General practice in London today

There are 1528 GP practices in London – of these 779 are GMS practices 697 are PMS practices and 52 are APMS practices.

There are a larger number of single-handed practices than elsewhere in the country and significant variation in the number of GPs in different boroughs. Some of the lowest ratios are found in areas of greatest health need – for example Havering, Redbridge, Barking and Dagenham, Hounslow and Waltham Forest all have less than 0.55 WTE GPs per 1000 patients. The highest GP to patient ratios are found in Camden and Islington with 0.75 WTE GPs per 1000 patients and Tower Hamlets which has 0.82 GPs per 1000 patients.

The average list size in London is 5,948. This varies by up to 40 per cent across London boroughs. 36 per cent of practices have fewer than 4000 patients and 75 per cent have list sizes less than 8,000 patients. There are only eight practices in London with more than 20,000 registered patients.

Figure 17: Number of London GP practices by number of registered patients (March 2013)



New emerging models of greater scale

Many models and configurations of services will emerge in response to the challenges general practice currently faces.

A number of trailblazers are now delivering general practice services for 50,000+ populations proving that scale is achievable with a mix of both small and big practice subunits. A report from the King's Fund and Nuffield Trust examined the following configurations: accountable care organisations, community-owned, community health organisations, community health organisations with in patient facilities, regional and national multi-practice organisations, marginalised groups, networks or federations, professional chambers, specialist primary care, super partnerships, super partnerships with inpatient facilities and vertically integrated systems. They concluded that whilst scope and scale was important in these different models, no single model for delivery should be advocated outside of the local context.[72]

A common feature of all new models of provision is a shared vision and purpose coupled with the business case and investment for development into the future.

Operating at greater scale has the potential advantages of:

- greater productivity gains and better access;
- a wider range of services available to all patients;
- a solution to premises constraints;
- a multidisciplinary workforce;
- access to specialist services and staff;
- potential savings on back office functions;
- consideration of the services and service models which require greater cohorts of patients;
- more time and resource to develop the practice business; and
- support for models of integrated care.

72. Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R, Walsh N (2013) Securing the Future of General Practice: New Models of Primary Care. The King's Fund and Nuffield Trust

As we have noted, GPs and practice staff are typically caught up in a 'hamster wheel' of managing demand. It is hard and unrelenting work – they don't often have an opportunity to stand back and consider what tools, skills and capacity they need to best deliver care. In other words, they are so busy working in the business that they do not have time to work on the business. Supporting the development of general practice will require the identification of suitable expertise and capacity to undertake both service improvement and business development.

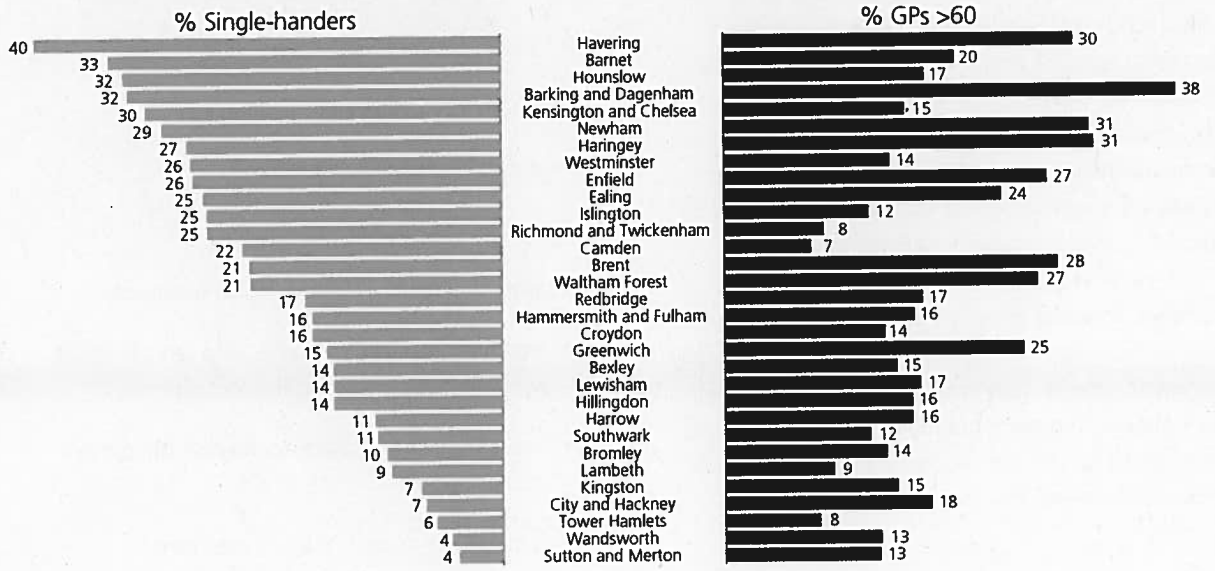
Workforce

Workforce growth and redesign are needed to address an increasing shortage of practitioners in primary care and difficulties recruiting to posts in London. As new service models for delivering more coordinated and integrated care emerge, the skills of the current workforce will also need to adapt. In future there will be a much greater emphasis on professionals working as teams for the benefit of the patient and an increased used of technology over face-to-face care. There will be an increase in the diversity of roles that deliver primary care services e.g. health trainers, advocates and clinical pharmacists. To deliver high quality care for all, general practice needs a well-trained, properly staffed, multidisciplinary primary care workforce, aligned with its population's health needs.

London is facing a GP shortage with a number of areas classified as under-doctored and to add to this pressure London is also facing a GP retirement bubble. Almost 16 per cent of London GPs are over 60 years old, compared with 10 per cent nationally. The percentage of GPs over 60 is typically higher in areas where there are many single-handers – these also tend to be areas of greater deprivation.

London has a higher percentage of salaried and locum GP workforce than other parts of the country which translates into a heavier workload for practice owners and partners who are also engaged in clinical commissioning. More GPs want partnership than can get them but the financial structure of the contracts and cost of premises make partnerships unattractive or unattainable for young GPs, limiting their career opportunities. In 2011, 43 per cent of all doctors in England were female[73] and it is estimated this will be over 50% by 2017.

Figure 18: Percentage of single-handers and GPs over 60 by area



Kings Fund (2012)

73. General Medical Council, 2012

By 2021 there could be 16,000 fewer GPs than are needed nationally.[74] An increasing number of UK-trained doctors, nurses and allied health professionals choose to move abroad, particularly to Australia, New Zealand and other developed English-speaking countries. The number of doctors seeking to register in the United States is rising, as is temporary migration to Australia.[75]

Every year since 2005/6, more nurses have left the UK than have arrived from abroad.[76] London has a significant practice nurse shortage compared with other parts of the country. In 2008, one in three nurses in England were aged around 50 plus and those aged 50 plus are concentrated in growing sectors of the health workforce, in particular in primary and community care.[77] This suggests a potential retirement bubble. There is therefore a need to develop a robust succession plan attracting new, younger nurses into the primary care workforce.

A focus group with nurses from across the capital highlighted significant low morale for this workforce and a lack of professional development support. These nurses described isolated working, not being allowed time off for essential training, problematic employer relations, a lack of career progression and concerns about gaps in basic clinical governance. Newly qualifying nurses have had insufficient exposure to general practice and it was not seen as an attractive profession given these difficulties. Londonwide LMCs (LLMCs) are keen to tackle these issues in partnership with London Education and Training Boards. LLMCs has already developed an accredited online training programme and a nurse placement and training scheme.

The increasing and changing demands on primary care – in particular larger numbers of elderly patients with complex co-morbidities – require staff to possess a new set of skills rather than the traditional model of GPs being trained largely in a hospital setting, working in silos and to a reactive illness model of healthcare.

There is a greater need than ever before for 'expert generalism' – professionals who can attend to the various needs of individuals and are comfortable dealing with clinical uncertainty and people with complex co-morbidities, (rather than just focusing on one condition, specialty or pathway) working in partnerships with other professionals and patients.

Many practices in London operate with only GP and nurse sessions but future healthcare delivery will require a redefining of the practice team to include physician assistants, health trainers and advisors, clinical pharmacologists and others. A cross-section of professionals will work in community, primary and social care settings to ensure that care is integrated and coordinated to meet the complex health and social care needs of the population.

Education and training

General practitioners in the UK have one of the shortest lengths of training compared with doctors working in equivalent health services, yet UK GPs do more, for more patients, and to a greater degree of complexity than most other general practitioners across the world. Currently UK GPs have just three years training post foundation years – and many do not have any specialist facing training in mental health or paediatrics. There is clearly a training gap – and to address this the RCGP has (2012) been granted approval by the Department of Health to extend and enhance GP training from its current three years to four years, likely to be implemented in 2016, subject to approval by the Treasury. There is also a need to expand support for new entrants into general practice, most of whom work as locum or sessional GPs, to extend their range of clinical, managerial and leadership skills.

The additional training will be important, not just in clinical areas, but also in areas such as public health, commissioning and leadership, all addressing the problems facing the NHS in London. Examples of placements that will need to be found include:

74. Royal College of General Practitioners, 2013
75. Organisation for Economic Co-operation and Development (OECD) 2010
76. Royal College of Nursing, 2011
77. Royal College of Nursing (2010) Who will care? Nurses in the later stages of their career.

- appropriately supervised secondary care-based placements that provide relevant experience in GP skills;
- integrated community-based placements (e.g. working part-time in a community rehabilitation service or alcohol service and part-time in general practice); and
- general practice-based placements.

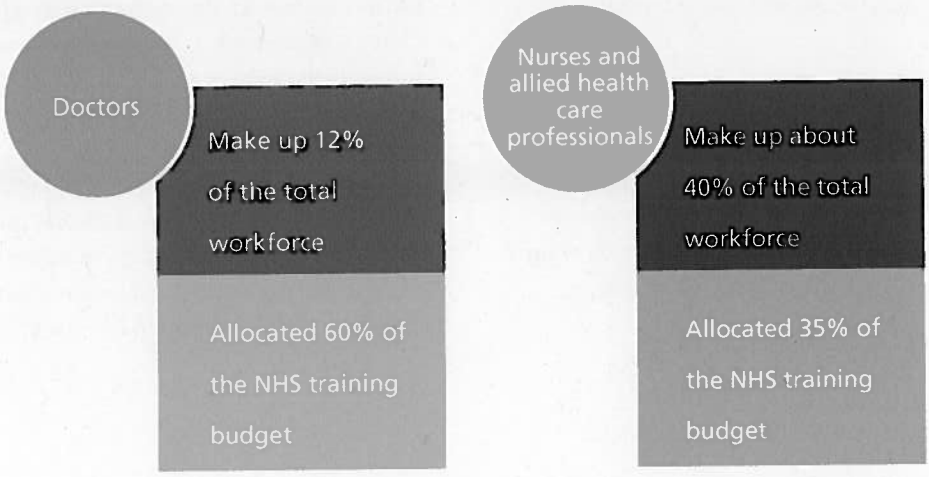
In the future, more and more patients will be treated outside of the hospital setting and training programmes will change to reflect this. For example, a trainee might undertake a placement where they work in general practice for part of the week and in a community-based specialist-supervised outpatient clinic for part of the week, in an area of direct relevance to the GP curriculum (such as paediatrics, end-of-life care or mental health).

Current debate amongst training bodies is also focusing on the training needs of other medical practitioners and the acknowledgement that only by improving the pool of generalist (as opposed to specialist) clinicians can we address the problems of poor continuity and fragmentation of care. There is a need to develop the primary care nursing workforce to ensure that they are enabled to be responsive to the changing care needs of London's population.

To this effect, the current policy direction of the major Medical Royal Colleges and Health Education England is to ensure that all doctors, irrespective of their final specialist designation would have a firm grounding in generalist practice – be that generalist practice in mental health, medicine, surgery and so forth. This means that in future, most practitioners will be able to support the delivery of unscheduled care and participate in on-call rotas, out of hours services, and in time, multidisciplinary teams that support 24/7 care for high risk patients. To achieve this aim will require expansion of training facilities able to deliver generalist training, for example, general practice premises with the room to deliver multi-professional learning and accommodate trainees from different medical and allied professional groups. The London Deanery has provided investment for training practices in the past; some polyclinic and LIFT developments have included post graduate training facilitates but these are not sufficiently widespread and often space requirements for clinical or management activities have been prioritised.

Across the wider community and primary care workforce, there is a similar debate around the need for a workforce that can support the changing needs of the population and deliver more services in the community. As care becomes more integrated, educational programmes need to be multi-professional with a focus on team working across professional and

Figure 19: The King's Fund (2013) Calculations from national workforce data (NHS Information Centre 2013) and breakdown of training budget (Imison et al 2009)



organisational boundaries. Trainees will also need greater exposure to primary care settings and as a greater focus is placed on prevention of ill health and maintaining health and wellbeing of the population, there will be a need for training to focus on health education.

Currently primary and community care nursing training earmarks distinct roles such as district nursing, school nursing and practice nursing. It is anticipated that in the future these nursing teams will work across professional boundaries. There is a growing need for educational programmes to consider a core set of generic skills for an out of hospital nursing workforce that could work flexibly within community and practice-based roles, whist still maintaining some of the specialist skills relevant for the setting within which they work. The benefit of this approach is to foster collaborative working, ensure that individual patients holistic needs are being met regardless of which professional has contact and to address nurse shortages.

For practice nursing, a specific challenge has arisen from the lack of standardised development programmes available. This has the potential to lead to inconsistent clinical practice. There are, however, a number of highly innovative programmes, such as the 'Open Doors' programme run in Tower Hamlets, City & Hackney and Newham. This supports the transition of nursing staff from acute settings into primary care and provides training in both core clinical skills and long-term conditions, leading to a BSc (Hons) in Primary Care (Practice Nursing). The Primary Care Placement pilot run by the London Deanery is another example of a programme aimed at providing placements in primary care settings for pre and post registration nurses. There is an urgent need to develop a standardised programme for practice nurse development that will ensure that future practice nurses possess the competencies required to meet the future challenges in primary care. This would need to be based on the competency framework for practice nursing that has been developed by the Royal College of GPs,[78] and an appropriately funded placement of pre registration nurses in primary care settings to provide student nurses adequate experience of primary care role.

As has already been highlighted, the isolation of practice nurses and lack of a support system in place to support effective practice and address poor practice is a challenge. Part of the development of practice nursing would need to include a system of mentorship, supervision and support for poorly performing nurses similar to that set up for GPs through the Professional Support Unit. As groups of practices develop cohesive networks this provides the opportunity to tackle the issue of isolation and bring practice nurses together into a 'team' supporting a whole population.

Health care assistants and support workers are becoming a common and important feature of the general practice workforce. There is currently no statutory requirement for health care support workers to undergo a standardised or approved training programme as this group of staff are not regulated. The Cavendish Review, commissioned following the Francis Report, has explored the need for health care support workers to possess skills and competencies that would enable them to deliver a service for the population with care and compassion.[79] For this to be realised we need to develop a training programme for health care support workers to equip them with the skills to undertake more diverse and integrated roles within primary care. The development of a supervision programme to support this staff group would also help develop their skills and competencies, both in generic and more specialist roles.

Technology enablement

General practices in London are relatively well served by technology. Levels of IT investment in primary care systems are generally higher than in other healthcare settings and GPs generally make good use of the technology they are provided with. Providers of data to GPs constantly adapt and review their systems to offer

78. Royal College of General Practitioners (2012) General Practice Foundation – General Practice Nurse Competencies
79. The Cavendish Review (2013) An independent review into HCA and Support Workers in Health and Social Care

greater functionality for practices. There are however issues that constrain greater use of technology:

- GP systems are practice based. This means that there are circa 1525 separately located information systems from three main application providers in use across London. Even when it is possible to do so, there are concerns and sometimes resistance to making the information that is contained in GP systems available to others (including the patient). There is no mandate for information sharing.
- There is no centrally provided infrastructure for information sharing between primary care and the circa 70 provider organisations that serve London.
- There are technical and information governance challenges to the real time exchange of information between GP practices and other organisations.
- GP systems have historically been centrally procured to provide the core functionality that is required to support each practice. Decisions to enhance these services have been left to local discretion and the availability of local funds.
- General practice IT systems have not been designed to optimise the clinical interactions that GPs and patients would wish to achieve together. Future IT systems will need to support immediate care delivery as well as the secondary uses of data – for such purposes as clinical audit, performance management, revalidation, invoice validation and risk stratification.
- The diverse provider landscape means that there is uneven use or purchase of the available functionality on offer for example from providers such as EMIS, iSOFT or Vision.

The use of technology (and the information exchanges it enables) is key to the transformation of primary care.

- More joined-up care can be delivered through an interoperable digital record in which patient data can flow seamlessly between organisations in support of care delivery and enable the patient to take greater control of their own health.
- Maintaining and improving access to general practice services in the face of capacity constraints is going to require an increase in the use of digital health channels by clinicians and patients.
- Improving the analytical capability of general practice populations will be key to identifying at-risk groups, anticipate problems and offer early, proactive interventions.
- Secure, safe, high quality care will require robust and flexible data sources that enable the measurement of vital indicators, clinical outcomes and patient experience.

NHS England is committed to achieving a comprehensive digital record encompassing health and social care by 2018 and to take forward agendas that put management of the patient experience and data sharing to the fore.

Whilst general practice systems provide a strong starting point, patients want to see increased use of email and digital health channels. These all have the potential to help deliver further care quality and productivity gains. Improvements in real time information exchange (for example through system interoperability) provide real opportunities to improve the integration of care delivery across organisational boundaries.

Past investment in general practice systems vary significantly from PCT to PCT and adoption of new technology innovations has been slow. For example, a third of patients would like to use the internet to book appointments and request prescriptions. The majority of practices now have this functionality available but don't or can't use it. Only a small percentage of practices across London are enabling patients to use these facilities:

- access their records (3 per cent of practices);

- cancel or book appointments on line (40 per cent of practices).
- order repeat prescriptions on line (40 per cent of practices).

By March 2015, general practices will be contractually required to provide the facility for patients to book appointments and order prescriptions online.

For patients who are terminally ill, or experiencing a crisis in the last months or weeks of their lives, the NHS 111 specification in London incorporates an electronic care planning platform 'Coordinate My Care' (CMC). The platform, visible also to London Ambulance Service (LAS), was introduced as Londoners are most likely to die in a place they have not chosen.[80] In 2011/12 over 60 per cent of Londoners diagnosed terminally ill died in an acute bed despite 70 per cent stating their preferred place of death was their home or nursing home. Across London, primary and community services for the terminally ill are variable; too often working in silos with access complicated by multiple referral approaches. CMC as a single electronic end of life care planning platform accessible to 111, GP OOH and LAS can enable a joined up approach to care at the end of life, particularly in crisis and during out-of-hour periods. To date over seven thousand CMC records have been created.[81] Patients with a CMC record are more likely to achieve their preferred place of death, up to 80 per cent of CMC patients have died in their preferred place of death.

Despite this improvement, uptake of CMC across CCGs is variable. Some London areas, particularly North East London, have very few electronic end of life records visible to NHS 111 or LAS. GPs want CMC electronically integrated with their GP systems. The CMC IT system is currently being re-procured for spring 2014 aiming to improve IT interoperability and system integration. Local incentives through LES payments or CQINs have improved GPs use of CMC to develop a care plan with patients that outlines their wishes and preferences for their place of treatment and death. Significant improvements need to be made before those Londoners in the final months of their life benefit from this or other electronic palliative care planning systems.

The barriers to new technology adoption include not having the capacity and capability, but can also be cultural. Developing the right systems that are extensively user-tested and user-friendly will massively increase the rate of adoption. Technology enablement will challenge existing ways of working and redefine the way patients and clinicians will interact in future.

Estate

General practice buildings will be used differently in the future. They will deliver a wider range of services as more care currently delivered in a secondary setting is moved into primary care, and patients will interact in new ways with clinicians, for example, using online technology which may result in fewer surgery visits.

One of the ways to improve the way that GPs deliver services is to re-imagine the physical environment in which they operate – the surgeries themselves. Many localities have already completed premises surveys and audits, developed estates strategies and invested time and resources in improving the primary care estate. Many general practices too have invested in securing newer, improved facilities to deliver a wider range of services.

However, this picture is by no means universal and London has a higher than average proportion of smaller general practice premises, mainly in converted residential housing or older, purpose-built, health centres.

It is incredibly difficult to find suitable premises in some parts of London, e.g. Westminster. This requires a concerted response by local authorities and NHS estates teams. In London the price of property, rents, public transport links, parking, the availability of land and building costs for conversion are particularly problematic.

80. Nationally 54 per cent die in hospital in London 60 per cent die in hospital [taken from NAO End of Life statistics]
81. As of August 2013 7,212 CMC personalised patient records have been created.

Whilst the traditional way of organising premises has provided some stability to the NHS it has also led to inertia. For example, whilst many other health services are now delivered peripatetically or across a number of hot desks in various locations, general practice is still largely delivered from a series of long established consulting rooms within long established buildings, to the extent that in some cases, opportunities for redesigning care to deliver more integrated services are, or are perceived to be, restricted by this established estate or landlords.

This is a complex area to tackle strategically in terms of the actual physical structure, funding and development regime and differing perceptions of individual GPs and practices. For example, the buildings themselves are sometimes more than just places of work – especially to those GPs who own the surgeries. They might represent a financial investment or provide an emotional connection with memories of family members who have worked or lived there in the past, or with particular communities. Patients often have such a connection too.

Investing in premises development can also have unintended consequences. There are examples in London of large infrastructure investments that have remained underutilised and partially unoccupied.

NHS England will continue to operate within a financial restraint and wherever premises improvements or redevelopments are reviewed and authorised, it is likely to require a thorough business case that clearly demonstrates value for money for the majority of schemes where financial support from the NHS is required.

In summary

Most practices in London remain relatively small and would benefit from shared economies of scale across some services, functions or infrastructure. London has an especially high number of single-handers and GPs nearing retirement as well as a significant practice nurse shortage. The use of other primary care roles such as physicians assistants and health trainers is patchy. Existing digital health opportunities are not being well utilised. A thorough diagnostic of one London area found 30 per cent of practices to be operating from inadequate premises – the proportion elsewhere is likely to be similar.
London needs a primary care service that has the capacity and capability to provide the best care possible in a modern environment that enables multidisciplinary working and training, and in which state of the art digital technology is deployed.

NHS England

Questions and Next Steps

A Clinical Board for Primary Care Transformation, chaired by Dr Clare Gerada and a Civil Assembly will work in partnership with the Office of the London Clinical Commissioning Council and Londonwide LMCs to oversee the *Call to Action for General Practice* engagement process.

The aim of the engagement process is to ensure that all stakeholders have the opportunity to review the challenges general practice is facing and are able to shape what happens next. You will see that General Practice – A Call to Action poses a series of questions which we would welcome your feedback on.

If you are viewing this document electronically, the questions below can be viewed and responses sent to us by following this link. Please send us your responses by 1 April 2014.

Or, if you prefer you can send your response to: Freepost RTGK-GHYG-HHRA, NHS England (London Region), Southside, 105 Victoria Street, London SW1E 6QT.

If you have any further enquiries, please email us at England.londoncalltoaction@nhs.net.

Questions

1. Which aspects of general practice care do you most highly value and would regard as critically important to safeguard?

2. What suggestions do you have about how the general practice service model should develop in the future to deliver more

   - accessible care?
   - coordinated care?
   - proactive care?

3. What implications will this have for how general practice infrastructure should evolve?

4. What needs to be put in place to enable general practice to develop?

Personal information

We would be grateful if you could provide personal information as it will enable us to better understand the responses and identify trends. However you are not required to provide these details.

Please tell us the organisation which you represent

How old are you? (please tick one box only)

☐ Under 25 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65 or over ☐ Prefer not to say

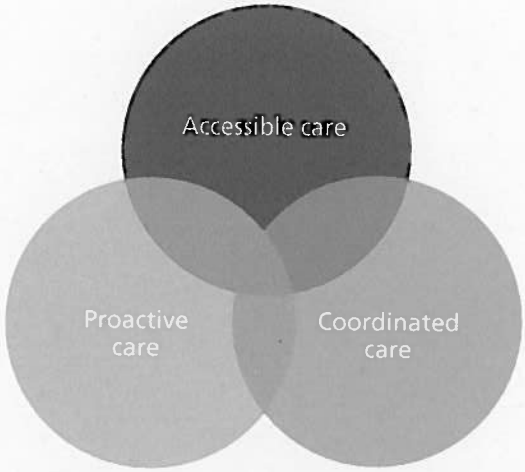
Do you work for the NHS? ☐ Yes ☐ No ☐ Prefer not to say

Do you consider that you have a disability? ☐ Yes ☐ No ☐ Prefer not to say

Please include your full postcode

Next steps

The case for change will be followed by a set of proposals describing the service offer that we believe all practices would like to provide, and that all Londoners should have access to the service offer will focus on three aspects of care – coordinated care, accessible care, proactive care.

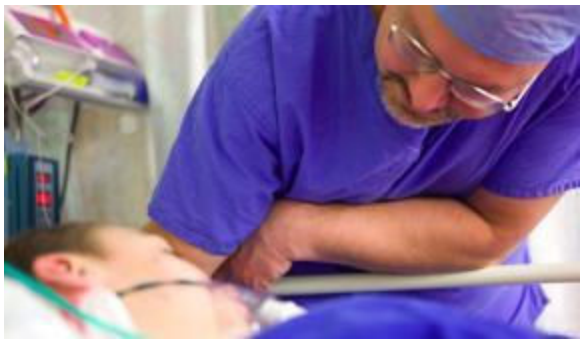


The service offer will be developed by expert panels that will take into account feedback from the London engagement exercise on the case for change. They will form a suite of general practice service redesign principles that undergo extensive engagement with practices, patients and other stakeholders early in 2014.

Once finalised this will define new parameters for delivering services that have the potential to transform care. In order to deliver the totality of the proposed service offer general practice in London will be required to embark on a programme of organisational development underpinned by investment.

A three to five year development plan for general practice will be developed and agreed with CCG Clinical Leads to ensure that London is quick to test and demonstrate the new service offer and able to quantify the impact and benefits that result from those improvements.

Cancer and cardiovascular services



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About the programme

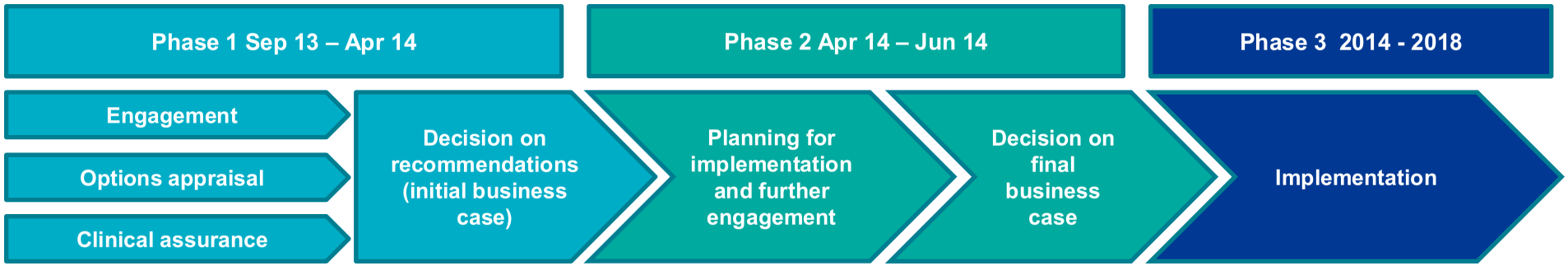
- Local services are not organised in a way that gives patients the best care
- Currently our specialists, technology and research are spread across too many hospitals
- To address this, clinicians have recommended:
  - Specialist cardiovascular services at The London Chest, The Heart Hospital and St Bartholomew's Hospital are consolidated to create an integrated cardiovascular centre at St Bartholomew's
  - For specialist cancer care, the proposal is to consolidate only some of the specialist elements of five cancers
- The majority of care would continue to be provided locally.

Specialist cancer services: scope

Clinical scope	Approx impact of the proposed changes
Brain cancer surgery	97 of 831 procedures
Head and neck cancer surgery	241 of 394 procedures
Complex prostate cancer surgery (radical prostatectomies)	93 of 275 procedures
Complex kidney cancer surgery (partial and full nephrectomies)	145 of 239 procedures
Complex bladder cancer surgery	32 of 71 procedures
Acute myeloid leukaemia (level 2b) treatment	18 of 118 patients
Haematopoietic stem cell transplantation (level 3b) treatment	53 of 274 procedures
OG (stomach or throat) cancer surgery	53 of 131 procedures

Programme update

- The majority of CCGs have submitted formal support for the proposals
- London Clinical Senate independent clinical assurance underway
- Initial business case expected to be published in April 2014



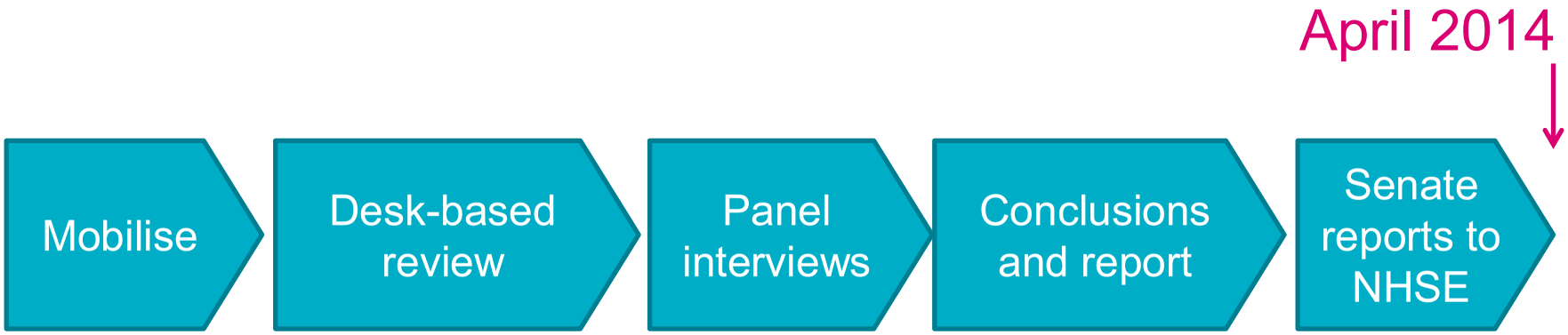
London Clinical Senate review: scope

- Advise on robustness of clinical process to arrive at recommended options, and depth of clinical involvement and support
- Advise on the future model and location(s) of radical prostatectomies, specifically:
  - A comparative analysis of current outcomes data
  - Which outcome measures should be used to compare radical prostatectomy performance
  - Implications of recently published NICE prostate guidance
- Professor Chris Harrison, Clinical Senate Council Vice-Chair, leading the process

Expert reference groups

Expert reference group (programme-wide)	Expert reference group (prostate)
• One clinician with expertise in cancer services and one with expertise in cardiac services • Two London Clinical Senate Lay Members • A GP • Director of Nursing and Medical Director (both drawn from the London Clinical Senate Council or Forum) • A member of another Clinical Senate	• Consultant Urologist/Andrologist, London Clinical Senate Council Member • Director, Centre for Clinical Practice, NICE or nominee • Chair of the Specialised Urology Clinical Reference Group or nominee • Clinical Audit Lead, British Association of Urological Surgeons (BAUS)

Clinical Senate assurance review: plan



Programme-wide clinical review

Prostate review

Initial business case approval

- A Commissioner Programme Board will have final approval of the initial business case
- The board will comprise NHS England and six CCGs who are majority commissioners for the proposed changes:
  - For **specialist cardiovascular** 59% of activity is CCG commissioned. Of this, 70% is commissioned by Haringey, City and Hackney, Enfield, Islington, Camden and Barnet CCGs
  - For **specialised cancer care** all the services are commissioned by NHS England, except acute myeloid leukaemia. This would particularly impact Enfield, Barnet, Haringey and Camden CCGs due to the proposed transfer of services to ULCH from other locations

Planning for implementation

	ROLE	***MECHANISMS***
Commissioners	• Ensuring plans meet the standards and requirements identified in engagement (eg management of co-dependencies, meeting volumes, deliverable in a safe and timely manner) • Ensuring system-wide benefits are identified and the overall change programme will deliver these benefits • Ensuring a framework is in place to assure the ongoing implementation • Deciding whether to proceed to implementation	NHS England: • Specialised Commissioning • Ops and Delivery CCGs Common Commissioner Board
Clinicians	• Signing-off clinical service models from a pathway perspective • Developing proposals for a individual pathways	• Pathway Boards • UCL Partners • Provider Clinical Directors
Providers	• Developing robust implementation plans and service models • Providing confidence to clinicians and commissioners that the plans and models are deliverable • Mobilising their own delivery programmes	• Provider programmes
TDA / DH/HMT	• Approving Barts Health OBC and FBC	TDA Board DH/HMT process

Planning for implementation: major trauma 1/2

- Full day clinically-led workshop in January - over 45 representatives from across the system including national clinical director for trauma care.
- Recognition of the excellence of the current trauma service, and the significant improvements that it has made with a clear commitment to maintain services and work collaboratively between trusts
- Importance of culture and interpersonal relationships to deliver excellent trauma services

Planning for implementation: major trauma 2/2

- Trauma services require many different specialties, skills and support services, which must continue to be available through effective collaborative working
- Programme of work underway between trusts, UCLPartners and commissioners to mitigate risks
- This element of work will form part of the wider planning for implementation phase of the programme

Phase two engagement approach

- Approach discussed with patient advisory groups and meeting scheduled to discuss approach with local Healthwatch groups
- Engagement period commence following approval of initial business case
- Plain English summary leaflet of proposals distributed to all stakeholders
- Information available online and cascaded via trusts, CCGs and stakeholders
- Engagement events:
  - 1x prostate discussion event in outer north east London
  - 3x stakeholder advisory group meetings covering travel, whole pathway integration, and service impacts
  - Open offer to attend meetings

Next steps

- Following endorsement of the recommendations in the initial business case, phase two of the programme will commence including:
  - Phase two engagement
  - Planning for implementation
  - Development of commissioner assurance and oversight frameworks
  - Development of decision-making business case
- The above will support final decision-making expected in June 2014

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Moorfields Eye Hospital NHS
NHS Foundation Trust

Providing a 21st century facility for Moorfields Eye Hospital

Involving patients and the public
Tell us what you think

Version: 1
Published: November 2013

Contents

1. Introduction

This document outlines a proposal by Moorfields Eye Hospital NHS Foundation Trust to move our main central London hospital from City Road near the Old Street roundabout to more modern facilities in the King's Cross/Euston area. We plan to do this in partnership with our research colleagues at the UCL Institute of Ophthalmology.

We need a new facility for several reasons:

- Our existing buildings in City Road are more than 100 years old and were built at a time when hospital care was provided very differently to how it is now – they are no longer suited to the provision of 21st-century clinical care, research or education
- Our ageing infrastructure is growing increasingly difficult and costly to maintain
- The configuration of our existing buildings offers little scope for true integration between the clinical, research and teaching elements of our work, which will be crucial if we are to achieve our vision for the future (see section 2 below)
- Although intermediate refurbishments go some way to improving the environment for our patients and staff, they are no substitute for purpose-built accommodation

An in-principle decision to focus all our efforts on moving, rather than trying to rebuild on our current campus, was taken by our board of directors in March 2013, following an extensive options appraisal. We are now keen to hear wider views to enable us to develop our plans further. In particular, we want to understand the factors that you consider the most important for us to take into account when we make a final decision about a new site.

In parallel with this engagement exercise, we are working with the local health overview and scrutiny committee and our host commissioners to ensure that we comply with our formal consultation obligations as set out in NHS legislation.

It is very important to stress that this engagement exercise is not about changing the services we currently provide. Wherever we are based, we will continue to offer high quality clinical care, research and education in a central London location, supported by a network of satellite locations in and around the capital, just as we do now.

Once you have read this document, we would be grateful if you could take the time to answer the questions on pages 9 and 10 so that you can tell us what you think.

2. Our vision for the new facility

Our aim, in partnership with the UCL Institute of Ophthalmology, is to create a fully integrated and flexible modern facility, enabling us to bring together – for the first time – patient-focused eye research, education and healthcare in a truly coherent way.

By doing this, we will be able to:

- Provide the highest quality clinical care in a modern, supportive environment for both patients and staff
- Enhance significantly our capacity and capability to undertake world-leading research, translating that research rapidly into treatments for patient benefit
- Attract the world's best ophthalmic scientists, educators and clinicians

We plan to pay for the new facility from a variety of sources, including cash reserves, borrowing, a significant contribution from UCL, the proceeds from the sale of the City Road site, and a major fundraising campaign, jointly with UCL, which we anticipate will raise around 25% of the money we need.

3. Background to the engagement exercise

Discussions have taken place over many years about the future development and growth of our central London hospital. During this time, we have considered a variety of options, including redevelopment on our existing campus and rebuilding from scratch elsewhere.

These discussions have involved a range of individuals and organisations including Moorfields' board of directors, our membership council (comprising the governors who represent our membership), members themselves, and existing and potential donors to the hospital. We now wish to broaden the discussions by involving many more people who use, or have an interest in, Moorfields' services.

4. Why we want to move

During 2012, we completed a detailed analysis of our space requirements in a new building, as well as the costs of moving off-site rather than rebuilding at City Road. These suggested that moving to a new location was likely to be less expensive than staying at City Road.

This is in large part because to redevelop the City Road site at the same time as continuing to provide services there would require us to find and pay for a significant amount of alternative accommodation over an extended period of time. This would not only be extremely expensive, but would also be very disruptive for patients, visitors and staff, and would also take a great deal longer to achieve.

At the same time, our colleagues at the UCL Institute of Ophthalmology have decided that their existing facilities in Bath Street, adjacent to our City Road building, will also require a fundamental redesign and expansion if they are to realise their ambitions for the future.

Taking all of this into account, we conducted an extensive options appraisal which looked at seven different ways of reconfiguring the existing buildings to meet our joint aims, and one to relocate elsewhere in central London. Each option was evaluated on the basis of cost and on a range of qualitative issues as follows:

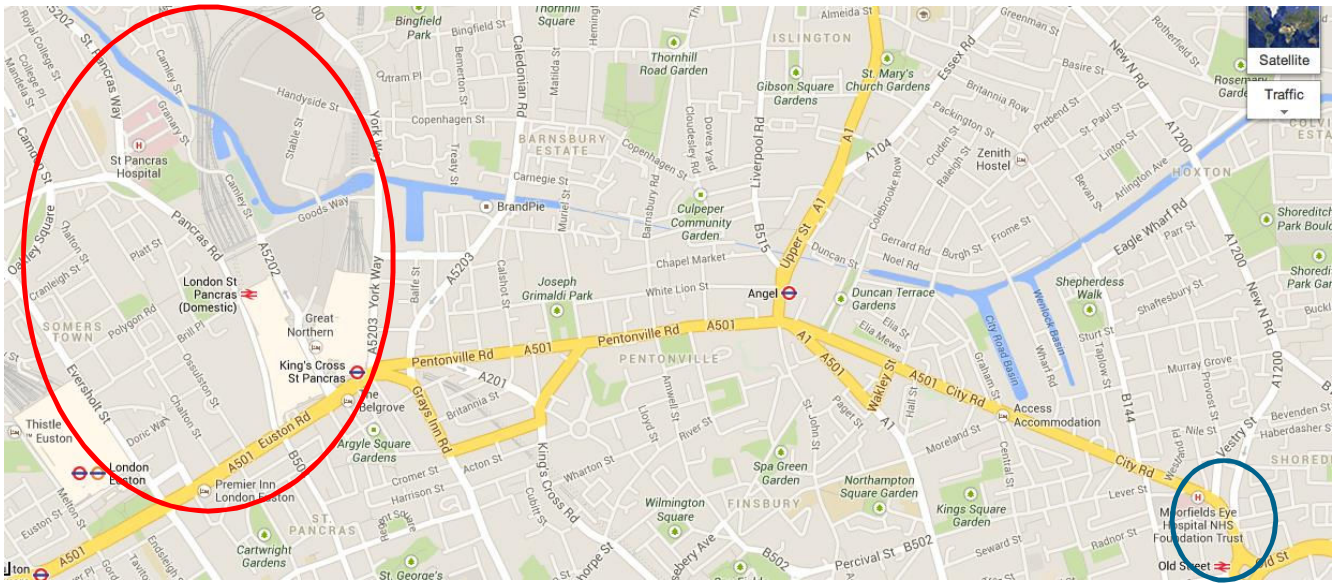
- Accessibility and quality of the surrounding environment
- Ability to realise the best clinical co-locations and patient experience
- Proximity to another acute hospital
- The impact of each option on existing service delivery and patient experience while work takes place
- Future flexibility
- Integration with the Institute of Ophthalmology, research and development and education and teaching capability
- Acceptability
- Brand and reputational impact
- Ability to accommodate additional patient activity

Relocating scored higher than rebuilding at City Road against every qualitative criterion, as well as on financial grounds. On that basis, our board of directors made an in-principle decision in March 2013 that we should focus all our efforts on identifying an alternative site at which to build a new integrated facility.

5. Why King's Cross/Euston?

Although we have looked at other parts of central London, King's Cross/Euston is the most attractive proposition for a variety of reasons:

- It is close to our current location (see map below), which will make any move easier for existing patients and staff
- The area is undergoing extensive regeneration, which means that there is land available on which to build, as well as other redevelopment opportunities
- The area is a major transport hub, providing easy access from across London and beyond
- Moving to this area will bring us closer to other important health and health research partners, including University College London Hospital, Great Ormond Street Hospital, UCL, and the new Francis Crick Institute



Please note that the red circle above is intended to show the broad area in which we are focusing our search and its relation to our existing site at City Road – it is not a definitive boundary

6. What we are engaging about

We are looking at several potential sites that meet our requirements in the King's Cross/Euston area and now want to hear your views about the most important criteria we need to consider in making a final decision on a new location for our integrated facility.

As part of this exercise, we also need to consider the potential impact of our proposal on people with protected characteristics, in line with the public sector equality duty. Protected characteristics are age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation. The general equality duty requires us to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups

Although we do not think there is likely to be any adverse impact on any group as a result of our proposals, we would like to know if there are any matters which you think we should take into account in this regard.

It is important to understand that this engagement exercise is not about a specific location, or the future of the buildings that make up the existing hospital in City Road. These issues will be the subject of future town planning consultations.

Nor is the exercise related to the services we currently provide. Wherever we are based, we will continue to provide high quality clinical care, research and education in a central London location, supported by a network of satellite locations in and around the capital, just as we do now. In addition, although we might expect more patients to choose to be treated in our satellite locations closer to where they live or work as services at those sites develop, the ultimate choice about whether to be cared for in our main hospital or in one of our satellites will rest with patients themselves.

7. How you can have your say

You will find a list of questions on pages 9 and 10 of this document, and we would be grateful if you could answer these and return them to us. There is also a space for you to give us your general views about our proposal to move to a new location.

This engagement exercise runs for 12 weeks from Monday 25 November 2013 to Friday 14 February 2014.

8. What happens next?

Once this engagement exercise closes, we will look at all the responses and write a report which will be posted on our website and sent out in hard copy on request. The report will then be used to develop the plans for a new home for Moorfields.

We are also keen to establish a reference group to ensure that patients' views are adequately represented as the project develops. If you would be interested in finding out more about this and what it will involve, please let us know using the contact details below.

9. Further information

We hope that this document contains enough useful information to help you contribute and have your say. You can also find a list of frequently asked questions about this project on our website at www.moorfields.nhs.uk.

If you have further specific questions, or need additional copies of this document, response forms or a copy in a different language or format, please contact us as follows:

- By email to projectoriel@moorfields.nhs.uk
- By telephone to 020 7253 3411, ext 4285
- In writing to Elizabeth Smith, Project Oriel project manager, Moorfields Eye Hospital NHS Foundation Trust, City Road, London EC1V 2PD
- By coming along at any time during one of our drop-in sessions: these will be held on **Thursday 5 December 2013** and on **Friday 24 January 2014**; both sessions will run from 10am to 6pm and will take place in the main entrance of Moorfields Eye Hospital, City Road, London EC1V 2PD

10. Tell us what you think

To let us have your views on our proposals, please answer the questions listed opposite and on the back page of this document.

Once you have finished, please detach the sheet from this document and send it in an envelope to:

Project Oriel team
FREEPOST NAT9528
Moorfields Eye Hospital NHS Foundation Trust
City Road
London EC1V 2PD

Alternatively, you can email your responses to projectoriel@moorfields.nhs.uk.

Published by Moorfields communications team

1. Do you agree with our proposal to move to the King's Cross/Euston area?

2. Which of the following criteria are most important in making a final decision about which site to choose? (Please rank in order where 1 is the most important and 9 the least important.)

Criteria	**Ranking**
Whether Moorfields can afford to pay for the site	
Value for money	
Accessibility – for example, proximity to a major transport hub and ease of access from that hub to the new facility	
Proximity to other hospitals with whom we work closely	
Continuity of clinical service delivery during construction works	
Future flexibility – to allow us to respond to changes in the way in which eye care is provided, or the demand for it	
Ability to integrate fully with the UCL Institute of Ophthalmology, our research partners	
Deliverability – for example, likelihood of obtaining planning approvals and ease of construction activity and process, including minimising disruption to staff, patients and neighbours	
Other – please specify in question 5 below	

3. Would moving the hospital to the King's Cross/Euston area affect you in any way – in particular, would it create any significant disadvantages for you?
4. Are there any specific issues for people with protected characteristics (see section 6) in what we are proposing, or which we should take into account in selecting the best location?
5. Do you have any further comments about our proposal?

Thank you for taking the time to answer these questions.

North Central London JHOSC

Forward Agenda

27 June (Islington)

1. Out of Hours Re-Commissioning

2. London Ambulance Service

3. Acquisition of Barnet and Chase Farm Hospitals by the Royal Free, including investment programmes for next five years.

4. Commissioning Support Unit – Further Development

TBA

Spend levels between primary and secondary care

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