

# Transforming the primary care landscape in North Central London



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## Dr Douglas Russell, Medical Director (Primary Care)

This is the underpinning Primary Care Strategy that has been developed since August 2011 in NHS North Central London. The strategy has been shaped by our aspirational vision “The Future Landscape of Primary Care – A patient’s perspective”. While many practices are already delivering some of that vision, we want to raise the standard across the board so that all patients have access to the very best in primary care.

Addressing quality, safety, and improving patient experience are the key aims in our primary care strategy. The strategy recognises that transformational changes are needed to support the development and capacity of primary care, and describes the steps towards implementing that transformation, but it will take time and resource.

We have therefore devised a major programme of transformational change requiring commitment and/or investment by all parties involved in the commissioning and delivery of primary care services, in order to make our vision a reality by 2016.

The process of developing the strategy has already included borough-based stakeholder workshops and direct engagement of GP and other independent contractor representatives. This is a co-production by many of the people directly involved in delivering primary care services.

Although it is strongly focused on the role of general practice in primary care, the implementation of the strategy will require the support of all independent contractors, nurses, therapists, hospital doctors and all other clinicians and managers involved in the delivery of primary and community care.

Currently, the quality and accessibility of primary care is variable across North Central London as a whole, and within individual boroughs. Allied to this, there is too much hospital activity in terms of Accident and Emergency attendances and unscheduled care admissions.

Primary Care has a pivotal role to play in reducing use of secondary care for basic healthcare provision and in improving population health. Radical change is required to improve quality, capability and productivity further, and to create capacity within primary care.

In this document we start by exploring what the primary care environment is in each borough, and acknowledge the legacy created in some areas by previous strategies and the extent to which they have been implemented. We then describe aspects of the care we aspire to provide, the vehicles for change that each borough will be able to draw upon as they set out their devolved implementation plans, and ultimately, what are the outcomes by which we will measure the success of this strategy in our future delivery of care.

It is my belief, shared by many primary care colleagues, that the high quality primary care we want to provide requires resourcing through upfront investment. Therefore this strategy is predicated on a substantial investment of pump-priming investment in the primary care strategy in Barnet, Camden, Enfield, Haringey and Islington. At the end of three years, we anticipate that the net savings of this strategy will more than cover any major investment.

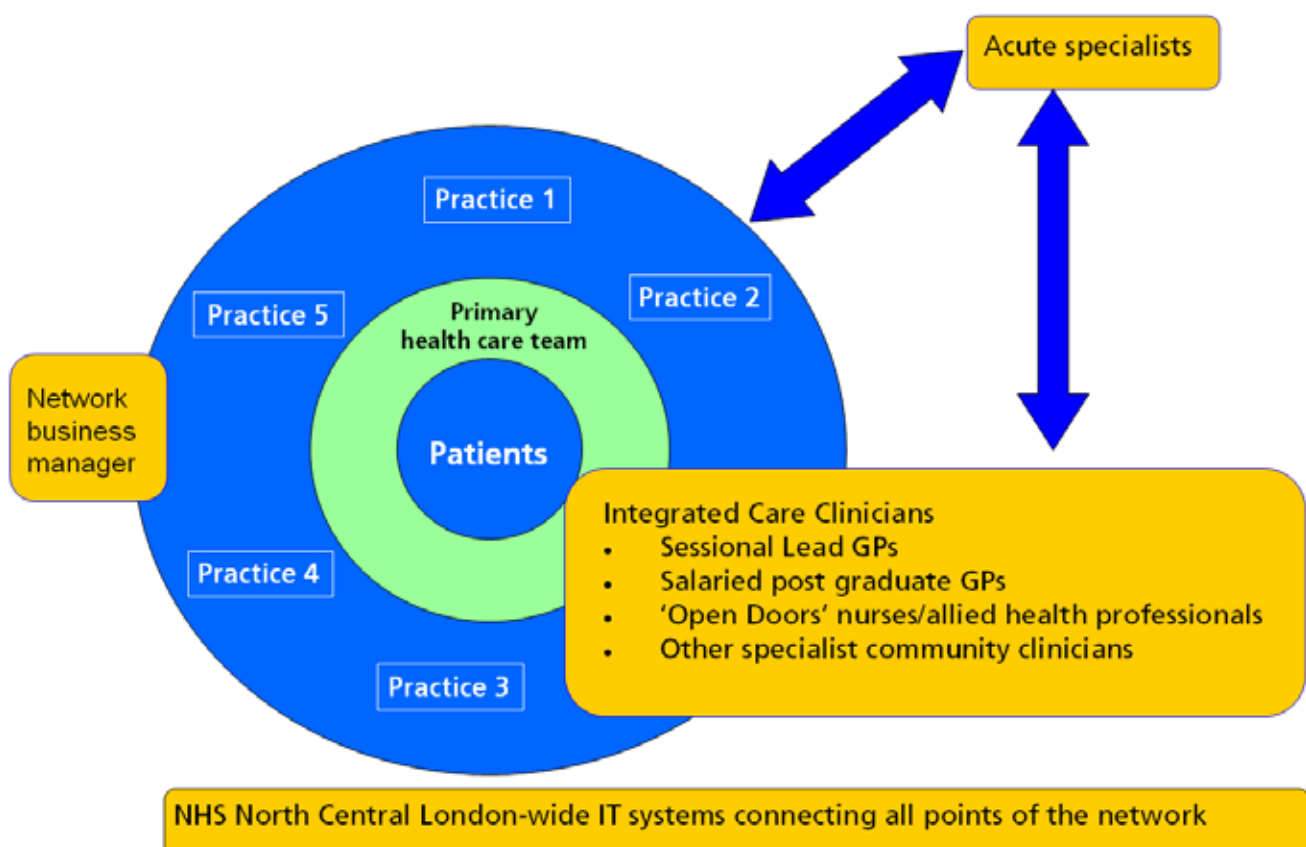
We are proposing nine strategic investment domains, of which the first three will form the Integrated Care Network (ICN) which is the heart of our new care delivery model.

We are asking practices to work together in local natural communities (of varying sizes) to create Integrated Care Networks, all the time retaining their autonomy as independent contractors. We will then provide funding for integrated care packages with community-based clinicians working along patient pathways from primary, through community and reaching into secondary care, where our hospital colleagues will provide professional clinical support to the networks and less hands-on care to those patients who can, and should, be seen in primary care.

Each network will be supported by an interactive, web-based, clinical information management network across NHS North Central London which will enable all healthcare providers to share patient records and to communicate electronically directly with each other to ensure that individual patient needs are met.

We are offering an example of what an Integrated Care Network may look like, but the actual design will be determined by each network.

## WHAT MIGHT AN INTEGRATED CARE NETWORK LOOK LIKE?



The Integrated Care Network is not merely a theoretical construct. It is based on solid evidence (The King's Fund Report "Improving the Quality of Care in General Practice" March 2010), including demonstrable results from other London boroughs. But the success will come from the primary care community embracing both the concept of integrated care and

## Foreword

the investment to create locally-based effective networks. It is a framework and we have not set out the micro-detail of how the networks should operate because we want those decisions to be made at a local level. This is the next stage of development.

Having provided the investment and devolved authority to the networks, NHS North Central London has a duty to ensure that it is spent as intended and that it delivers the desired results. We will work with our independent contractors to motivate, incentivise and support them on the transformational journey. But we will also monitor their performance to ensure that our contractors do deliver those higher standards of quality, safety and patient experience.

Our intention is not to create any contractual changes. We are seeking to promote a change in “how things are done” rather than “what is done”. We are therefore proposing a mutually beneficial investment in primary care which requires independent contractor practices to achieve explicit quality standards of inputs and outcomes in return for the financial investment. Our message to our independent contractors is “If you do these things well with our investment, then together we will achieve the desired outcomes”.

Those outcomes, will have explicit quality markers by GP practice and network, agreed with GPs, whereby in return for the investment we can expect to achieve improvements in:

- Patient safety
  - Clinical effectiveness
  - The experience of patients.
- } Health outcomes

I recognise that this primary care strategy is but one of many such initiatives in the current environment and that there is a real danger of change fatigue. Clinical leadership has never been more in demand, particularly from, and for, GPs. We need to separate our new role and responsibilities as commissioners from our traditional role as providers.

This strategy is about GPs in North Central London taking the opportunity to lead change in that traditional role. I am confident that secondary care colleagues, local authority colleagues, patients and the public will all respond positively to the successful implementation of this strategy.

In his foreword to The King’s Fund Report “Improving the Quality of Care in General Practice”, Chief Executive Chris Ham states:

“The gauntlet thrown down by this report is to accelerate the pace of improvement in general practice and to develop a system that is fit for the future”.

**I invite all independent contractors, other clinicians and managers in both health and social care to join me and rise to this challenge in North Central London over the next three to five years.**

**Dr Douglas Russell**

# 1. Introduction

In August 2011, NHS North Central London set up a project to develop a North Central London-wide Primary Care Strategy. This document describes a major programme of transformational change which will require commitment and/or investment by all parties involved in the commissioning and delivery of primary health care services. Its aim is to improve quality, capability and productivity further, and to create capacity within primary care.

The need for a strategy is in recognition that primary care services across North Central London are currently so variable in so many aspects that we need to transform our primary care services to raise the standard across the board so that all patients have access to the very best in primary care.

Through working with local people and partners we will improve the health and wellbeing of our population, reduce inequalities and maximise value in terms of outcomes, quality and efficiency from services provided to patients. We will:

- Enable our population to live longer, healthier lives, in particular tackling the significant health inequalities that exist between communities
- Provide children with the best start in life
- Ensure patients receive the right care, in the right place, first time
- Deliver the greatest value from every NHS pound invested.

We will achieve this:

- By actively engaging local people in decisions about their own and their community's health and wellbeing
- Through working collaboratively with partners to deliver seamless care.

This strategy underpins the development of our five borough-based implementation plans by defining the medium/long term goals, priorities, principles, investment criteria and performance expectations. It is a strategic shift from the previous premises-led agenda to one that is quality-led, and which focuses on:

- Promoting health, wellbeing and illness prevention
- Addressing health inequalities
- Further improving the quality of primary care services, particularly in General Practice, to enhance the patient experience with better outcomes.

The combined strategy and implementation plans will determine how the NHS in north central London will invest in primary care in each of the five boroughs over the coming years. The payback will be in the improvement in clinical and service quality and in a reduction in hospital usage and costs.

The strategy has been developed using, amongst others, the following inputs:

# Introduction

- The case for change in primary care in north central London
- The Barnet, Enfield and Haringey Clinical Strategy
- The King's Fund Report "Improving the Quality of Care in General Practice" (March 2011), which includes best practice examples in similar health economies, including Tower Hamlets
- "Value-Based Health Care Delivery", Michael Porter, Harvard (UCLP January 2011)
- "Improving access, responding to patients - A 'how-to' guide for GP practices" (Practice Management Network- August 2009).

The process of developing the strategy has already included borough-based stakeholder workshops and direct engagement of GP and other independent contractor representatives. This is not a top down imposition, but rather a co-production by many of the people directly involved in delivering primary care services.

Throughout the strategy, the definition of primary care should be assumed to be the independent contractor groups of GPs, dentists, pharmacists and optometrists, who all form a vital part of our primary care services. Community-based services such as district nursing, health visiting and therapy services are partners with the primary care independent contractors as members of the Extended Primary Care Team. This strategy describes how the partnership will work within an integrated network model.

The aspirational "vision" is set out from a patient perspective in the section "The future landscape of primary care - A patient's view of primary care in North Central London in the boroughs of Barnet, Camden, Enfield, Haringey and Islington in the year 2016". This is a deliberately challenging way of creating a vision, by starting from a single patient's view of the local healthcare system. It concludes with the following statement of purpose:

**"Our aim, and that of all our practices, is to offer you a high quality primary care team service, linked, when necessary, to more specialist services; all of which will enable you to live the best possible lifestyle in respect of your personal health and wellbeing."**



## 2. Background

### “This is how it was and how it is”

In our first NHS North Central London-wide strategy document Commissioning Strategy Plan 2010/14 (CSP) dated January 2010, we noted that:

“The primary care landscape in North Central London is characterised by a significant variation in general practice size. There are a significant number of single handed GPs and many are in old buildings and estate that is not fit for purpose.” (Page 35)

There were then 269 practices serving a registered population size of 1,374,253, at an average of 5,109 patients per practice.

The central theme of the plan was to implement the London-wide strategy set out in “Healthcare for London - A Framework for Action” (2007) and to support our PCTs in developing polysystems. This was a major investment in a premises-led strategy.

In January 2011, we published the first version of the NHS North Central London cluster Commissioning Strategy and QIPP Plan 2011/12 – 2014/15. This was subsequently issued as an updated version 30 June 2011. The foreword to the plan reflects a move away from the emphasis on the premises-led polysystems approach towards a more qualitative approach based on patient research:

“The plan builds on our previous Commissioning Strategy Plan (CSP) published in January 2010 and retains the key themes of that plan of transferring care, where appropriate, from hospitals to community and primary care settings. Our discussions with General Practitioner (GP) commissioners as part of the planning process highlighted this as a key priority for them, along with improving services for mental health patients. Other priorities in the plan reflect work undertaken across London to improve patient outcomes in specialist services such as cancer and cardiovascular, local services such as maternity, and areas where we have benchmarked our performance against others and identified improvement opportunities.

“Our plan takes account of the approval of the Barnet, Enfield and Haringey (BEH) Clinical Strategy in January 2011 and assumes that the consultation on the reduction of mental health bed capacity with Camden and Islington NHS Foundation Trust leads to bed closures taking place. At this point, our plan does not include other major service or provider reconfigurations other than those agreed across London in specialist services. Throughout the course of our planning we have continued to discuss and review with providers the implications of our plan on them both in the short and longer terms. Potentially, these discussions may conclude that there is a need for further changes to the pattern of services within North Central London.”

The plan included a number of initiatives within primary care including list maintenance, reviewing enhanced services, pan-London performance management and review of the personal medical services. The 2011/12 programme of work has been focused on delivery of these initiatives.



## “This is how it was and how it is”

By mid-2011, there were a total of 258 general practices with 1,413,086 registered patients, excluding the three GP-led health centres and PCT Special Practice.

FIGURE 1 - NUMBER OF PRACTICES, BY LIST SIZE, BY BOROUGH, AT JULY 2011

List size	Barnet	Camden	Enfield	Haringey	Islington	Totals
< 2,000	9	2	4	7	2	24
2-5,000	27	19	35	28	14	123
5-10,000	23	9	16	12	17	77
10,000-15,000	7	8	5	4	4	28
>15,000	2	1	0	3	0	6
Number of practices	68	39	60	54	37	258
Total registered patients	373,715	251,016	299,119	272,236	217,000	1,413,086

FIGURE 2 - THE AVERAGE NUMBER OF PATIENTS PER PRACTICE VARIES FROM UNDER 5,000 IN ENFIELD TO ALMOST 6,500 IN CAMDEN:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	5,496	6,436	4,985	5,041	5,865	5,477

FIGURE 3 - A MORE DETAILED ANALYSIS SHOWS THE VARYING NUMBER OF PATIENTS REGISTERED BY SIZE OF PRACTICE:

Number of patients by practice Size at 1 July 2011	Barnet	Camden	Enfield	Haringey	Islington	Totals
Practices <2,000	16,148	4,541	6,878	8,424	3,959	39,950
% of total patients	4%	2%	2%	3%	2%	3%
Practices 2-5,000	89,126	63,356	121,098	87,331	44,714	405,625
% of total patients	24%	25%	40%	32%	21%	29%
Cumulative	28%	27%	43%	35%	22%	32%
Practices 5-10,000	158,129	68,078	112,386	82,142	120,588	541,323
% of total patients	42%	27%	38%	30%	56%	38%
Cumulative	70%	54%	80%	65%	78%	70%
Practices 10-15,000	76,949	96,759	58,757	45,843	47,739	326,047
% of total patients	21%	39%	20%	17%	22%	23%
Cumulative	91%	93%	100%	82%	100%	93%
Practices >15,000	33,363	18,282	0	48,496	0	100,141
% of total patients	9%	7%	0	18%	0	7%
Cumulative	100%	100%	100%	100%	100%	100%
Total registered patients	373,715	251,016	299,119	272,236	217,000	1,413,086

From Figure 3 we can see that:

- Fewer than 40,000 patients (ie 3%) in North Central London are registered in practices which have fewer than 2,000 patients, with the largest number (16,000) in Barnet (but still only 4% of Barnet total)
- 43% of Enfield patients are registered in practices with fewer than 5,000
- In Islington, the comparable figure is 22%
- In Camden, 46% of patients are registered in the larger practices with over 10,000, compared with the North Central London average of 30%
- Across North Central London there are six practices with over 15,000 registered patients and three of those are in Haringey, accounting for 18% of their total patients.

FIGURE 4 - NUMBERS OF DENTISTS, OPTOMETRISTS AND PHARMACISTS

April 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Dental Practices	70	42	44	51	23	230
Optometrists	88	77	72	33	53	323
Pharmacies	71	65	61	56	46	299

# 3. The case for change

## “Why do we need to change?”

In July 2011, recognising the need for more fundamental and transformational change, Dr Douglas Russell, NHS North Central London Medical Director of primary care, produced a discussion paper titled “Starter for 10 - NHS North Central London case for a primary care strategy” to frame a further discussion about the need to develop a new primary care strategy for the five boroughs of north central London. He set out the argument for the definition and measurement of both activity and quality before engaging in a developmental programme with primary care contractors and concluded:

“We need to engage the clinical leadership with a new vision of a transformed, supported and developed high quality GP and primary care landscape across the whole cluster attracting and retaining the highest quality staff, both clinical and support. There are a set of core documents published recently that fill out a lot of background detail and evidence of the vision of what we would like to achieve over the next five years, from sources such as the Royal College of General Practitioners, Kings Fund, Information Centre, Primary Care Commissioning. The King's Fund report on “Improving quality in general practice” is a key resource document.”

There is a common theme that five years ago most strategies were looking to develop care pathways based on hub and spoke models. Healthcare for London led to most plans being re-packaged as polysystems, including new-build locality centres. Over the past year, without any new build financing, plans have been modified to take account of the original hub and spoke model plus any polysystem developments that were approved.

Undoubtedly, the strategic focus and planning over the past five years has been premises-led. However, despite the elaborate planning, implementation has been slow. Strategically the picture across NHS North Central London has not changed dramatically.

Everything in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield and Haringey Clinical Strategy. First developed in 2006, it has now been ratified by the Secretary of State and implementation has recommenced. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

Any new developments in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield and Haringey Clinical Strategy, which was given the green light for implementation by the Secretary of State for Health in September 2011. We are in the process of developing an integrated implementation plan which will recognise the close relationship between the two strategies and bring together the work to implement each.

The Primary Care Strategy supports delivery of better services in Camden and Islington as well as Barnet, Enfield and Haringey and, while there have been many recent developments in primary care in each of the five boroughs, many more are being developed or are planned. We will make the changes in hospitals when clinicians tell us that the primary care system is sufficiently developed to provide better and safer care than in hospitals.

## “Why do we need to change?”

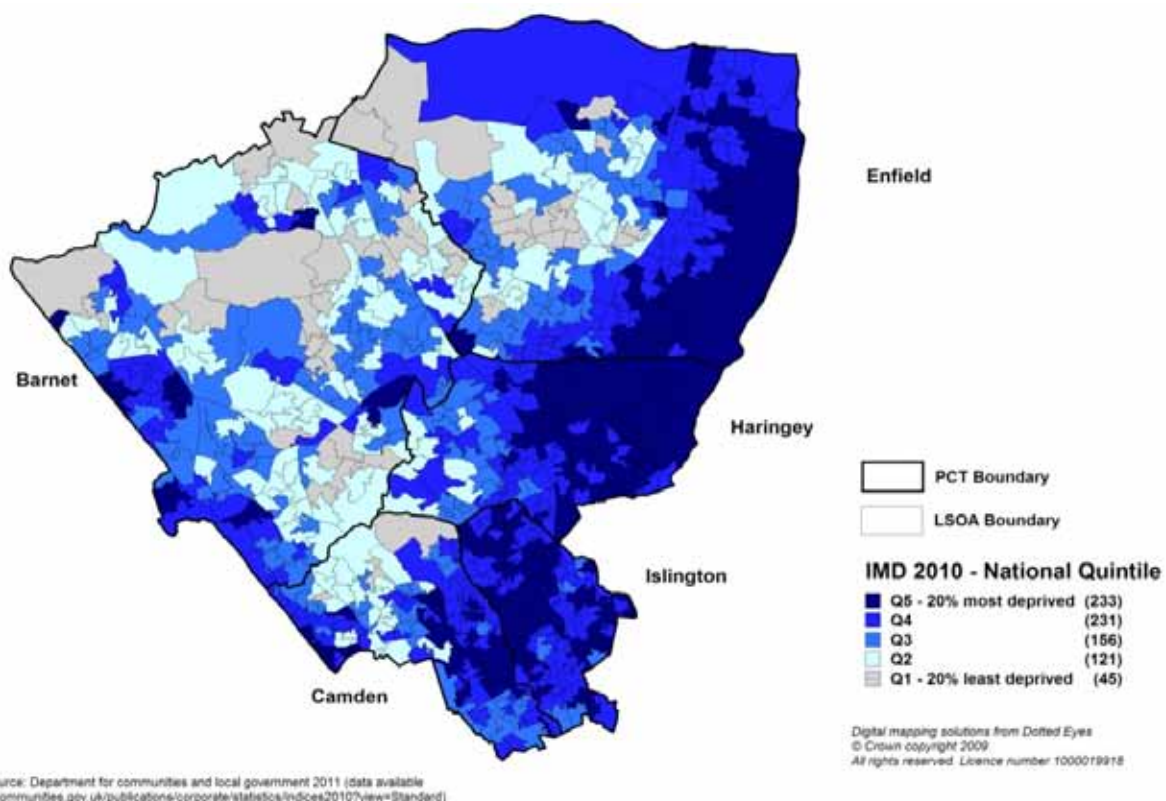
At its best, Practice Based Commissioning has tended to focus on pathway redesigns and has delivered improvements in some areas, but it has been variable across North Central London.

### DEPRIVATION

There are significant differences in levels of deprivation between NHS North Central London’s boroughs as well as marked differences within the boroughs.

In general, deprivation in North Central London increases as one goes from west to east, with the greatest concentrations of deprivation across most of Islington, the eastern half of Haringey, eastern edge of Enfield and parts of Camden.

IMD 2010 national quintile of overall deprivation score by North Central London sector LSOAs



### LIFE EXPECTANCY

At 76.0 years, the male life expectancy at birth in Islington was the lowest in London, and in Haringey (at 77.4) was also significantly below the national and London averages. Enfield (79.5) and Barnet (80.4) were significantly above. The rate in Camden (78.5) was in line with the national and London rates, however there is a 10-year difference in male life expectancy between the south and north of the Borough.

Female life expectancy is generally higher than that for males. Whilst Islington’s female life expectancy of 81.4 is significantly below the London average, Enfield’s of 83.0 is not. Barnet’s life expectancy of 84.4 is above both London and national averages, whilst Camden (83.8) and Haringey (83.7) are in line with London but significantly above the England average.

# “Why do we need to change?”

For both men and women, deprivation and lifestyle factors account for much of the difference in life expectancy between and within boroughs.

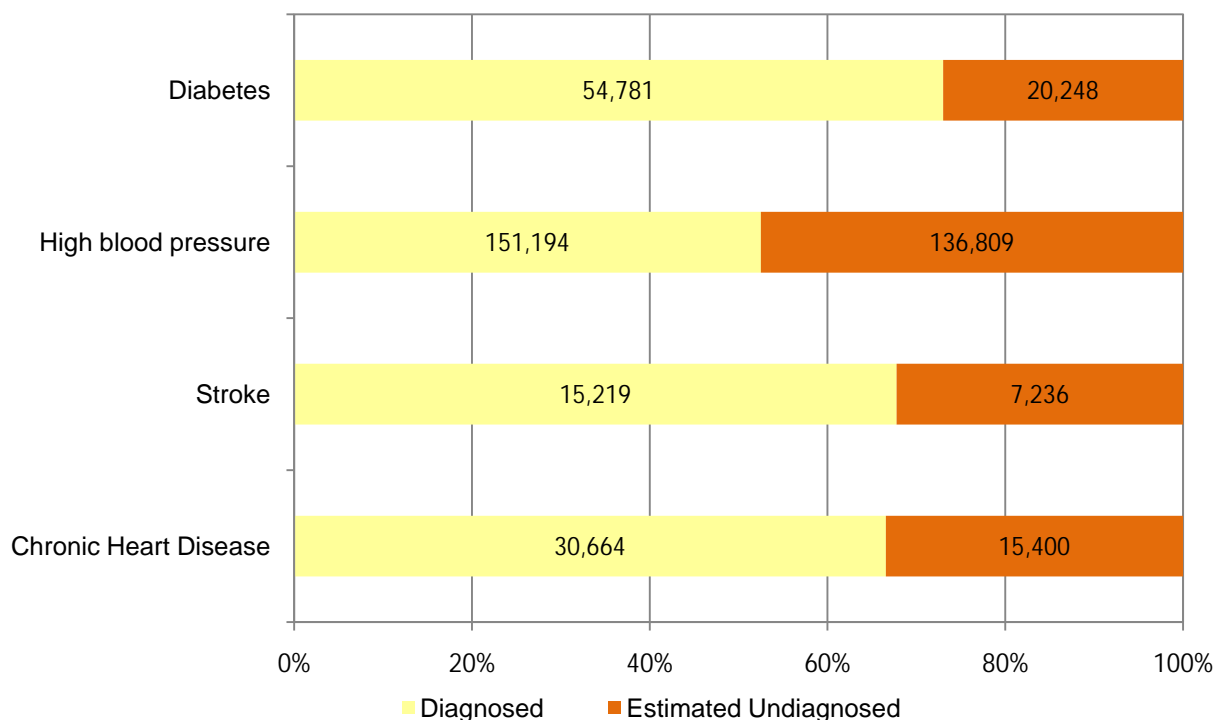
## MORTALITY

There are approximately 8,000 deaths per year in North Central London. The three leading causes of death - cardiovascular disease (CVD), cancer, and respiratory disease - account for approximately 75% of all deaths, including 70% of all premature deaths (deaths under the age of 75).

## PREVALENCE OF LONG-TERM CONDITIONS

There is significant under-diagnosis of long-term conditions across NHS North Central London, therefore many individuals cannot benefit from prevention and early intervention, resulting in poorer long term outcomes, higher use secondary care (including for emergency care). This includes cancer, chronic obstructive pulmonary disease (COPD), HIV and the following estimates of undiagnosed cases of diabetes, high blood pressure, stroke and coronary heart disease (CHD).

## NUMBERS WITH LONG-TERM CONDITIONS – DIAGNOSED AND ESTIMATED UNDIAGNOSED. NORTH CENTRAL LONDON 2009/10



# “Why do we need to change?”

## LIFESTYLES AND PREVENTION

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There is some evidence to show that those living in the most deprived areas of London are likely to have a concentration of people with lifestyle choices which can be changed such as alcohol intake or smoking.

- Smoking is responsible for 20% of deaths in the sector
- Obesity is strongly linked to diabetes, cardiovascular disease and cancer. Over 200,000 adults are estimated to be obese (estimated to be below national levels)
- Physical activity. Nearly a million people across North Central London are considered not to be engaging in sufficient physical activity. Adult physical activity levels are above the London average in Camden and Haringey, but lower in Barnet, Enfield and Islington
- Alcohol. Across North Central London, less than 5% of the 54,000 estimated harmful drinkers are in treatment, ranging from 2.2% in Enfield to 8.7% in Islington
- Health Checks. Across North Central London, 16,744 people received a health check in 2010/11, 4.2% of the eligible population (though 13% was achieved in Islington).

Quality in NHS North Central London Primary Care - How can we really measure true quality?

“Quality is complex and multidimensional. No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality in general practice”  
(Improving the quality of care in general practice The King’s Fund March 2011)

We have had Balanced Scorecards (five very different), Quality and Outcomes Framework (generally good), MORI Survey (not so good) and prescribing data. We have trialled and will be implementing the London-wide GP Outcomes Framework from April 2012.

OVERALL QUALITY AND OUTCOMES FRAMEWORK ACHIEVEMENT SCORES BY BOROUGH PCT 2010/11

Borough PCT	Number Practices	Exception Reporting	Number of Practices by overall QOF scores 2010/11 and % of total practices								PCT Ave
			<50%	50-80%	80-90%	90-93.3%	93.4-94.6%	>94.7%			
Barnet	69	4.5%	0	2	6	7	93.3 London Ave.	12	94.7 England Ave.	42	93.7%
			22%					17%		61%	
Camden	40	5.4%	0	1	3	6		8		22	93.8%
			28%					20%		55%	
Enfield	62	4.0%	1	5	12	15		8		21	90.4%
			53%					13%		34%	
Haringey	53	5.2%	0	5	6	11	6	25	92.0%		
			42%				11%	47%			
Islington	38	6.0%	0	0	2	4	7	25	95.0%		
			16%				18%	66%			
NHS North Central London	262		1	13	29	43	41	135			
			33%				16%	52%			
London		4.9%	Better than London and England Averages								
England		5.4%	Better than London / Worse than England Averages								

Key points to note:

Worse than London and England Averages

- 52% of NHS North Central London practices score higher than London and England averages
- Islington overall score higher than London and England averages
- Enfield and Barnet have low Exception Reporting

- One in three practices (86) score less than London average
- Of those 86 practices, 33 are in Enfield, equating to over half of the Enfield practices
- Enfield and Haringey overall score less than London average
- Islington has the highest Exception Reporting at 6%

- 67% score higher than London average
- Barnet and Camden overall score higher than London



# “Why do we need to change”

MORI PATIENT SURVEY MARCH 2011

## Overall Satisfaction Levels by Borough PCT

MORI 2010/2011 Scores	Satisfaction with care received	Recommending a GP surgery to someone moved into area
Results – England as a whole	89%	84%
London SHA	85%	77%
Barnet	85%	80%
Camden	83%	79%
Enfield	85%	77%
Haringey	81%	74%
Islington	85%	79%

Worse than England but better than London average

Worse than both England and London Average

On the two overall satisfaction questions, none of the boroughs achieve the England average, but Barnet, Enfield and Islington all equal or better the London average. Haringey fails to achieve the London average in both areas.

ACCESS

	Barnet	Camden	Enfield	Haringey	Islington	London	England
Ease of getting through on the phone	62%	63%	66%	65%	66%	67%	69%
No appointments available	84%	81%	84%	80%	83%	82%	84%
Times didn't suit	19%	20%	16%	17%	18%	18%	15%
Satisfied with opening hours	74%	74%	79%	76%	74%	78%	80%
Know how to access out of hours care	56%	52%	55%	52%	52%	54%	62%

Source: GP Survey 2010/11

## “Why do we need to change?”

### PRIMARY CARE CONTRACT COSTS (SEE APPENDIX A FOR FULL ANALYSIS)

These costs are provided to illustrate the variations across NHS North Central London. A key issue from this data is that there seems to be no direct correlation between costs and outcomes.

#### General Practice

- Total GP costs range from £119 per capita (Barnet) to £140 (Camden).
- Total costs per practice range from £606k (Haringey) to £898k (Camden)
- General Medical Services contract costs are from £104 per capita (Haringey) to £124 (Camden)
- Ignoring Islington with only two PMS practices, PMS contract costs are from £128 (Haringey) per capita to £168 (Barnet)
- Barnet GMS contract costs are £109 compared to PMS contract costs of £168 per capita.

#### Dental, optometrists and pharmacists contractor costs:

- Total dental, optometrist and pharmacist contractor costs per capita:
  - Dental from £38 (Islington) to £56 (Haringey)
  - Optometrists from £6 (Islington) to £10 (Barnet)
  - Pharmacists from £19 (Camden) to £26 (Barnet).
- Number of dental contractors varies from 23 (Islington) to 70 (Barnet)
- Haringey dental costs are an outlier at £56
- Number of optometrists in Haringey is only 33
- Optometrist costs per capita from £6 (Islington) to £10 (Barnet).

Total costs of all independent contractors range from £184 (Islington) to £215 (Enfield), while prescribing costs range from £101 (Camden) to £160 (Barnet). The data on Astro PU costs indicates a range from £21.94 (Camden) to £25.47 (Barnet).

**In summary, the quality and accessibility of primary care is variable across North Central London as a whole and within borough PCTs. Primary care has a pivotal role to play in reducing use of secondary care for basic healthcare provision, as well as improving population health. Radical change is required to develop primary care capacity and capability and ensure higher quality and productivity in primary care.**

## 4. The future landscape of primary care

### - A patient's perspective

"This is how we want it to be"

A patient's view of what primary care in North Central London will be like in the year 2016 in the boroughs of Barnet, Camden, Enfield, Haringey, and Islington.

Hi - I've just moved into the area and I'd like to find out about what's available to me from the local NHS. I've got friends who used to live in North Central London back in 2011 and they've told me some worrying stories about how variable the availability and quality of primary care used to be. Apparently it was something of a lottery with many really good general practices and some, allegedly, barely fit for purpose. At its very best it was fantastic and compared well with anywhere in the country. At its very worst, you could experience any or all of the following:

- Great difficulty in finding a practice with which to register
- Not being able to get through on the phone to make an appointment
- Very difficult to get an appointment suited to your lifestyle
- Unwelcoming reception staff
- Premises in poor condition, not clean and very uncomfortable
- Despite having an appointment, you often had to wait ages to see the doctor
- When you did get to see a doctor, apparently some of them didn't know anything about you as a person, didn't seem to have relevant history notes and didn't really sort out the problem.

I understand at that time too many patients took the easy option of going to the urgent care services – A&E, Walk in Centres and Urgent Care Centres. That can't have been the best solution for them or the NHS.

So my first question is – has anything actually changed since 2011?

Welcome to North Central London from the primary care part of the NHS. Yes things have changed greatly for the better. You're right – back in 2011 it was a very variable quality service with some excellent practices side by side with some not-so-good. In those days the "better" practices (as perceived by patients) were sought after and couldn't cope with the rising demand.

Then in 2011/12 we introduced a primary care strategy and development plan to improve poor performance and to ensure that all of our practices now meet explicit high quality standards. It is only fair to say that many of them already did meet those standards back in 2011 and what we have done is to ensure that all patients can now get that high quality service.

So, firstly, we want to get you registered as a patient in our area, and we don't want you to wait until you actually need our services. We aim to make it as easy as possible. You may already have had an information pack from your estate agent or letting landlord, giving you details of our services and a range of different ways to register with us.

## “This is how we want it to be”

For online registration, go to our website and click on the “I want to register as a new patient” link and just follow the on-screen instructions on the application form if you want to send us your details in that way (please read the internet security caution).

If you don't want to register online, call in at any of our NHS-signed premises – doctors, pharmacies, optometrists, dentists, community-based health services or clinics - or at any of your local council offices, Job Centre Plus, Citizens Advice Bureau, Libraries, and some local estate agents. You do not need to bring anything with you and we'll get you signed up straight away. When you arrive at the practice we will ask you to sign the form as a legal requirement and that is it – you will be registered. At the surgery you will be able to find a complete list of all of the services available both at your base surgery and in the NHS and social care network locally. (All of this information will also be available via our website as well and is available in different languages). This will include:

### A. NAMES AND ADDRESSES AND FULL INFORMATION ABOUT LOCAL GENERAL PRACTICES WITH THEIR RANGE OF SERVICES AND DETAILS OF THEIR STAFF AND OPENING TIMES

Generally speaking, you should be able to find a choice of practices within 20 to 30 minutes travel time from wherever you live in Barnet, Camden, Enfield, Haringey, or Islington. You can then choose the one that best meets your personal lifestyle preferences. Be assured that the quality of care is uniformly high at all of our practices, and that the differences in location, premises, size, opening hours, languages and/or translation service and the range of clinical services available on-site are the criteria by which we want you to choose, according to what suits you.

We know that many patients prefer a small practice where they will know, and be known by, all the staff. Because there are fewer clinicians it should be easy to get personalised continuity of care. But, depending on the range of services offered by that practice, sometimes it may mean that patients have to go to another nearby practice for care that cannot be delivered safely and effectively in every practice. We also know that other patients do prefer a larger “one stop” centre where they may not always know, or be known by, all the staff but a wider range of services may be available. It's really your choice!

### B. AN OPPORTUNITY FOR YOU TO GET A CHECK-UP BY BOOKING A NEW PATIENT HEALTH CHECK AT THE PRACTICE OF YOUR CHOICE

We want to ensure that the practice gets to know about you so that it can work with you on your total health service. This opportunity will also be extended to your family members if you are also registering them. We understand that your time is valuable so as much detail as possible can be filled in online through a health questionnaire, and some of the detail can be filled in later, possibly at a self-check station in one of our community pharmacies or other NHS premises. If there are any gaps we will fill them in next time you come in. You will be able to access care straight away, but the more we know about you from the outset the better and safer it will be for you.

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C. A LIST OF PHARMACIES IN YOUR AREA, WITH OPENING TIMES AND ADDITIONAL SERVICES

Our practices operate a “standing order” system of repeat dispensing of many medications, (with some exceptions) which means that you may not have to get a repeat prescription from your GP every time you need your regular medication. Do note that our pharmacists are able to provide advice and a wide range of services which could save you having to go to your doctor at all. These include general health promotion, dealing with minor illnesses such as colds, hay fever, allergies, tummy upsets, emergency contraception, travel advice, medicines advice, NHS Health Checks and some immunisations and smoking cessation. Plus lots more – it’s all in the leaflet.

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D. AN INFORMATION PACK ON THE FULL RANGE OF SERVICES AVAILABLE AND HOW TO ACCESS THEM, FROM DENTISTS AND OPTOMETRISTS

Dentists can provide advice on oral health, nutrition and smoking cessation. Optometrists can advise you on colour blindness, cataracts, glaucoma, “acute red eye” and early eye disease signs of some long term conditions. Again, full details of these and other services are in the leaflet.

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E. ALSO THE INFORMATION LEAFLET WILL EXPLAIN HOW TO FIND YOUR WAY THROUGH THE LOCAL NHS WHEN YOU NEED US URGENTLY

We offer a range of urgent care services. The hospital accident and emergency department is reserved for the most serious cases. The majority of urgent care can be delivered by your doctor, pharmacist, dentist or optometrist. If you’re not sure you can always phone us on 111, the NHS one stop phone number service, who will help you access the right people for your care.

Do be aware that if you do go straight to the hospital A&E, they may re-direct you back to your local primary care service for the type of care that you need. If you are unwell out of normal working hours, many of our surgeries offer extended opening hours including evenings and weekends. We have the 24 hour 111 telephone helpline and you can visit an urgent out of hours centre or, if housebound, a home visit is available for those who really need it. Remember, patients attending in person can be seen much more quickly than those on home visits.

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F. DETAILS OF THE SOCIAL SERVICES AVAILABLE FROM YOUR LOCAL COUNCIL ARE ALSO IN THE PACK

This will include guidance on how to access those services and how they work in an integrated way with our primary health care teams and the voluntary sector.

## SO, AS A NEW PATIENT, WHAT CAN I EXPECT FROM MY GENERAL PRACTICE?

Firstly, we can assure you that the premises will be fit for purpose, irrespective of the age and type of building. We have a mix of new and old, large, and small buildings; but they are all clean, bright, and tidy and will display only current relevant information about our services. The building will be accessible for all, including the disabled, and will conform to all health and safety requirements and be a safe environment. There will be a comfortable waiting area and all of our practices are child friendly, understanding the needs of both parents and children, at what may be a stressful time. All consulting and treatment rooms will be appropriate for their use, and there will be decent toilet facilities should you need them.

All practice premises are open and staffed, as a minimum, all day from 8am to 6.30pm Monday to Friday and some are open in the evenings and at weekends. When you contact them, you will be offered an appointment or telephone consultation with a healthcare professional relevant to your needs, which, depending on clinical urgency, may include same day access. From the information we sent you, you will already be aware of your choice of clinician, including gender and language preferences.

On arrival, the practice reception staff will be welcoming and you will be able to check-in confidentially, either face to face, or electronically. As a new patient, you will be introduced to our “Self care management and co-creating health programme” either face-to-face or electronically, to guide you through the things that you may find useful including:

- How to get your personal health profile
- Self-care and lifestyle advice
- Exercise on prescription
- Housing, benefits, employment, healthy foods and cookery advice
- Specialist advice on drugs and alcohol abuse
- Details of how to access all our services.

Your practice healthcare team will view you as a member of the local health community and will provide you with public health information about disease patterns, likelihood and symptoms. We know the expected patterns of ill-health in a community and can advise you on healthy living, prevention and early diagnosis. Health promotion and illness prevention is as much a part of our service as care and treatment.

## AFTER MY INITIAL VISIT, HOW WILL I BE ABLE TO CONTACT THE PRACTICE?

Weekdays between 8am and 6.30pm, you can contact any of our practices by phone, online appointment booking or in person. Some of our practices are open until 8pm and at weekends. Occasionally, a practice may close for a half-day staff training session, but they will have arranged for a nearby practice or an urgent care provider to cover any patient needs.

We offer consultations with doctors and nurses face to face, by phone and sometimes by e-mail. When you enquire about making an appointment the practice will agree with you which is the most suitable option for you, or you can just book online, if you know which clinician you need to see.

## “ This is how we want it to be ”

If you prefer continuity of care, then practices will always try to offer you an appointment with the clinician of your choice. Sometimes, particularly if you require an urgent consultation, they will offer you an appointment with the first available clinician. If you sign up for our “Reminder” service, the practice will always send you a text message to your mobile phone 24 hours before your appointment. If you are unable to attend, please let us know immediately so that we can offer your slot to another patient.

Outside these surgery hours, please ring 111 for the Out-of-Hours Doctor Service.

Whichever type of consultation you have, and whatever the time of day or night, with your permission, we can arrange for your medical records to be available to the clinician so that they can see all relevant information. If you have an out-of-hours consultation, we will ensure that your registered practice is aware of it, and they will update your records accordingly within 12 hours.

### WHAT SERVICES DO YOU OFFER THROUGH YOUR PRACTICES?

All our practices work within a local primary care network across a number of practices in a “natural community”. The network principle is that you will always be able to access, within the network, all of the services that we offer as part of our guaranteed standard services list (see enclosed).

Every practice offers on-site, as a minimum, the range of core services that you would expect from any general practice. Some practices offer a wider and growing range of additional services. If you are registered with a practice that does not offer the full range of guaranteed services, you may have to attend another nearby practice in the local network for some of those services. Here are some examples of how the network functions:

- All practices offer a range of patient diagnostic tests in-house. If you need a blood test, then the sample may be taken in your own or a nearby network practice, and the samples sent away for analysis. You will then be able to contact the practice for your results within 72 hours and they will be available to you online on your health record
- Some practices offer more specialised testing, such as ultrasound scanning, for their own patients, and for those from nearby practices in the network
- If you require more specialist support and advice for a condition such as diabetes, your GP may refer you to attend an appointment with a diabetes GP or nurse locally in the network
- If you need more specialised diagnostics, such as an x-ray, your GP has direct access to order tests as required, usually within the borough.



## “ This is how we want it to be ”

The local primary care network includes a wide range of community-based clinicians known as the Extended Primary Health Care Team. The team will service the network patients across a number of practices. The services include:

- District nursing, including community matrons to help you plan and support you in your care
- Specialist nursing including school nurses, paediatric nurses and other clinical specialties
- Health visiting
- Midwifery
- Physiotherapy
- Podiatry
- Speech and language therapy
- Occupational therapy
- Primary mental health services, including psychology and a range of counselling and therapy services
- Social services care.

The local network includes a team of Integrated Care Clinicians who manage the care pathways, (how you move through the NHS during your treatment) liaising with the hospital specialists, community services and the network GPs to ensure rapid and effective delivery of the services along those pathways. Each network has differently skilled and specialised Integrated Care Clinicians according to local needs.

Communication between practices is usually electronic. Most practices use the same computer system, but those few who have a different system can still communicate with each other across the IT network. Practices are also able to communicate directly with other community-based clinicians and hospitals to ensure effective transfer of relevant patient information across organisational boundaries.

In line with national policy, you will also be able to log on to the same system to check your own health summary care record at any time. If you don't have a computer or smart phone available to you, you can use the surgery patient computer to check your records, make future appointments or re-order your medication.

In addition to the above services, all practices provide home visits for housebound patients. When appropriate, we can also offer some patients self-monitoring equipment to measure blood pressure, blood sugar levels and other routine regular monitoring tests. The clinicians will teach you how to use the equipment, what the results mean, how to care for yourself if your condition changes, and when to contact your healthcare team. Supported self-care is a key part of our total healthcare service. If you are a patient who has a full or part-time carer, this also includes support for your carer.

We are very pleased that children in North Central London rarely get measles. GPs have been working closely with the community in ensuring that over 90% of the children in our area have received their childhood immunisations. With this excellent coverage we have minimised the risk of children developing measles, mumps, rubella or tetanus, diphtheria, whooping cough and polio. You are no longer restricted to a specific clinic on a specific day as immunisations are offered in a range of settings.

We have also have excellent flu vaccination rates amongst our elderly and people with long term conditions, meaning there are less complications as a result of the flu.

## “This is how we want it to be”

Dentists, pharmacists and optometrists are all an important part of our primary care services and you can contact them directly. Our information pack will give you full details of your nearest practitioners and how to access them both routinely and in an emergency. Sometimes they will be co-located with our general practices or will be in nearby premises, offering a range of services to support your health and wellbeing.

Our GPs will only ever do what they know they can do safely in their own practice, and sometimes it will be necessary to refer you for further diagnostic tests and/or treatment. Your GP will be able to offer you a consultation locally, often with a specialist community-based service, or will arrange a hospital appointment for you. Our integrated care pathways mean that your GP, the community services and the hospital consultants can communicate electronically to share information and agree on the best course of action to meet your particular needs.

In addition to their role as specialist clinicians in the primary care team, our GPs are also the skilled navigators to guide you through the care system to ensure that you receive the right care, in the right place, first time.

### WHAT IF I NEED TO GO IN TO HOSPITAL FOR AN OPERATION?

Our GPs will do as much as they can in primary care to avoid unnecessary hospital admissions. However, following your consultation with the specialist, if you and they decide that an operation is necessary, your GP will:

- Advise you on what to expect
- Offer you a choice of hospitals, if you wish to go elsewhere
- Have the technology to place you on the appropriate waiting list and be able to update you on your list status, as hospital waiting lists are now fully accessible by our GPs
- Increasingly, arrange for you to be a day case patient without any overnight stay
- Liaise with the hospital to ensure that, if you do stay in, it will only be for the minimum time and that they get you discharged as soon as it is safe to do so
- Have access to information to confirm that the hospital makes all parties aware of your discharge arrangements and discharge plan details
- Support your rehabilitation and convalescence at home or in a community setting
- Work with the hospital to arrange any follow up consultations with the most appropriate clinician, who may be the GP, the hospital consultant or another specialist clinician.

## WHAT ABOUT PATIENTS LIVING WITH A LONG TERM CONDITION – HOW DO YOU MANAGE THAT?

A long term condition is one that will require monitoring and treatment over a long time such as asthma or diabetes. Firstly, we aim to achieve an early diagnosis of any such condition so that we can start treating it as soon as possible.

When a patient is first diagnosed with a long term condition, our practices will:

- Provide you with full educational information about your condition soon after diagnosis
- Introduce you to our nursing team who lead much of our long term conditions management
- Advise you of additional support services, which will often be patient groups or charities, who are expert in the management of your condition
- Agree a package of care with you based on your needs. This will include a written Care Plan with mutually agreed goals and periodic and annual reviews.
- Agree with you what you can do for yourself as supported self-care and when to seek the help of your healthcare team. We want you to become confident in managing your own condition as much as possible.

If you have a complex condition, or set of conditions, our team will appoint a named care co-ordinator, to work with you and the rest of the team. They will then help you to implement your Care Plan; you will have one integrated plan, not many disconnected ones.

All community members of our teams have modern technology, including telephones with GPS navigation, so that colleagues can locate them and they can locate you as quickly as is necessary. You will also be able to e-mail and text them whenever you need to do so. Our staff will respond as soon as they can within time periods that we will publish and on which we will be monitored on.

The primary care team is professionally integrated with specialist hospital consultants, who can advise the team, and you, on your individual case management as well as providing ongoing education, training and clinical supervision. Occasionally, the team may decide that you need a review with the consultant and will offer you an appointment. The team will aim to provide you with as much of your routine care as close to home as possible.

## WHAT SERVICES DO YOUR PRACTICES OFFER TO PREGNANT WOMEN?

Hopefully, your practice will already know you and have offered you pre-conception advice as part of our normal service. The practice will want you to confirm your pregnancy as early as possible and can advise you on locally available pregnancy testing. Then, at no later than 12 weeks, they will offer you, and your partner, a range of ante-natal services including exercise and parenting classes. Our team of midwives will work closely with you and your GP to monitor your pregnancy and to support you in a safe birth including your choice of birth settings.

After the birth, the practice team of doctors, nurses, midwives and health visitors will provide additional support services for the first two years. This will include:

- Post-natal classes

## “This is how we want it to be”

- Immunisations
- Child development monitoring
- Parenting skills support
- Ongoing conception advice.

### WHAT IF I HAVE FAMILY MEMBERS WITH SPECIAL NEEDS?

The specific needs of the patient groups concerned are reviewed against the latest evidence and take advantage of shared knowledge from consultants, specialist nurses and therapists across the wider primary care team based in a highly integrated way rather than in a purely reactive way.

For example with patients with learning disabilities, who as a group have significantly reduced life expectancy, the network and each individual practice are fully up to date with the special needs of each registered group with ready access to the appropriate expertise and advice. They also identify individuals at increased risk and agree individual care plans with the patients, and where appropriate, their carers.

### WHAT SUPPORT CAN YOU OFFER ME IF I AM DIAGNOSED WITH A TERMINAL ILLNESS?

It is important that your GP knows your wishes for your care soon after your diagnosis. They will then develop a Care Plan with you based on the Macmillan Gold Standard Framework (GSF) for end-of-life care. In addition to your GP, our extended primary health care team will help to look after you and support and advise you on your options requiring decisions.

Through the team you will have direct and speedy access to specialist clinicians most qualified to advise on your care.

### WHAT ABOUT THE RISKS OF CANCER?

In spite of significant advanced of treatment in cancer, UK survival rates remain disappointing compared to Europe. But we know that much of this difference is accounted for by the differences in one-year survival and that strongly suggests that delayed diagnosis is a significant contributory factor.

## “ This is how we want it to be ”

Therefore, all our practices take a multi-strand approach, firstly to prevent, and secondly to diagnose as early as possible through:

- Continued emphasis on prevention (smoking cessation, reducing obesity, healthy diet, regular exercise)
- Improving the uptake of screening
- Targeted social marketing to increase awareness and encourage earlier presentation by patients
- Clinician awareness of early presenting features suggesting possible cancer.

### WILL I STILL HAVE A GP IF I HAVE TO GO INTO A NURSING/RESIDENTIAL HOME?

You'll certainly have access to the full range of services that we've described. We have contracts with selected practices to provide primary care services to the nursing/residential homes in our area and they have particular knowledge and experience in meeting the needs of those residents. So you'll be able to choose whether to stay registered with your existing practice or whether to transfer to one of those other practices.

### WHAT ABOUT PRESCRIPTIONS AND MEDICINES – HOW DOES THAT WORK?

For those patients who need repeat prescriptions such as those for long term conditions or oral contraception, our practices operate a “standing order” system of repeat dispensing of prescriptions (with some exceptions), from your named pharmacy, without the need to request a repeat prescription from your GP. The pharmacist is an expert in medicines management and will advise when you need to see your doctor again for a review of your clinical condition.

Your pharmacist runs a New Medicines Service. When you are prescribed new medications, they will spend time with you teaching you about the new medicine. Many patients say that they find this service really helpful in understanding their new medicines.

Your pharmacist is also available to advise you on any side-effects or concerns that you have arising from your medication and will consult with your doctor about any recommended changes.

### HOW DO YOU ASSURE THE QUALITY OF YOUR GPs TO KNOW WHETHER THEY ARE DOING A GOOD JOB FOR THEIR PATIENTS?

In accordance with best practice, we define and monitor the quality of primary care under three headings - patient safety, clinical effectiveness and the experience of patients.

The NHS in London, working with GPs, has developed a set of standards, often known as indicators, for GP practices which give you the information you need to make decisions about your healthcare.

There are 22 standards, covering areas like diagnosis, screening, vaccinations for children, and ease of getting appointments, making it easier for you to:

## “ This is how we want it to be ”

- See how effective your GP services are in areas of healthcare that matter to you
- Understand what your practice is doing to meet the healthcare standards required by you and your family
- Make a decision about registering with a practice that best suits your particular needs.

You can compare the performance of individual practices on the Myhealthlondon website.

All practices have to be registered with the Care Quality Commission (CQC).

All our GPs are committed to ongoing professional development. They all have written personal development plans, and take part in an annual appraisal of their performance with a qualified GP appraiser. They attend regular education and development programmes on key GP skills. Since 2012/13, all GPs have been required to apply for professional revalidation every five years. Many of our practices are also qualified to train new GPs.

In addition, GPs arrange for their practice staff to attend regular professional development training and education programmes suitable to their role. In addition to professional clinical training for our clinicians, this includes customer service training for our reception teams. Our practices aim to build a culture of high standards of clinical care and service.

As part of all of the above there are a number of contractual measures by which we assess the overall quality of service provision by our primary care colleagues.

We encourage a culture of incident reporting and group learning. Our practices actively seek and welcome feedback from patients on their experience of services, and view complaints as an opportunity to improve services. For that reason ask you to speak directly to, or send any complaints to, the Practice Manager at your registered practice. They will acknowledge your complaint within 48 hours and keep you advised of progress.

If you are unhappy with any aspect of the service that you have received, but don't want to engage directly with the practice then please contact our Patient Advice and Complains Service (PALS).

We undertake regular patient surveys at all practices and the results are published on our website. In addition, patients can go on to the NHS Choices website practice page and leave comments about their experience. Practices are required to develop action plans to address any areas where potential improvements have been identified.

Many of our practices engage directly with their patients through Patient Participation Groups. These provide a forum for local feedback and improvements by practice users.

We also engage in more formal public involvement through Local Involvement Networks (LINKs, or their successor HealthWatch), the independent consumer organisation. They have the statutory right of entry to visit the premises of service providers and to report their findings.

Our aim, and that of all our practices, is to offer you a high quality primary care team service, linked, when necessary to more specialist services; all of which will enable you to live the best possible lifestyle in respect of your personal health and wellbeing.

# 5. Transformation Strategy

“This is what we’re planning to do to make it happen”

The “Future landscape of primary care – a patient’s perspective” in the previous chapter is our aspiration for the future. Many practices are already delivering some of that vision. We want to raise the standard across the board so that all patients have access to the very best in primary care.

The rest of this document describes our plans to transform primary care over the next five years to make the aspirational future landscape a reality. This section sets out our transformation strategy, explains our thinking and identifies specific areas for investment.

Addressing quality, safety and improving patient experience are key aims in the North Central London primary care strategy. This strategy recognises that transformational changes are needed to support the development and capacity of primary care, and describes the steps towards implementing that transformation. It will take time and resource. We want to work with our independent contractors to motivate, incentivise and support them on the transformational journey. But we will also manage their performance to ensure that our contractors do deliver those higher standards of quality, safety and patient experience.

The strategy aims to improve the quality, capability, capacity and productivity in primary care. The focus will be on promoting health, wellbeing and illness prevention and addressing our health inequalities. It will enhance patient experience and outcomes by improving clinical and service quality and life expectancy. Operating across the traditional boundaries it will begin to integrate the delivery of care, reduce the variation between practices, and increase the number of people registered with a GP in a way that is culturally appropriate.

We recognise this will need upfront investment. As part of this strategy, we are submitting a Business Case to NHS London for three years of pump-priming financial investment to cover additional and/or double running costs. At the end of three years, we anticipate that the savings in acute care will more than cover the then ongoing recurrent higher costs of primary care. This is set out in the strategic cost/benefit analysis in Section 9. We are proposing nine strategic investment domains:

1. Integration
  2. Clinical services
  3. Information technology
  4. Public Health
  5. Premises
  6. Productivity
  7. Workforce, leadership and team development
  8. Commissioning
  9. Communications.
- } = Integrated Care Network



## STRATEGIC DOMAIN 1 - INTEGRATION

The long term aim is to overcome organisational boundaries and to replace them with networks of service delivery along care pathways. There are five identified levels of integration:

### 1. PRACTICE TO PRACTICE.

Individual GP practices grouped geographically into networks of natural communities of registered patients. Each practice will retain its own GMS/PMS contract for delivery of core services. The network (or a nominated lead practice) will contract by “Super local enhanced service” (or possibly alternative provider of medical services) to provide all additional services on a guaranteed list, and decide at which locations the services will be available. In some networks, all practices may choose to provide all services. The patient guarantee is that all patients within all networks will be able to access the same guaranteed primary care services, which will address the previous issues of inequity of provision.

### 2. EXTENDED PRIMARY HEALTH CARE TEAMS ATTACHED TO THE GP NETWORKS PROVIDING THE STANDARD RANGE OF COMMUNITY SERVICES.

This can be facilitated by Clinical Commissioning Groups specifying and commissioning community services as complete teams.

### 3. INTEGRATION AT APPROPRIATE POPULATION LEVEL (BASED ON DISEASE PREVALENCE), OF ALL SERVICES – AND INCREASINGLY MOVING TO NON PAYMENT BY RESULTS (PBR) TARIFF “WHOLE PATHWAY” FUNDING.

The integrated pathway will include specialists and additional clinical resources drawn from a local Clinical Pathway Pool comprising:

- Lead experienced GPs working on a part-time sessional basis (replacing the current sessional lead GP arrangements)
- “Open doors” specialist long term conditions nurses/allied health professionals recruited from secondary care to liaise with the hospital specialists, community services, GPs and practice nurses to ensure rapid and effective delivery of the services along those pathways
- Recent post-graduate GPs to provide flexible, additional capacity in the network
- Other community specialist clinicians as required.

The Pool will be borough-wide and will be designed by the network practices. It could be populated by clinicians from practices, community services, acute services, voluntary sector and other expert organisations. Each network will have a budget to buy in resources as required from the Clinical Pathway Pool on a not-for-profit basis.

The combined network budgets in a borough will pay for the total resources in the pool. Payment will be made to the employing organisation who will informally lend clinicians into the pool, either full or part time in line with demand. If, as expected, local practice GPs wish to become part of the pool, their practices will be reimbursed from the pool budget.

## “This is what we’re planning to do to make it happen”

The design and operation of the networks and Clinical Pathway Pools will require more development. We want to work with GP colleagues to create the most effective models for each network.

### 4. INTEGRATION BETWEEN HEALTH AND ENHANCED SELF CARE AND SOCIAL CARE.

We want to build the a personal network around individual patients, combining the right level of professional input from both health and social care, with pro-active support for the highest level of self care suitable to individual circumstances.

### 5. INTEGRATION WITH ACUTE SPECIALIST

Input may include:

- Fewer and highly selective face-to-face individual patient consultations (might still be in a hospital setting or a community based consultation)
- Case based discussion of selected individual cases using records and data in multi-disciplinary teams occurring on a regular basis
- Sharing of knowledge, teaching, research findings, new drugs, new interventions and new technologies
- Clinical governance, clinical audit, clinical supervision of network clinical leads
- Outcomes /metrics management of one network compared with another using dashboards data, and within networks with outlier individual practice(s)
- Outreach to support poorly performing networks.

## STRATEGIC DOMAIN 2 - CLINICAL SERVICES

People are living longer, but rather than being healthy for longer with the same health issues and costs concentrated at the end of life, they are tending to develop long term conditions earlier in life and live with them for longer, with physical and mental health problems for many years consuming ever escalating costs of health resources.

It is unusual to have a single long term condition, the majority of patients have more than one, often inter-related conditions most of which are linked to or exacerbated by lifestyle choices, which in turn are linked to deprivation and lower income. These lifestyle factors include smoking, obesity, physical inactivity, excessive alcohol intake and poor diet.

Diseases include diabetes (type 2), coronary heart disease, hypertension, stroke, COPD, heart failure, renal impairment, liver disease, muscular-skeletal problems, degenerative joint disease, chronic pain, depression and anxiety. Traditional primary care has tended to address these problems at the level of the individual in a reactive way that has often been centred on the clinician rather than the patient and certainly not on the population.

Our ambition is to transform this to a much more proactive, population view, patient centred service based on a transformed approach to health status monitoring of the population and

## “This is what we’re planning to do to make it happen”

much earlier and more patient friendly interventions. The Kings Fund Report describes the required change:

“The required modernisation agenda for general practice has been described in the United States as ‘the transformation from cottage industry to post-industrial care’. This is because it combines three key elements – standardising care, measuring performance, and transparent reporting – and eliminates unwarranted clinical variation, waste, and defects.

“At its heart, general practice in much of England remains a cottage industry, and we believe that this must change radically.”

The King’s Fund Report also describes the changing role of the GP:

“General practice needs to see itself at the hub of a wider system of care, and must take responsibility for co-ordination and signposting to services beyond health care – in particular, social care, housing and benefits.

“General practice needs to move from being the gatekeeper to specialist care to being the navigator that helps steer patients to the most appropriate care and support.

Combining this redefinition with all the other component parts of this strategy, it all adds up to what may be a significant culture change for many GPs. However, our intention is not to create any contractual changes. We are seeking to promote a change in “how things are done” rather than “what is done”.

This will be achieved through an education programme, based on the King’s Fund Report, designed to support GPs in becoming system navigators whilst retaining the essential parts of their traditional role as gatekeeper.

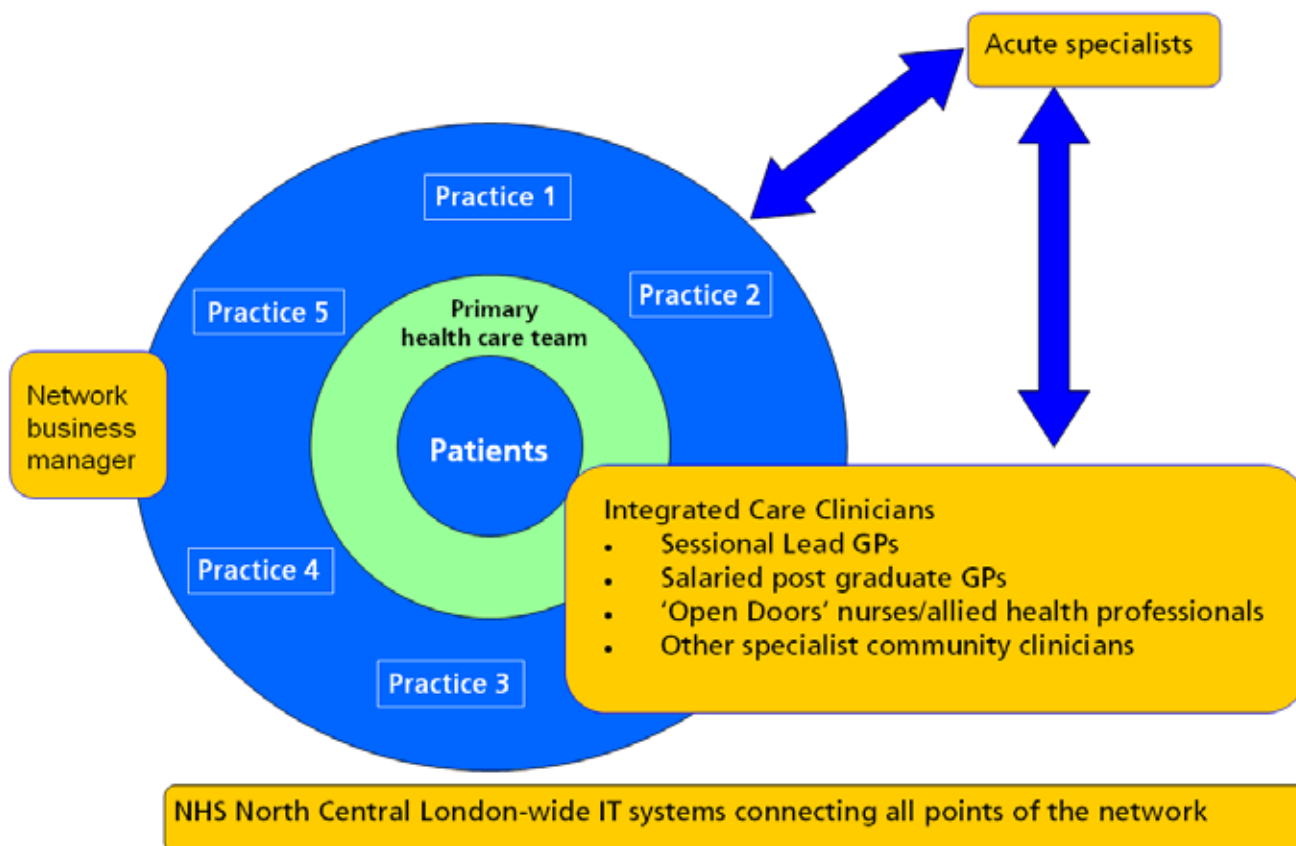
### STRATEGIC DOMAIN 3 – INFORMATION TECHNOLOGY

This is a major theme which will require significant investment. The ideal end state will be to have all health care providers able to share patient records and to communicate electronically directly with each other to ensure that individual patient needs are met. We intend to commission an interactive web-based clinical information management network across NHS North Central London.

“This is what we’re planning to do to make it happen”

The first three domains, as described above, are combined together to create an Integrated Care Network (ICN). We are offering an example of what an ICN may look like but the actual design will be determined by each network.

WHAT MIGHT AN INTEGRATED CARE NETWORK LOOK LIKE?



STRATEGIC DOMAIN 4 - PUBLIC HEALTH

Public health intelligence is vital to health care planning. We want each network service delivery unit to have tailored disease-specific prevalence data by practice for their area. Each network will then be able to take a more proactive population view, using public health status monitoring of the population. The target will be to address health inequalities by closing the gap between expected and actual prevalence.

STRATEGIC DOMAIN 5 - PREMISES

Rather than focusing on premises-led strategies, primary care providers must now focus on the quality of clinical care, patient pathways or packages of care, and patient experience, where premises will be an essential enabler. Practice size will not be an issue but delivery of high quality care and patient experience will be.

Traditionally there has been an overlapping relationship between PCTs as both commissioners and often as landlords, and GPs as both service providers and as tenants. This dual role for PCTs will end when PCT-owned premises are transferred to providers, leaving the NHS North Central London cluster PCTs as purely primary care commissioners and

## “This is what we’re planning to do to make it happen”

contractors. It is this role that will then transfer to the NHS Commissioning Board in April 2013.

NHS North Central London intends to commission only high quality primary care as defined in the strategy. In support of this aim, the primary care strategy will include the following principles relating to practice premises:

- If any practices in unsuitable premises are unable to achieve the premises quality standards, but wish to remain as contracted providers, NHS North Central London may require, and will support them, to relocate within a given time period. If they are unable to improve or find suitable alternative premises, NHS North Central London may require them to move into NHS-owned premises on a resource-sharing basis, subject to NHS landlord approval.
- If any practices in unsuitable premises are unable to achieve the required quality standards and decide to exit from provision, NHS North Central London will not necessarily replace them like for like.
- If any practice wishes to relocate and the relocation will impact on the GMS cost/rent reimbursement, then NHS North Central London will require a business case to be submitted before the relocation occurs. Providing the business case meets the required quality delivery markers, NHS North Central London will approve the financial reimbursement.
- NHS North Central London, in the role of primary care commissioners, is not responsible for providing or maintaining premises for independent contractors. However, after many years of supporting general practice through primary care premises development programmes, NHS North Central London recognises the mutual benefit to be gained from premises improvements. We intend to invest in additional premises management expertise to work with GPs who are proactively seeking renovation or relocation. We will seek to appoint and/or contract with entrepreneurial business development specialists who can work with GPs to put together innovative commercial development projects.
- Premises developments have both capital and revenue implications. It must be assumed that there will be some, but limited, NHS capital for new premises. NHS North Central London will welcome innovative schemes from stakeholders to create new and/or modernised premises for GPs and primary care teams. This could include third party developers, GPs, other independent contractor groups, local authorities and not-for-profit organisations. Development planning gain may present opportunities. Normal NHS rent reimbursement arrangements will apply, but in order to manage the cost pressures on revenue, all such developments must demonstrate value for money and will be subject to the prior approval of business cases by NHS North Central London.

## STRATEGIC DOMAIN 6 – PRODUCTIVITY

Access is always reported as a key issue for patients, although they are often prepared to trade-off immediate availability in order to receive continuity of care, particularly with long term conditions management. The reality is that both access and continuity are dependent on the ability of a practice to balance demand and supply. Some years ago much work was done on balancing through programmes such as Advanced Access. But it is not a one-off adjustment – it must be continuously refreshed.

We propose to undertake a programme to audit access and create improvements by supporting system redesign where necessary. This will include defining the number of GP and nurse appointments that should be available in every practice to meet the reasonable needs of their registered population – in line with the national GP contract.

We also propose to invest in general practice productivity improvement programmes and we will encourage and incentivise practices to take part in, for example:

- “Improving access, responding to patients - A ‘how-to’ guide for GP practices” (Practice Management Network- August 2009)
- The RCGP Practice Accreditation award
- The Productive General Practice programme “Releasing Time” from the NHS Institute for Innovation and Improvement
- “Doctor 1st” Telephone Access.

## STRATEGIC DOMAIN 7 - WORKFORCE, LEADERSHIP AND TEAM DEVELOPMENT

The (re)establishment of the extended primary health care team will require leadership and team development to focus on:

- Agreeing roles and responsibilities
- Sharing clinical skill sets
- Understanding network accountability
- Defining the challenges and opportunities in the network
- Creating a shared vision for the network
- Agreeing on who will deliver what, where and when
- Metrics reporting.

In addition there will be topic-specific development programmes for GPs, practice nurses, practice managers and reception staff, covering clinical and non-clinical skills development.

## STRATEGIC DOMAIN 8 – COMMISSIONING

It is clearly understood that primary care contracting and performance management will be the responsibility of the new NHS Commissioning Board. However, Clinical Commissioning Groups (CCGs) will have a role to play in primary care commissioning, when as the strategic commissioners, they will want to define their expectations of primary care services. This will include decisions on specifying Local Enhanced Services (LES) to be contracted by the NHS Commissioning Board. This primary care strategy also requires CCGs to commission

“ This is what we’re planning to do to make it happen ”

community services on a network team basis. It is also likely that CCGs will want to shift the provision of some services from hospital to a community setting and will seek bids from primary care contractors to provide parts of, or whole, new pathways.

In this way, with CCG leadership, investment will be redirected from secondary to primary care.

#### STRATEGIC DOMAIN 9 – COMMUNICATIONS

We will invest in a communications programme designed to inform the public about primary care services available to the population and how to access them as easily as possible. This will be combined with self-care and healthy living advice.



Having provided the investment to create the transformation, for implementation, NHS North Central London has a duty to ensure that the investment is spent as intended and that it delivers the desired results. We have already stated that our intention is not to create any contractual changes. We are seeking to promote a change in “how things are done” rather than “what is done”.

We are therefore proposing a mutually beneficial investment in primary care which requires independent contractor practices to achieve explicit quality standards of inputs and outcomes in return for the financial investment. Our message to our independent contractors is “If you do these things well with our investment, then together we will achieve the desired outcomes”. This section now focuses on defining and monitoring the inputs and actions that are required to implement the strategy.

## STANDARDS BY STRATEGIC DOMAIN

### DOMAIN 1 - INTEGRATION

- To be signed-up member of the local practices network
- Explicitly connected into the local Integrated Care Network
- Full participation in a Primary Health Care Team development programme.

### DOMAIN 2 - CLINICAL SERVICES

- To provide as a practice, or jointly provide within the network through a Super LES, the full range of additional services in line with the patient guaranteed list
- Set up repeat dispensing arrangements with pharmacies
- Produce and manage long term conditions care plans, including self-care
- Produce and manage MacMillan GSF Plans
- Participation in patient surveys and development of improvement plans based on those surveys.

### DOMAIN 3 – INFORMATION TECHNOLOGY

- Switch over to the NHS North Central London web-based system within the required timescale
- Install patient self check-in system
- Provide a designated patient computer terminal
- Have a practice website with online appointment booking and electronic repeat prescribing
- Patient access to health care records in line with national policy.

## “Making sure that the right things are done well”

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### DOMAIN 4 - PUBLIC HEALTH

- Proactively use the network/practice disease profiles to case find and maintain practice disease registers
- Plan services as part of the network based on the disease profiles and create plans to improve population health including measurement of outcomes.

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### DOMAIN 5 - PREMISES

- Health and safety compliant
- Disability Discrimination Act compliant
- Care Quality Commission ready
- NHS external signage
- Internal cleanliness and patient friendly
- Patient toilet facilities.

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### DOMAIN 6 – PRODUCTIVITY

- Undertake access audit/improvement programme
- Offer agreed number of appointment slots per week/month/year based on access audit calculations \*
- Take part in a productivity improvement programme
- Practice opening hours minimum 8am to 6.30pm \*
- Same day urgent access available \*
- SMS text reminder service.

\* There will be no additional funding for these elements, which are already funded as part of the GP contract.

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### DOMAIN 7 - WORKFORCE, LEADERSHIP AND TEAM DEVELOPMENT

- Full participation in all GP/practice manager/practice nurse/receptionist training and development programmes
- Undertake appraisals
- Achieve revalidation.

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### DOMAIN 8 - COMMISSIONING

- To be a signed-up member of the Clinical Commissioning Group.

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### DOMAIN 9 – COMMUNICATIONS

- To display and distribute all NHS North Central London patient literature.

## CONTRACT PERFORMANCE MANAGEMENT

All independent contractors are subject to routine contract performance management of their practices against national/local contracts. It is this function that will transfer from NHS North Central London to the new NHS Commissioning Board. This strategy does not propose any changes to the agreed national contract and performance management requirements.

In addition to existing contracts, and where required, Integrated Care Networks will be held accountable by Super LES contracts for their delivery of the guaranteed services in their network. Borough teams will be involved in the setting up of non-core contract elements (i.e. those wrapped into the super LES contracts) and it is expected that the performance management aspect will then be carried out by NHS North Central London primary care contracting and performance staff, although future management arrangements are not yet finalised.

NHS North Central London has a comprehensive performance management process to support GPs in improving their care. This is key to supporting the transformational change. NHS North Central London will invest in additional staff, including clinicians and managers, to provide additional capacity for the performance management of core contracts and individual performer concerns.

## PERFORMANCE MANAGEMENT OF THE PRIMARY CARE STRATEGY

Performance management and the implementation of the strategy will be the responsibility of NHS North Central London primary care contracting and performance staff. Clear programme governance arrangements will be put in place to ensure that the primary care strategy is delivered to time and provides the inputs/actions set out above in return for the investment in each strategic domain in order to deliver the outcomes listed in the next section.

## “Getting the right results”

“Quality is complex and multidimensional. No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality in general practice”  
(Improving the quality of care in general practice - The King’s Fund, March 2011)

There will be explicit quality markers by practice and network, agreed with GPs, whereby in return for the investment, we can expect to achieve improvements in:

- Patient safety
  - Clinical effectiveness
  - The experience of patients.
- } Health Outcomes

### HEALTH OUTCOMES

A full list of target outcomes will be developed within each borough’s implementation plan and based on local practice population profiles. It should include:

#### MEDIUM TERM:

- Improved early detection and management of long term conditions leading to improved outcomes, in particular: diabetes, HIV, hypertension, COPD and CVD
- Improved cancer early detection and survival rates
- Increased smoking cessation
- Reduced obesity
- Improved self-care management, e.g. COPD Pulmonary Rehabilitation.

#### LONG TERM:

- Sustained top quartile performance against national quality metrics
- Improved life expectancy
- Closed gap for observed and predicted disease
- Herd immunity immunisation levels leading to reduced incidence
- Improved quality of dental care.

### INNOVATIONS IN PATIENT CARE

#### SHORT TERM:

- Defined care packages for different stratification of disease risk.

## “Getting the right results”

### MEDIUM TERM:

- Network of practices delivering comprehensive primary care.

### LONG TERM:

- Integration across all providers of health system
- Transformation of the primary care brand in north central London – a demonstration to local stakeholders that we are serious about improving primary care.

## PRODUCTIVITY

### MEDIUM TERM

- GPs as systems navigators increasing both General Practice and system productivity
- Reduction in A&E attendances
- Fewer non-elective admissions for patients with long term conditions
- Improving biological measures for long term conditions e.g. HBA1C, Blood pressure control.

## PATIENT EXPERIENCE

This could be described as customer care, but that label does not represent the true nature of the relationship between GP and patient. Traditional models of customer care imply that the onus and obligations are all exclusively on the service provider and that the customer has full rights and no responsibilities.

In order to work to its fullest potential, the GP/patient relationship needs to be more collaborative and to recognise the mutual benefits to be gained from working together with explicitly agreed rights and responsibilities for both parties. However, GPs must accept that the ultimate verdict on the total experience will be delivered by the patient based on their perception and as reported in:

- High scores on MORI and GPAQ surveys
- Positive feedback on NHS Choices website
- Positive performance as reported on the Myhealthlondon website
- Positive feedback from PPG/LINKs/HealthWatch/Local Health and Wellbeing Board
- Increase in access through core minimum hours of offering appointments using existing contract
- Fit for purpose premises – improving patient experience, quality and productivity
- Increased proportion of the population of North Central London registered with a GP practice
- Management of complaints.

# 8. Local borough implementation plans

“This is how we are going to do it in each borough”

## BARNET

### BACKGROUND

Barnet has by far the largest registered patient population number (373,715 at July 2011) in North Central London, but a much lower capitation funding of 327,404. Much of the demography of Barnet is closer to that of the Home Counties than to inner London boroughs, although there are pockets of significant deprivation. This mixed profile introduces different challenges.

GPs report that their health-aware residents are very high consumers of any/all services offered. Additionally, there is anecdotal evidence to suggest that, with a generally older age profile, many retired residents have switched from using private insurance provision to NHS services, and that much of this workload is in general practice supporting long term conditions management.

Like Enfield and Haringey, primary care in Barnet, must be viewed in the light of the BEH Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State and is being implemented. The implications for primary care have been emphasised in many documents.

Any new developments in Barnet, Enfield and Haringey must be viewed in the light of the Barnet, Enfield and Haringey Clinical Strategy, which was given the green light for implementation by the Secretary of State for Health in September 2011. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

The Primary Care Strategy supports delivery of better services in Camden and Islington as well as Barnet, Enfield and Haringey and, while there have been many recent developments in primary care in each of the five boroughs, many more are being developed or are planned. We will make the changes in hospitals when clinicians tell us that the primary care system is sufficiently developed to provide better and safer care than in hospitals.

In 2007, the primary care strategy stated that there were too many (then 73), and too small, practices, operating from unsatisfactory premises. The strategy set out plans to move to a “hub and spoke” model and to reduce both practices and premises. Most of the focus has been on the health system infrastructure, yet little seems to have actually changed for most practices. The re-building of Finchley Memorial Hospital (due to open in 2012) is the most significant and tangible achievement. Along with the existing Edgware Community Hospital, the health economy will be unusual in London by having two community hospitals.

The key challenges now facing primary care in Barnet would seem to be:

## “This is how we are going to do it in each borough”

- To rise to the BEH Clinical Strategy challenge, particularly given the high number of smaller practices which lack the capacity to expand their services
- To ensure that all practices are capable of achieving the highest quality standards
- As part of that quality drive, to improve the overall premises standard
- To establish the re-built Finchley Memorial Hospital as a fully functioning community hospital
- The need to get into financial balance.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

### CAMDEN

#### BACKGROUND

Previous Camden strategy documents refer to a strong reputation for innovation and for delivering continuous performance improvement. The April 2010 CSP reflects broader whole system thinking and it introduces QIPP and robust performance management measurement. In terms of general practice, the PCT always maintained that:

“NHS Camden is committed to supporting and developing a diverse provider landscape for general practice and believes that patients want to see a mixed economy of small, medium and large practices.”

However, with just 39 practices, it is interesting to note that Camden has the highest number of registered patients per practice at almost 6,500 compared with Enfield, below 5,000, and the North Central London average of 5,500.

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	5,496	6,436	4,985	5,041	5,865	5,477

The CSP notes that 80% of practices have received investment to improve premises over recent years, and that, although there are a few problem sites, the overall state of GP premises has been improved considerably.

Camden, along with Islington, is one of the few PCTs in the country to have published a GP balanced scorecard on its website. It is set out as a RAG-rated league table and is perceived by practices themselves to have been a very effective performance improvement driver for all practices.

Camden GPs are considered to be among the most cost-effective prescribers in England and will continue to maintain this by working with their strong Medicines Management Team.

## “ This is how we are going to do it in each borough ”

Camden is also one of the few PCTs who agreed (three) APMS contracts with new providers, but these contracts have not been without their problems which has included a change of provider.

The growth of Haverstock Healthcare, the Camden GP Provider Federation, means that there is now a single provider organisation through which NHS North Central London can communicate directly with most of their GP practices.

Camden is projecting a financial surplus at the end of 2011/12.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

### ENFIELD

#### BACKGROUND

Enfield has the second largest registered patient population number (292,819 at July 2011) in North Central London. The demography of Enfield is similar to much of Barnet in the west and significantly more like the most deprived inner London Boroughs to the east. Both demographically and in terms of service provision it is a two-tier health economy.

With 60 practices, Enfield has the lowest average number of registered patients per practice in NHS North Central London:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	5,496	6,436	4,985	5,041	5,865	5,477

43% of Enfield patients are registered in the 39 practices which have fewer than 5,000 patients. Many of these smaller practices are in sub-standard premises. This is an issue that is mentioned in all of the previous strategic planning documents and one that those strategies have sought to address, but little seems to have changed in terms of numbers or premises conditions. As a result, the primary care scene in Enfield seems to be the most under-developed in North Central London.

Like Barnet, primary care in Enfield must be viewed in the light of the BEH Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

The challenges facing primary care in Enfield seem to be:

- The ongoing issues arising from previous failed primary care premises strategies



## “This is how we are going to do it in each borough”

- To rise to the BEH Clinical Strategy challenge, particularly given the high number of very small practices which lack the capacity to expand their services and are working in totally unsuitable premises
- To ensure that the high number of PMS contracts (31) and the high cost (£143 unified weighted population) are delivering commensurate value
- To ensure that all practices are capable of achieving the highest quality standards.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

### HARINGEY

#### BACKGROUND

Haringey is unusual in London in that it does not have a District General Hospital site within the borough boundary. North Middlesex University Hospital NHS Trust lies to the north east and Whittington Health to the south west. The demography places Haringey on the cusp of outer and inner London. The relatively well and wealthy west gives way to more areas of deprivation and inequality as you move eastwards, and the hospital landscape means the two trusts cater for two very different Haringey populations.

Having been one of the early implementers of polysystems, Haringey does benefit from new and modern estate - Hornsey Central, The Laurels and Lordship Lane. All are now becoming fully operational but there is more opportunity and there is potential for some major investment decisions to be made about upcoming developments in Tottenham and on the St Ann's site.

As with Barnet and Enfield, Haringey must be viewed in the light of the BEH Clinical Strategy. Started in 2006, it has now been ratified by the Secretary of State. The implications for primary care have been emphasised in many documents. It is acknowledged that investment in primary care is integral to the successful implementation of the Clinical Strategy.

General practice in Haringey is still characterised by large numbers of small practices. The registered practice population has reduced by 7,500 (-3.2%) over the past year, mainly as a result of list cleaning. Average list size is just over 5,000.

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
Ave. registered patients per practice	5,496	6,436	4,985	5,041	5,865	5,477

This extract from the overview in the January 2010 CSP provides a good description of the primary care scene in Haringey:

## “This is how we are going to do it in each borough”

“Haringey has a diverse provider base with a large number of both GP and dental practitioners but the number and size of practices means this is a potentially fragmented system.

### CHARACTERISTICS

- There are a large number of single handed GPs
- Despite the introduction of the polysystem model there is a fragmented provider base
- There are 270,000 GP registrations in Haringey, higher than the estimated population figures of 226,000. This could mean that patients are registering from neighbouring boroughs
- GP services vary significantly depending on the practice in terms of access, quality, and condition of premises and range of services available.

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

## ISLINGTON

### BACKGROUND

The growing population combined with the low number of practices means Islington has the second highest average patient population per practice in north central London:

July 2011	Barnet	Camden	Enfield	Haringey	Islington	Total
<b>Ave. registered patients per practice</b>	<b>5,496</b>	<b>6,436</b>	<b>4,985</b>	<b>5,041</b>	<b>5,865</b>	<b>5,477</b>

The Primary Care SWOT analysis in the January 2010 CSP still provides a good description of the primary care scene in Islington:

- General Practitioners account for approximately 50% of the PCT primary care budget. The majority of the 38 GP practices provide services in core hours. 12 single handed practices, five of which are within the central locality. Out of hours care is provided by CAMIDOC. (Now provided by Harmoni)
- Pharmacy and prescribing accounts for 38% of the total budget and operates from 45 locations spread across the borough
- Dental practices offer NHS treatment to Islington residents from 25 locations accounting for 13% of the overall primary care budget. 49% of residents access an NHS dentist

## “This is how we are going to do it in each borough”

- There are 49 contracted optometrists operating in Islington operating from 27 practices. Services are centrally purchased.

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### CHALLENGES

- Providing accessible and modern facilities given some of the primary care estate
- Lower than anticipated poor outcomes on patient experience
- Inequitable access to enhanced services for the population
- Supporting a high proportion of single handed GP practices - 10 out of 38
- Disparities in the quality of care across some of our practices
- Limited capacity to respond to urgent care needs in and out of hours
- Multiple demands to respond to enhanced service requirements
- Attaining CQC registration status
- Improving the oral health of children
- Differentials in expected and recorded numbers on disease registers.

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### STRENGTHS

- Good coverage of GP and pharmacy services throughout the borough
- Mix of experienced and new GPs
- Offers a range of enhanced services
- Good QOF outcomes, but high levels of exception reporting.

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### IMPLICATIONS FOR CSP/CHOICE

- Strengthen commissioning of GPs for quality, support access
- Tender for additional dentistry including oral health promotion focus
- Introduce services to provide more comprehensive urgent response

The Borough Implementation Plan will start from here – expected spring 2012

It is important to note that the strategy sets out a framework but does not detail the developments which are needed and will take place in each borough and network. Detailed plans for improvements are needed for each individual borough and these are being developed with our local partners.

# 9. Strategic cost/Benefit analysis

## “How we justify the investment”

The Primary Care Strategy pump priming investment to deliver the transformational strategy is £46.7m (risk adjusted) across three years. In common with all PCTs, until our annual operating plan is approved by the Department of Health, we cannot confirm the spend for 2012/13. However, we are currently optimistic that our plans will be approved by the end of March 2012.

Investment will be across the nine strategic domains of:

- |  |   |                           |
|--|---|---------------------------|
| <ol style="list-style-type: none"> <li>1. Integration</li> <li>2. Clinical services</li> <li>3. Information Technology</li> </ol>  | } | = Integrated Care Network |
| <ol style="list-style-type: none"> <li>4. Public Health</li> <li>5. Premises</li> <li>6. Productivity</li> <li>7. Workforce, leadership and team development</li> <li>8. Commissioning</li> <li>9. Communications</li> </ol> |   |                           |

As well as strengthening general practice performance monitoring and analysis and programme management costs.

### PRIMARY CARE PUMP PRIMING 2012/13 – 2014/15 (£M)

	2012/13	2013/14	2014/15	Total £m
<b>Total spend</b>	12.0	17.5	17.3	46.7

The gross savings will be a multiple of the investment in the strategy and represents less than 1.5% of acute expenditure. The savings will be confirmed as part of the work that is being undertaken as part of the Integrated Care financial analysis.

## APPENDIX A - FACTS AND FIGURES

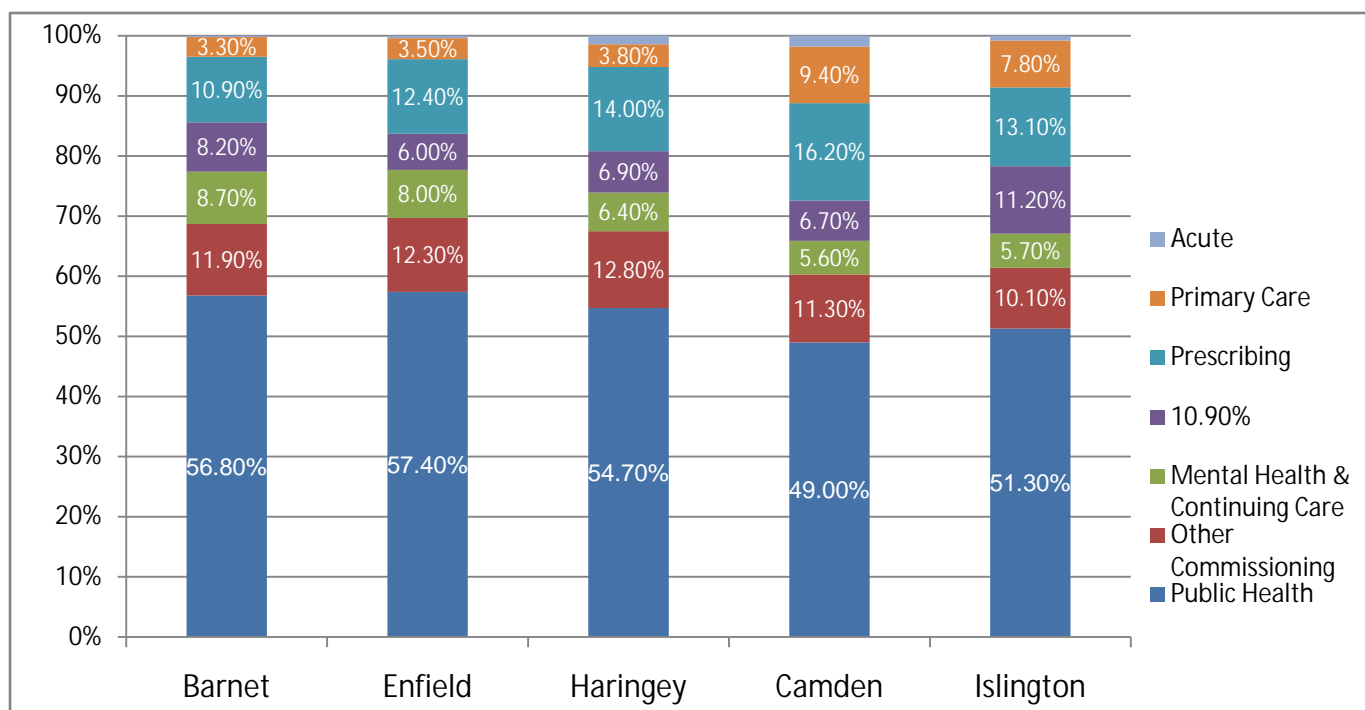
FIG 1 - GENERAL PRACTICES (WITH LISTS) BY TYPE OF CONTRACT

	Barnet	Camden	Enfield	Haringey	Islington	Total
<b>GMS</b>	42	20	28	23	35	<b>148</b>
<b>PMS</b>	26	16	31	30	2	<b>105</b>
<b>APMS</b>	0	3	1	1	0	<b>5</b>
<b>Totals</b>	<b>68</b>	<b>39</b>	<b>60</b>	<b>54</b>	<b>37</b>	<b>258</b>

FIG 2 - GP PRESCRIBING COSTS PER WEIGHTED AVERAGE LIST SIZE (RANK ORDER)

2010/11	Camden	Haringey	London Average	North Central London Average	Enfield	Barnet	Islington
<b>Cost per Astro PU</b>	£21.94	£22.06	<b>£23.40</b>	<b>£24.15</b>	£25.33	£25.47	£25.93

FIG 3 - NORTH CENTRAL LONDON EXPENDITURE – VARIATION IN 2011/12 FORECAST EXIT RATE SPEND BY CATEGORY - % OF SPEND (EXCLUDING CONTINGENCY AND OTHER CORPORATE)



There is a significant variation in acute spend as a percentage of total spend across NHS North Central London PCTs, ranging from 49% to 57.4%. Across London the average PCT spend is 47.6%.

Note: Public Health spend includes the running costs associated with the Public Health function

FIG 4 - FUNDING AND POPULATION NUMBERS

How much money will North Central London/PCTs spend in 2011/12?		£000s				
	Barnet	Camden	Enfield	Haringey	Islington	NCL
Total spending by PCT 2011/12 as at Month 6 projected to full year	£579,500	£518,499	£482,704	£469,554	£481,540	£2,531,797
<b>How much is that per head "crude population"?</b>						
"Crude Population" numbers @ 1st July 2011	351,286	247,303	277,429	244,489	191,810	1,312,317
£s per head "Crude Population"	£1,650	£2,097	£1,740	£1,921	£2,511	£1,929
<b>How much is that per head "registered patients"?</b>						
"Registered patient" numbers @ 1st July 2011	373,715	251,016	299,119	272,236	217,000	1,413,086
£s per head "Registered Patients"	£1,551	£2,066	£1,614	£1,725	£2,219	£1,792
<b>How much is that per "unified weighted population"?</b>						
"Unified Weighted Population" numbers 2011/12	327,404	256,243	289,265	275,792	236,084	1,384,787
£s per head "Unified Weighted Population"	£1,770	£2,023	£1,669	£1,703	£2,040	£1,828
<i>% difference between "Registered patients" and "Unified Weighted Population"</i>	-12.4%	2.1%	-3.3%	1.3%	8.8%	-2.0%

- a) Department of Health funding can be viewed on a per capita basis in various ways. The weighted capitation formula produces a PCT 'Unified Weighted Population'. This is a hypothetical population that DH uses as a target to guide most of the PCT's allocation. It is based on a weighted combination of 19 socio-economic factors that are seen as convenient proxies for health needs.
- b) The apparent massive funding differential using "Crude" or "Registered" populations is significantly reduced to the range of £1,669 per capita in Enfield to £2,040 in Islington. Using UWP means that the Barnet population theoretically reduces whilst Camden, Enfield, Haringey and Islington theoretically increase.
- c) The difference between Registered Patients and UWP also highlights a funding challenge in Barnet.

FIG 5 - EXPENDITURE PER CAPITA (UNIFIED WEIGHTED POPULATION) ON PROVIDERS AND PRESCRIBING

Commissioned Services spend per capita UWP	Barnet	Camden	Enfield	Haringey	Islington	North Central London
<b>Acute</b>	£1,014	£887	£979	£938	£955	£958
% of total projected spend on Providers and Prescribing	57.3%	51.3%	58.0%	55.9%	51.7%	55.0%
<b>Mental Health</b>	£119	£225	£147	£176	£222	£173
% of total projected spend on Providers and Prescribing	6.7%	13.0%	8.7%	10.5%	12.0%	10.0%
<b>Community</b>	£150	£122	£103	£116	£212	£139
% of total projected spend on Providers and Prescribing	8.5%	7.0%	6.1%	6.9%	11.5%	8.0%
<b>Other</b>	£115	£191	£107	£131	£166	£139
% of total projected spend on Providers and Prescribing	6.5%	11.0%	6.3%	7.8%	9.0%	8.0%
<b>Total Commissioned Services per capita</b>	<b>£1,399</b>	<b>£1,424</b>	<b>£1,336</b>	<b>£1,361</b>	<b>£1,556</b>	<b>£1,410</b>
<b>% of total projected spend on Providers and Prescribing</b>	<b>79.0%</b>	<b>82.4%</b>	<b>79.2%</b>	<b>81.0%</b>	<b>84.2%</b>	<b>81.0%</b>

Independent Contractor Services spend per capita UWP	Barnet	Camden	Enfield	Haringey	Islington	North Central London
<b>GP</b>	£136	£137	£132	£119	£118	£129
% of total projected spend on Providers and Prescribing	7.7%	7.9%	7.8%	7.1%	6.4%	7.4%
<b>Dentists, optometrists and pharmacists</b>	£77	£66	£83	£86	£66	£76
% of total projected spend on Providers and Prescribing	4.3%	3.8%	4.9%	5.1%	3.6%	4.4%
<b>Total Independent Contractor Services per capita</b>	<b>£212</b>	<b>£203</b>	<b>£215</b>	<b>£205</b>	<b>£184</b>	<b>£205</b>
<b>% of total projected spend on Providers and Prescribing</b>	<b>12.0%</b>	<b>11.7%</b>	<b>12.7%</b>	<b>12.2%</b>	<b>10.0%</b>	<b>11.8%</b>

	Barnet	Camden	Enfield	Haringey	Islington	North Central London
Prescribing spend per capita UWP	<b>£160</b>	<b>£101</b>	<b>£137</b>	<b>£114</b>	<b>£107</b>	<b>£126</b>
% of total projected spend on "Providers and Prescribing"	9.1%	5.8%	8.1%	6.8%	5.8%	7.2%
£s per capita UWP spent on "Providers and Prescribing"	<b>£1,771</b>	<b>£1,728</b>	<b>£1,688</b>	<b>£1,680</b>	<b>£1,847</b>	<b>£1,740</b>
% of total projected spend on "Providers and Prescribing"	100%	100%	100%	100%	100%	100%

FIG 6 - DENTISTS, OPTOMETRISTS AND PHARMACISTS (£000S)

<i>How do we spend the dentists, optometrists and pharmacists funding?</i>	Barnet	Camden	Enfield	Haringey	Islington	North Central London
<b>Dentists</b>	£13,160	£10,010	£13,514	£15,546	£9,018	£61,248
Number of Contractors	70	42	44	51	23	230
£s per contract	£188,000	£238,333	£307,136	£304,824	£392,087	£266,296
£s per capita UWP	£40	£39	£47	£56	£38	£44
<b>Optometrists</b>	£3,345	£2,183	£2,550	£2,368	£1,531	£11,977
Number of Contractors	88	77	72	33	53	323
£s per contract	£38,011	£28,351	£35,417	£71,758	£28,887	£37,080
£s per capita UWP	£10	£9	£9	£9	£6	£9
<b>Pharmacists</b>	£8,574	£4,751	£7,816	£5,755	£5,065	£31,961
Number of Contractors	71	65	61	56	46	299
£s per contract	£120,761	£73,092	£128,131	£102,768	£110,109	£106,893
£s per capita UWP	£26	£19	£27	£21	£21	£23
<b>Total Dentists, optometrists and pharmacists</b>	<b>£25,079</b>	<b>£16,944</b>	<b>£23,880</b>	<b>£23,669</b>	<b>£15,614</b>	<b>£105,186</b>
<b>% of total projected spend on Providers and Prescribing</b>	<b>4.3%</b>	<b>3.8%</b>	<b>4.9%</b>	<b>5.1%</b>	<b>3.6%</b>	<b>4.4%</b>
<b>£s per capita UWP</b>	<b>£77</b>	<b>£66</b>	<b>£83</b>	<b>£86</b>	<b>£66</b>	<b>£76</b>



FIG 7 GENERAL PRACTICE (£000S)

<i>How do we spend the general practice funding?</i>	Barnet	Camden	Enfield	Haringey	Islington	North Central London
<b>Total GMS</b>	£20,863	£15,273	£12,916	£10,952	£26,526	£86,530
Number of practices	42	20	28	23	35	148
£s per practice	£496,734	£763,650	£461,286	£476,174	£757,886	£584,662
Registered patients at 1st July 2011	217,695	120,664	117,557	104,334	207,468	767,718
£s per registered patient	£96	£127	£110	£105	£128	£113
Estimated Unified Weighted Patient population (using % difference)	190,701	123,198	113,678	105,690	225,725	758,992
Estimated £s per capita UWP	£109	£124	£114	£104	£118	£114
<b>Total PMS</b>	£23,013	£18,043	£24,090	£21,786	£1,103	£88,035
Number of practices	26	16	31	30	2	105
£s per practice	£885,115	£1,127,688	£777,097	£726,200	£551,500	£838,429
Registered patients at 1st July 2011	156,020	118,717	173,862	167,902	9,532	626,033
£s per registered patient	£148	£152	£139	£130	£116	£141
Estimated Unified Weighted Patient population (using % difference)	136,674	121,210	168,125	170,085	10,371	606,464
Estimated £s per capita UWP	£168	£149	£143	£128	£106	£145
<b>Total General Practice Budgets</b>	£44,399	£35,019	£38,251	£32,738	£27,864	£178,271
Number of practices	68	39	60	54	37	258
£s per practice	£652,926	£897,923	£637,517	£606,259	£753,081	£690,973
Registered patients at 1st July 2011	373,715	251,016	299,119	272,236	217,000	1,413,086
£s per registered patient	£119	£140	£128	£120	£128	£126
Unified Weighted Patient Population	327,404	256,243	289,265	275,792	236,084	1,384,787
£s per capita UWP	£136	£137	£132	£119	£118	£129