Interim Report

Development of NCL Primary Care Strategy

7th October 2011

1. Introduction

This report sets out the background work currently undertaken to develop a draft Primary Care Strategy for North Central London. This work is at an early stage and is presented to involve the JOSC early in this important work.

The purpose of the Primary Care Strategy is to further improve quality, capability and productivity in Primary Care and to create capacity within Primary Care through transformational change. This will be through the joint development of borough plans to implement the **Primary Care Strategy for North Central London**. The strategy will underpin the subsequent development of our 5 borough-based primary care plans by defining the medium/long term goals, priorities, principles, investment criteria and performance expectations. It will be a strategic shift from the previous premises-led to a quality-led agenda and will focus on:

- Promoting health, well being 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 plans will determine how NHS North Central London and the successor organisations will invest in primary care in each of the 5 Boroughs over the coming years.

This is an interim report that identifies the emerging themes to date. The emerging themes are being discussed with provider groups (e.g. GPs, Dentists, Optometrists, Pharmacists and other providers), NCL boroughteams and stakeholder groups (including LiNKs and Joint OSC) and will help inform the development of the strategy.

2. Programme of Work

The following activities were set out for the initial 4 weeks:

2.1 Desktop research

- Reading existing documents provided by NCL
- Creating the macro picture by starting the first draft of the NCL Primary Care Strategy document
- Compare/contrast/challenge the 5 PCT Borough strategies to inform the “Synopsis and Analysis”.

2.2 Stakeholder engagement

We agreed to run Borough-based workshops to include GPs, Dentists, Optometrists, Community Pharmacists and LiNK representatives at which the strategic questions will be posed to the attendees.

We are talking to local stakeholders prior to wider engagement at the borough level.

3. “Starter for 10 NHS North Central London case for a Primary Care Strategy”

This document, written by Dr Douglas Russell, followed an introductory discussion at the Senior Leadership Team on 9th July 2011. He undertook to produce a very basic “starter for 10” document around which to frame a further discussion about the need to develop a primary care strategy. He sets out the argument for the definition and measurement of both

activity and quality prior to engaging in a developmental programme with primary care contractors.

Universal, accessible high quality general practice supported by well developed primary care teams integrated with social care and third sector is likely to be more capable of addressing the QIPP challenge than our current landscape.

We need to engage the clinical leadership with a new vision of a transformed supported developed high quality GP and primary care landscape across the whole sector attracting and retaining the highest quality staff, both clinical and support.

We need to be clear about what we mean by quality. The "Darzi" definition is still useful – with the 3 domains of Safety, Effectiveness and Experience, all predicated on cost.

There are a set of core documents published that fill out a lot of background detail and evidence of the vision of what we would like to achieve over the next 5 years, from sources such as the RCGP, Kings Fund, Information Centre, Primary Care Commissioning.

Access is one dimension of care quality for the acutely ill but as important if not more so to patients with long term conditions is continuity.

Kings Fund report on improving quality in general practice is a key resource document. We should not simply measure process but also consider structure process and outcomes (Donabedian).

At the heart of the clinical contact is the consultation, with consultation skills, communication skills, diagnostic skills, skills in interventions such as high quality prescribing and appropriate and timely referral, team work, handovers, risk reduction, and clinical governance all important components of quality that are more difficult to measure.

Most difficult of all is one of the most vital – care and compassion. This starts from a sense of vocation but needs nurtured by a culture of professionalism and continuing professional development and support, peer comparison and personal reflection.

As a starting point we need data on what we currently have with benchmarking on matters such as have appeared on a number of "dashboards" – but these need to be developmental and implemented with collaboration of GP leaders and not used as a blunt managerial "stick" alone.

4. North Central London Primary Care Strategy – Facts and figures, findings to date

There are a total of 258 general practices with registered patients, excluding the 3 GP Led Health Centres where there are no lists.

Number of practices, by list size, by Borough, at July 2011 (January 2010 figures in brackets).

List size	Barnet	Camden	Enfield	Haringey	Islington	Totals
< 2,000	9 (10)	2 (4)	4 (6))	7 (7))	2 (4)	24 (31)
2-5,000	27 (29)	19 (19)	35 (36)	28 (31)	14 (15)	123 (130)
5-10,000	23	9	16	12	17	77

	(21)	(13)	(16)	(14)	(15)	(79)
>10,000	9 (9)	9 (5)	5 (5)	7 (6)	4 (4)	34 (29)
Number of practices	**68** **(69)**	**39** **(41)**	**60** **(63)**	**54** **(58)**	**37** **(38)**	**258** **(269)**
Total registered patients	**373,715** **(366,367)**	**251,016** **(235,187)**	**299,119** **(292,819)**	**272,236** **(280,887)**	**217,000** **(198,993)**	**1,413,086** **(1,374,253)**
Patients % change	+2.0%	+6.7%	+2.2%	-3.2%	+9.1%	+2.8%

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

A more detailed analysis shows the varying number of **patients registered by size of practice**:

Number of patients by Practice Size at 1st July 2011	Barnet	Camden	Enfield	Haringey	Islington	Totals
Practices <2,000	16,148	4,541	6,878	8,424	3,959	39,950
% of registered patients	4%	2%	2%	3%	2%	3%
Practices 2,000-5,000						
% of registered patients	89,126	63,356	121,098	87,331	44,714	405,625
	24%	25%	40%	32%	21%	29%
Cumulative	28%	27%	43%	35%	22%	32%
Practices 5,000-10,000	158,129	68,078	112,386	82,142	120,588	541,323
% of registered patients	42%	27%	38%	30%	56%	38%
Cumulative	70%	54%	80%	65%	78%	70%
Practices >10,000	110,312	115,041	58,757	94,339	47,739	426,188
% of registered patients	30%	46%	20%	35%	22%	30%
Cumulative	100%	100%	100%	100%	100%	100%
Total registered patients	**373,715**	**251,016**	**299,119**	**272,236**	**217,000**	**1,413,086**

From the above analysis we can see that:

- Just less than 40,000 patients (ie 3%) in NCL are registered in practices below 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 less than 5,000
- In Islington the comparable figure is only 22%
- In Camden 46% of patients are registered in the largest practices of over 10,000, compared with the NCL average of 30%.

General Practices (with lists) by type of contract

	Barnet	Camden	Enfield	Haringey	Islington	Total
GMS	26	20	28	23	35	**132**
PMS	42	16	31	30	2	**121**
APMS	0	3	1	1	0	**5**
Totals	68	39	60	54	37	**258**

GP prescribing costs per weighted average list size (Rank order)

2010/11	Camden	Haringey	London Ave	NCL Ave	Enfield	Barnet	Islington
Cost per Astro PU	£21.94	£22.06	**£23.40**	**£24.15**	£25.33	£25.47	£25.93

Overall QOF Scores by Borough PCT 2009/10 (2010/11 figures awaited)

Borough	Number	Exception	PCT Ave	Number of Practices by overall QOF scores 2009/10							
PCT	Practices	Reporting		<50%	50-80%	80-90%	90-92.3	92.4 London Ave.	92.4-93.6	93.7 England Ave	>93.7
Barnet	68	4.49%	93.9%	0	1	6	9		6		46
									9%		68%
Camden	40	5.76%	92.1%	1	1	5	3		7		23
									18%		58%
Enfield	63	4.19%	90.9%	0	5	14	10		9		25
									14%		40%
Haringey	52	5.33%	90.8%	1	3	11	7		6		24
									12%		46%
Islington	38	6.16%	93.9%	1	0	4	1		3		29
									8%		76%
London		5.13%									
England		5.41%									
	261			**3**	**10**	**40**	**30**		**31**		**147**
% of Practices by band				**1%**	**4%**	**15%**	**11%**		**12%**		**56%**

- 68% of NCL practices score above London average and 56% above England average
- Barnet, Camden and Islington are the highest scores, with Enfield and Haringey lowest
- Islington have very high exception reporting, with Barnet and Enfield both very low.

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	**89.00%**	**84.00%**
London SHA	**85.00%**	**77.00%**
Barnet	85.00%	80.00%
Camden	83.00%	79.00%
Enfield	85.00%	77.00%
Haringey	81.00%	74.00%
Islington	85.00%	79.00%

- On the two overall satisfaction questions, none of the Boroughs achieves the England average, but Barnet, Enfield and Islington all equal or better the London average.
- Haringey fail to achieve the London average on both questions.

Other independent contractors - Dental, Pharmacy and Optometry at April 2011

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

There is more data available on contractors in each borough, but it is not in a standard format to enable comparisons to be drawn.

5. NCL Primary Care Strategy – Emerging Themes

Themes	
Previous/existing strategies	• There is a common theme that 5 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 5 years has been premises-led. • However, despite extensive planning, implementation has been slow. Strategically the picture across NCL has not changed dramatically. • In Barnet, and Haringey there were detailed plans to reduce the number of practices substantially. But these plans generally did not have the support of GPs and were not implemented. • Enfield GPs had agreed to reducing practice numbers by relocations into new premises, but became disillusioned when this was not fully implemented • Camden and Islington seem to have had most impact by focusing on implementing their local plans, irrespective of external drivers. • At its best, Practice Based Commissioning has tended to focus on pathway redesign and has delivered improvements in some areas, but it has been variable across NCL.
Quality of service and care	**<u>How we really measure true quality?</u>** • *"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 currently have Balanced Scorecards (5 different), QOF (generally good), MORI Survey (not so good) and Prescribing Data. We will be implementing the London-wide GP Outcomes Framework from April 2012. • Anecdotally we know that there are issues in all boroughs and some more so than others • Access is a proxy indicator for outcomes
Data	• Data rich, information poor. Data sets are often incomplete, inconclusive, different form, different content, hard to find, locally

	specific or non-existent. • We need both hard and soft data. • Islington Public Health Informatics team currently produce disease profiles by practice and have the ability, but not the capacity, to extend across all practices in NCL.
Premises	• There is variability in the quality of the premises across North Central London
IT	There are 4 dimensions to the lack of standardisation in IT systems: • Practices across NCL using different systems and suppliers • Practices within a Borough using different systems and suppliers • Practice systems not able to communicate with Community Services systems (Usually RIO) • The extent to which practices are (un)able to communicate with Acute and Mental Health provider systems
GP Productivity	**<u>How we really measure productivity?</u>** • Need to be able to measure productivity in General Practice. • Value = outcomes/cost • "2006/07 UK General Practice Workload Survey" is the most recent definitive study • See "Improving the quality of care in general practice" (King's Fund March 2011) for links between Quality and Productivity

6. Summary

The facts and figures and the emerging themes will be discussed with stakeholders and an underpinning strategy will be developed through this discussion.