NHS
Havering
Clinical Commissioning Group

Transforming Primary Care in Havering

Our strategy 2016 – 2021

April 2016

Contents

1 Executive summary

For patients, primary care and their relationship with their local GP form the foundation of the NHS service they expect and receive. If the NHS is to be clinically and financially sustainable in the years ahead, primary care and the rest of the system need to be transformed. If this can be done right, primary care can be a rewarding place to work for the professionals working in it, now and in future.

Nationally, the NHS faces significant future challenge in the form of the increasing health needs and expectations of the population, changes in treatments and technologies, and increasing pressures on finances - both from reduced spending growth in the NHS and cuts to social care budgets. Current projections from Monitor and NHS England estimate that the NHS will face a £30 billion funding gap by 2020/21. To tackle these challenges within Government funding limits, the *Five Year Forward View*[1] sets out a transformational change agenda for the NHS that involves:

- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability.

In response to this, the General Practice Forward View offers funding opportunities and practical steps to stabilise and transform general practice through addressing workforce, workload, infrastructure and care design issues.

Havering, along with the wider Barking and Dagenham, Havering and Redbridge (BHR) system, has a greater commissioning challenge than the national average in the form of a system-wide budget gap of over £400m. The BHR system needs to be transformed to:

- Meet the health needs of the growing, ageing population where an increasing number of people are living with one or more long-term condition in its local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national and regional quality standards for care
- Close a £400m budget gap.

To achieve this, commissioners agree that acute hospital care should be reserved for acutely ill patients and the majority of care should be delivered nearer home. Key themes for the development of primary care are that it should be accessible, coordinated and proactive.

So what is the current state of primary care in Havering and how does it need to be transformed to meet commissioners' requirements and the needs of local people?

Significant progress has been made in improving access to general practice, with the establishment of hub-based urgent evening and weekend GP appointments. However, local GPs and stakeholders have told us that the current model in primary care is unsustainable. The workforce is stretched, with recruitment and retention of staff challenging. Workload is

[1] Five Year Forward View NHS England, October 2014

increasing, and will do further with an ageing population, and practices cannot deliver the quality of care their patients need without becoming financially unsustainable. While national funds are available for clear, coherent transformation strategies, there is no additional on-going funding available in the system beyond funding potentially released through a proportional reduction in acute hospital care. Primary care needs to change to better meet demand and be a rewarding place to work and attractive to future potential recruits.

The CCG's vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. This will involve the establishment of geographical 'localities' within Havering, each with a population of 50 to 70,000, as the basis of place-based care.

Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long-term conditions and avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The locality-based care model has at its foundation highly productive GP practices working collaboratively to deliver care, free up GP time and reduce administrative costs, making best use of available IT solutions. General practice will lead a highly effective extended locality team of community, social care, pharmacy, dental and ophthalmology professionals and the voluntary sector providing local people with the majority of their care. With input from local patients, this team will decide local pathways, how the care workload is shared, and where care delivered from, in line with standards set and common assets managed at the BHR system level.

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. In 2021, provision may continue in the form of an alliance of autonomous providers. Alternatively, by then, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

A system-wide programme will be established to refresh the roles and mix of professionals needed for locality-based care and to develop the career packages needed to sustainably attract and retain the GPs, nurses and healthcare assistants needed.

With the balance of care delivery shifting away from hospital care, a commensurate share of the existing funding envelope will fall to general practice and fellow locality team providers. In time, it is likely that contractual arrangements will change to incentivise population-level outcomes rather than reward provider activity.

The CCG aims to have locality-based care fully operational within two years. Key changes will be:

1. GP practices will work more productively and free up GP time to provide and oversee patient care.

2. Collaborative working between GP practices in localities and with the extended team of care professional will become established, raising quality and increasing capacity for locality care services and helping reduce the cost of administration.

3. Clear boundaries between primary care and acute hospitals, with good handovers between teams.

4. A programme will be put in place to recruit, develop and retain a primary care workforce suited to delivery in a place-based model in Havering.

5. Increasingly, reliable IT solutions will enable joined-up patient care and the automation of administrative tasks, and locality-based providers will adopt and use them with confidence.

2 Introduction

This strategy sets out a future vision for primary care in Havering in the context of wider change in Havering and the BHR health system, defines the overall scope and approach for the associated primary care transformation programme and provides a detailed plan for 2016/17.

The strategy addresses the future roles, form and sustainability of general practice specifically, given the role of the CCG in commissioning primary medical services. It also considers the future role of other primary care services such as community pharmacy, dentistry and ophthalmology as participants – along with community health, social care and voluntary sector providers – in integrated local care services.

Chapter 3 describes the drivers for change, summarising the commissioning agenda at national, London and local levels and presenting a thematic analysis of the issues and opportunities raised at grassroots level by local stakeholders.

Chapter 4 assesses the strategic options for a future primary care model, making the case for change, and Chapter 5 describes the future vision and how it addresses the drivers for change.

Chapter 6 describes what will change over the first two years of the programme and Chapter 7 presents the detailed 2016/17 plan.

In developing this strategy, we have engaged extensively with stakeholders a role in the Havering health and care economy: patient representatives, patient groups, GPs, practice managers, pharmacists, nurses, community and mental health services provided by NELFT NHS Foundation Trust, acute services provided by Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), the Partnership of East London Co-operatives (PELC), the Local Medical Council (LMC), the local authority, NHS commissioners and Care City. We have also consulted with primary care and workforce leads at NHS England London. Thanks are due to individuals who have provided their time and perspectives.

In formulating the vision, programme and plan we have worked closely with the BHR primary care transformation programme board. Many of the issues that have been identified in the development of this strategy are local and specific to Havering. Others we share with our neighbouring boroughs in Barking and Dagenham and Redbridge, and where we believe that a collaborative approach can be taken to addressing them, we will.

We have also consulted BHR commissioning colleagues responsible for parallel strategic work on planned care, mental health and urgent and emergency care to ensure alignment of vision and clarity on programme scope where proposals overlap.

3 Drivers for change

3.1 The commissioning context

3.1.1 National

Nationally, the NHS faces significant future challenge in the form of the increasing health needs and expectations of the population; changes in treatments and technologies; and increasing pressures on finances, both from reduced spending growth in the NHS and cuts to social care budgets. Current projections from Monitor and NHS England estimate that the NHS will face a £30 billion funding gap by 2020/21. To tackle these challenges within Government funding limits, the *Five Year Forward View*[2] sets out transformational change for the NHS to be driven by commissioners and realised by providers. This involves:

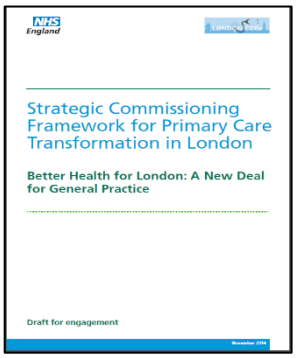
- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability.

The *Five Year Forward View* recognised that primary care has been underfunded compared to secondary care and general practice faces problems with workforce, workload, infrastructure and care design. In response to this, the *General Practice Forward View*[3] offers funding opportunities and practical steps to stabilise and transform general practice through a plan focusing on:

- Growth and development of the workforce within general practice
- Driving efficiencies in workload and relieving demand
- Modernisation of infrastructure and technology
- Support for local practices to redesign the way primary care is offered to patients.

3.1.2 Regional

At a London level, the *Better Health for London*[4] report from the Mayor's Office contained a range of recommendations that related to primary care. In particular, it called for significant investment in premises, developing at-scale models of general practice and the need for ambitious quality standards. This vision for primary care was further



[2] Five Year Forward View, NHS England
[3] General Practice Forward View, NHS England
[4] London Health Commission: Better Health for London

articulated by the publication of the *Strategic Commissioning Framework for Primary care in London*[5] which outlines a key set of specifications (service offers) aligned to the areas that patients and clinicians feel to be most important:

- **Accessible care** – better access to primary care professionals, at a time and through a method that's convenient and based on choice.
- **Coordinated care** – greater continuity of care between the NHS and other health services, including named clinicians and more time with patients as and when needed.
- **Proactive care** – more health prevention by working in partnerships to improve health outcomes, reduce health inequalities, and move towards a model of health that treats causes and not just symptoms.

The 17 indicators under these themes will be used across London to ensure a consistent, high quality service offer is available across the city.

3.1.3 Local

Havering, along with the wider Barking and Dagenham, Havering and Redbridge (BHR) system, has a greater commissioning challenge than the national and London average. The system-wide budget gap for BHR is more than £400m, and the key challenges are set out in figure 1 below.

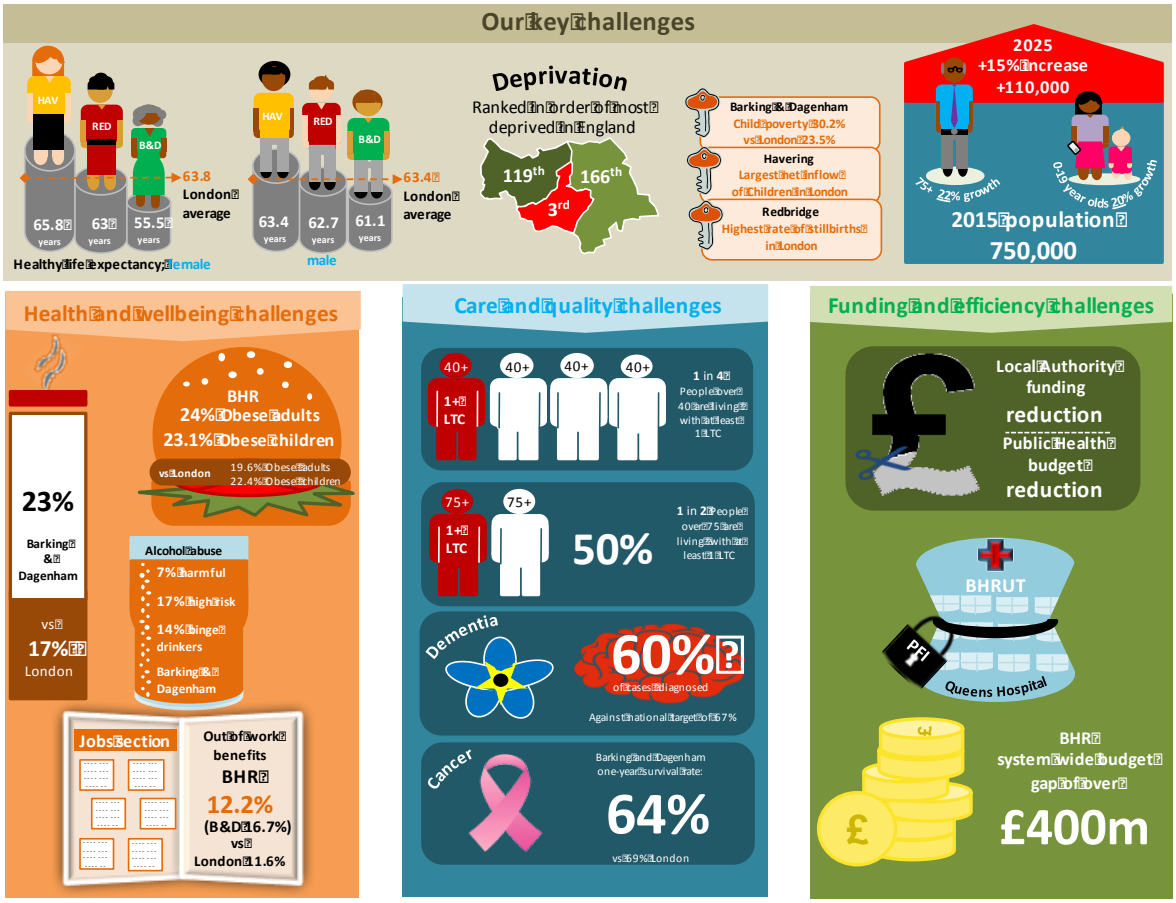


Figure 1: Key challenges for BHR CCGs

The BHR system needs to be transformed to:

[5] Transforming Primary Care in London, NHS England

- Meet the health needs of the diverse, growing and ageing populations in its various local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national quality standards for care
- Close a £400m gap.

To achieve this, commissioners and local providers agree that acute hospital care should be reserved for acutely ill patients and deliver the majority of care nearer home, and that more emphasis is needed on prevention to improve outcomes and contain demand for care.

Local strategies

Within BHR, strategies are in development that will have a large impact on the transformation of primary care, in terms of future service configuration and contracts, supporting infrastructure, and work that must be coordinated to achieve maximum benefit across the local health system (e.g. workforce development). These include:

- A new model of urgent and emergency care, which will radically transform local urgent and emergency services, removing barriers between health and social care and between organisations. Urgent care will be simple for people to use and services will be consistent, no matter where people use them (i.e. by phone, online or in person). This will be enabled by the use of the latest technology to make care records accessible to patients and clinicians.
- The mental health and planned care strategies, which are in early stages of development.
- The preventative care strategy, which aims to allow all Havering residents to have the support needed to improve their health and wellbeing and to reach their full potential. This involves primary, secondary and tertiary preventative interventions and services to help people get the right care, in the right place, at the right time, enabling them to live independently and at home for as long as possible.
- The BHR partnership is currently drawing up a business case to explore opportunities through an Accountable Care Organisation (ACO) pilot. If implemented, it would deliver structural changes in the local health economy that align incentives and payment mechanisms to enable common goals and integrated working. The creation of an ACO locally would be a further demonstration of local ambition and see a large part of the budget currently controlled by NHS England and Health Education England devolved to the new body to spend on local needs. No decision to form an ACO has yet been taken by BHR partners.

Services within the scope of primary care include:

Preventative care	Health and wellbeing advice: healthy eating, physical activity, mental health, kicking bad habits
	Screening
	Immunisations
Planned care	Self-care, self-management with coaching, education and support from primary care to manage their condition and to have a plan for escalation/emergency
	Planned and preventative case management
	Pharmacy services: dispensing, medicine reviews, prescribing
	Enhanced services
	Specialist input
	Transitions between secondary care/reablement
Urgent and	Urgent care - holistic assessment, streaming, booking

emergency care	Minor ailments advice and treatment
	Planned GP appointment

3.2 Performance and future sustainability of the current primary care model

Our analysis shows that current performance is mixed and the current model will not be able to cope with higher demand and meet care quality expectation. The headlines are:

- Our primary care workforce is already stretched
- Demand is growing due to a growing and younger population, with high levels of migration in and out of the borough, and more patients having more than one long term condition
- A high proportion of GPs are nearing retirement, and recruitment and retention is challenging
- There is too much variation in primary care quality
- There has been substantial progress in improving the accessibility of general practice, but there remains more to do
- There is too much variation in patient satisfaction, particularly around access
- Some of our premises are poor quality
- Patients are being seen in a hospital setting for conditions that could be better managed in primary care.

3.2.1 Workforce

Our workforce is stretched, and recruitment and retention is challenging

Havering has some of the lowest rates of GPs per 1,000 population in London, with 0.47 GPs for every 1,000 registered patients, compared to a London average of 0.55 (see figure 2). The practice nurse picture is more positive with 0.2 nurses per 1,000 population, which is also the London average.

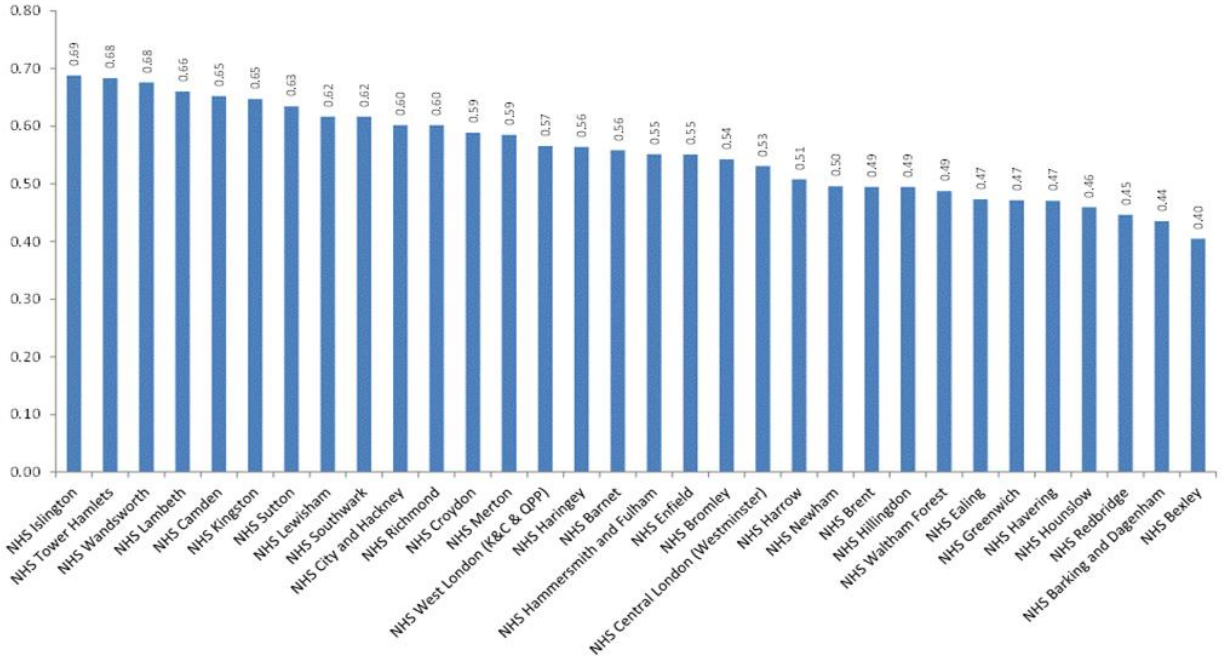


Figure 2. London CCGs rate of full time equivalent GPs (exc. registrars and retainers) per 1,000 patients

Traditionally, outer London has found it harder to attract newly qualified GPs than inner London. It is difficult both to recruit and retain salaried GPs and to attract GP partners in Havering, as well as other members of the primary care workforce. The reasons identified by stakeholders are set out in the following table.

Isolated GPs	Salaried GPs and long-term locums feel disenfranchised and isolated. High numbers of single handed GPs.
Older GPs	High proportion GPs reaching retirement age.
Older nurses	High proportion nurses reaching retirement age.
Overworked GPs	Lowest quartile of GPs per head of population in the country.
Nationwide shortage of GPs	Shortage of medical students going into general practice despite mandate from Health Education England. Training posts remain unfilled.
Cost of living in London	Inner London posts attract inner London weighting whereas outer London posts attract the lower band of outer London weighting.
Brand and reputation	Other parts of London are further ahead in marketing themselves and adjacent opportunities e.g. career development, research opportunities, honorary positions.

High proportion of GPs nearing retirement

In addition to the current challenges faced by the shortage of GPs working in Havering, the age profile (see figure 3) of the GP workforce signals that this challenge will be greater in future years. Havering has more than twice as many GPs over the age of 60 than the national average: 34% of GPs are over 60, compared to 15% in London and

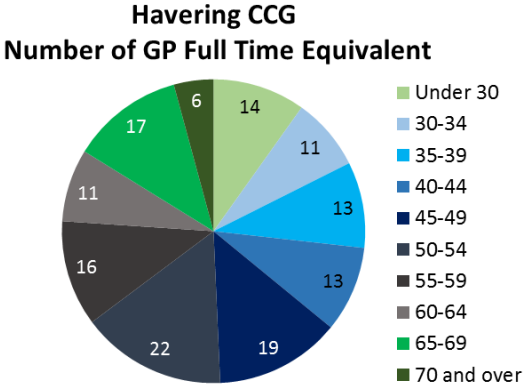


Figure 3: GP age profile, (practice reported): HSCIC General and Personal Medical

9% nationally (figure 3). With potential retirements in this already stretched workforce, this is clearly a local priority.

3.2.2 Workload

Local stakeholder interviews provided us with a consistent narrative of increased demand, increased workload and, especially, increased time spent on bureaucracy and administrative tasks. Havering's GPs find their current workload unsustainable. Many are overworked, and feel they are spending too much time on administrative tasks and chasing information, with not enough time for patient care. This work can be from external sources (e.g. patients who are discharged from secondary care with increased demands from primary care) as well as work generated within their practices (e.g. time spent on repeat prescriptions). Delegating care to other healthcare professionals/services can be difficult, with uncertainty over resources and capacity elsewhere in the system. Lack of information sharing between services makes it difficult for all members of the primary care team to know what other professionals are doing. This means work may be duplicated and confidence in the whole system working in an integrated way is reduced.

Patient behaviour also contributes to GP workload. Many patients find the primary care offer around urgent care confusing and will seek an appointment with their own GP, on top of contact with GPs/other professionals in urgent care, to 'check' their treatment is correct. Others still feel they need to see their GP for minor illnesses such as coughs and colds when another professional such as a community pharmacist could provide that care.

Population growth and demographic change – growing population and a rise in the number of patients suffering from one or more long term conditions

The population of Havering is growing and local healthcare needs are changing.

- Havering's population in 2014 was almost 246,000 and is projected to increase by 6%, 11% and 13% in 2020, 2025 and 2030 respectively.
- The largest increase will occur in children (under 18s) and older people (65 years and above). These groups are the most likely to access healthcare and older people are more likely to have a number of long-term conditions.
- More than 21,000 residents are aged 75 or over, of whom about 5,250 (25%) live alone. The retirement age population is expected to grow by almost 20% by 2025, even though the borough already has the highest proportion of pensioners in London.

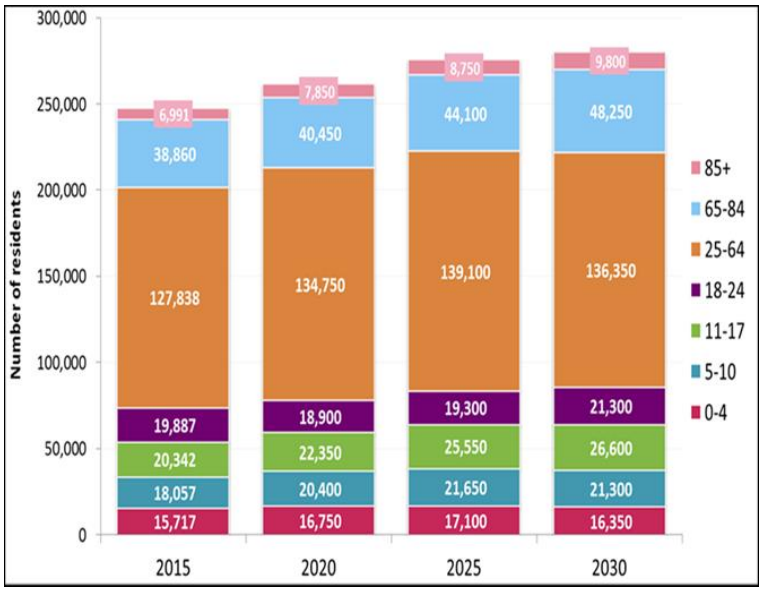


Figure 2. Havering projected population growth 2015-2030, ONS

Overall, it is a relatively affluent borough but has pockets of deprivation to the north and south. Life expectancy is 80 years for males and 84 years for females. Havering's population is predominantly white (83%) though this is a projected to decrease slightly to 80% in 2030 with the black African population expected to increase as a share of population.

Long-term conditions

In addition to the growth in population, Havering is seeing a growth in the number of people living with one or more long term conditions.

- About 10% of the population has caring responsibilities for someone who is ill, frail or disabled.
- Of those aged 75 and over living alone in the borough, almost 4,100 (41%) are living with a long term condition and 1,317 have dementia. In 2014, 357 elderly people needed hospital admission following a fall and 256 had a stroke.
- The annual patient survey (2015) indicated that 43% of patients in Havering do not feel they have enough support to manage their long term condition, against a national average of 36%.

General practice has a key role in the identification, treatment and management of long term conditions and mental health. These trends impact on the demand on GPs and the primary care team.

Improved care coordination is central to the model of care provided to patients with long term conditions. It has been shown to deliver better health outcomes, improve patient experience and is vital for people living with multiple conditions. Better care coordination is key to delivering an integrated health service. However, care coordination is complex and requires a shared approach across the healthcare system.

3.2.3 Quality

There is variation in the patient outcomes across Havering. General practice makes a significant contribution to improving the health of the population and influencing patient health outcomes. Across Havering there are examples of excellence in practice. We need to learn from these examples of excellence to reduce the variation that currently exists.

Quality outcome framework (QOF) achievement in Havering is an indicator GP practices will be familiar with, which highlights the needs for reducing variation in the quality of care between practices in the borough. The variance in QOF achievement in 2014/15 ranged from 282 to 559 (maximum). Lower QOF scores affect both the care of patients with long-term conditions and practice income.

CCG	Average achievement (559 maximum)	Lowest score	Highest score
Barking and Dagenham	530	458	559
Havering	516	282	559
Redbridge	522	443	559
London	521	139	559
England	530	139	559

Table 1: BHR CCGs QOF achievement, 2014/15

Achievement against the general practice outcome standards (GPOS) allow us to see how GP practices perform against a set of 26 indicators for quality improvement agreed with GP leaders, clinicians, the London-wide LMCs, commissioners and other health care professionals, think tanks and patient groups. Havering CCG has a higher proportion of GP practices rated as 'achieving' against GPOS compared to London as a whole. However, 29% of practices are in the lowest performing category of 'review identified' (14 practices). Practices in this category have nine or more triggers in total, or at least three level two triggers (where they are well below target/England average). For more detail on individual indicators where comparison to the England average is possible see figure 6 below.

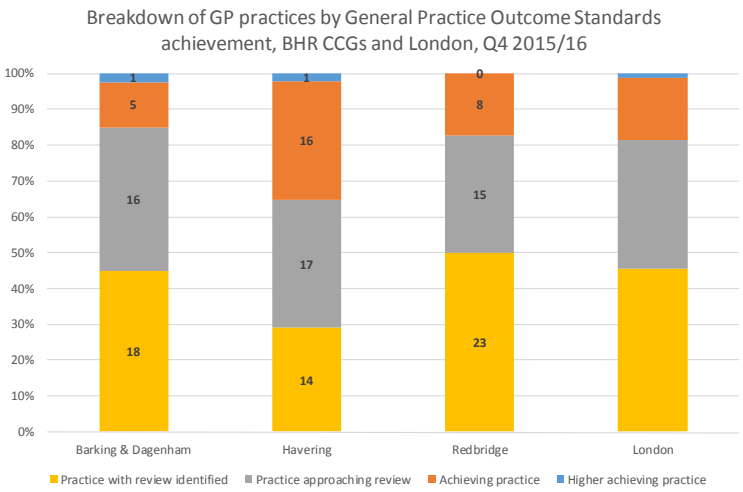


Figure 3: Breakdown of GPOS performance by BHR CCG

Indicator Name	Period	CCG Avg	England	Chart
4) Recording Smoking Status	Y13Q0	89.3	86.63	
5a) Smoking Cessation Advice	Y13Q0	97.08	94.65	
6c) Anti-Coag for AF	Y13Q0	84.32	84.66	
8a) Flu Vaccination (over 65s)	Y13Q0	71.22	72.99	
8b) Flu Vaccination (at risk)	Y13Q0	51.75	53.23	
13a) Dementia Diagnosis Rate (Adj)	Y14Q4	51.61	62.06	
14a) %Naproxen and Ibuprofen	Y14Q3	80.86	77.74	
17) Satisfaction (Quality) a-g	Y14Q2	610.57	623.9	
18) Satisfaction (Overall Care) a-b	Y14Q2	152.81	164.13	
20) Patient Experience	Y14Q2	60.26	58.86	
21) Satisfaction (Access) a-c	Y14Q2	233.67	246.9	
25) Detection Rate for Cancer	Y13Q0	52.05	47.57	
26c) Depression Assessment	Y13Q0	91.42	88.88	
27c) SMI Physical Health (BP)	Y13Q0	93.37	91.63	
27d) SMI Physical Health (d1+d2)	Y13Q0	171.96	167.66	

Figure 4: Havering CCG compared with national performance in general practice outcome standards

Key: Yellow diamond represents the CCG value; blue line the national average for the standard; yellow line the level one trigger value; red line the level two trigger value.

Some of our premises are of poor quality and need further investment

To ensure that patients receive high quality, accessible and safe care it is fundamental that general practice is able to deliver care from buildings that are fit for purpose and have the relevant facilities. Investment in primary care estates and IT has lagged behind investment in secondary care. Some general practices are working from inadequate buildings with limited facilities. This creates a poor environment for patients and staff. Much of the primary care estate is out-of-date, under-developed and cannot provide the facilities needed to deliver high quality care.

The primary care estate in Havering presents a mixed picture of some newer health clinics and some primary care services delivered from terraced housing. Some of the primary care estate is in poor condition, with a large number of single-handed practices operating out of old houses.

There are opportunities presented by the new modern primary care facilities, which now need to be fully utilised with extended opening hours. Most of these facilities consist of generic space that would benefit from sessional booking and use. This will allow for rationalisation of the remaining NHS Property Services sites, a lot of which are in poor condition and not fit for purpose.

An additional consideration for the primary care estate in Havering is the number of regeneration schemes that are planned in the borough. Havering is required to meet a target for the provision of 11,400 new homes by 2028 at a rate of at least 760 new dwellings per year. Securing the funding that is available to Havering Council from housing developers through funding to support public infrastructure, such as primary care, as a result of these developments.

There are variable levels of patient satisfaction, particularly in terms of access

Improving access to primary care professionals, at a time and through a method that's convenient and based on choice is outlined as a key priority for the delivery of primary care services in London. General practice core hours of operation are 8.30am to 6.30pm, Monday to Friday. The direct enhanced service for access incentivises practices to open additional hours outside of this core offer. Across Havering there are 11 practices, just under a quarter, that are not open during core hours and this impacts on the amount of access available to their patients

GP must be open more hours. Well trained and responsive reception staff

As part of the engagement on the development of this strategy, a survey was circulated to patients, carers and their representative groups to seek their views on local primary care services. Access to services was highlighted as an issue for some respondents and an area where things could be improved. The boxes on the right show a selection of the comments received about access.

It needs to be easier to get an appointment on the day

Access has been a key priority for primary care development in recent years and work has begun to develop the strong foundations for opening up access to patients across Havering. In collaboration with Barking and Dagenham and Redbridge CCGs integrated primary care services through access hubs during evenings and weekends are being offered across the network, provided by the local GP federations. This new model of extending access has so far achieved a 90% patient satisfaction rate and has opened up an additional c5,000 urgent care slots a month.

GP services are getting worse, unable to make an appointment by phone, nearly always engaged. Shorter hours than previously

Patients are being seen in a hospital setting for conditions that could be better managed in primary care

As the usual first point of contact for patients when accessing the healthcare system, primary care plays a crucial role in preventing unnecessary hospital attendances and admissions.

Across Havering the rate of patients attending A&E is similar to the London average. It may have been appropriate to treat some of these patients in primary care. Figure 7, on the next page, shows the attendance rate per thousand registered patients at each practice in Havering in 2013-14:

- The average attendance rate is 316 per 1,000 registered patients
- The London average in in 2012/13 was 312 per 1,000 population, which was the highest in the country
- Variation locally in A&E attendance rate by practice ranges from approximately 181 to 439 per 1,000 and is unlikely to be as a result of population factors alone.

This suggests that more can be done to treat patients in primary care, ensuring they have access to the care closer to home.

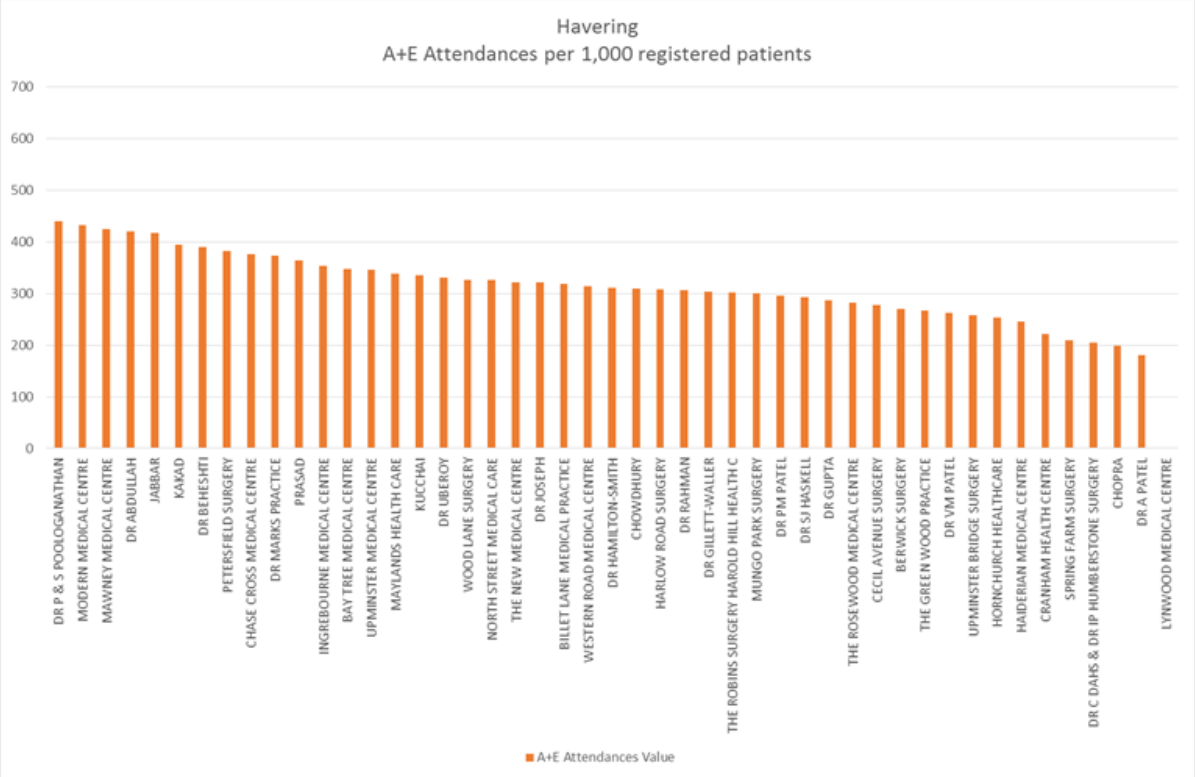


Figure 5: A&E attendance by practice per 1,000 population

Outpatient referrals show a similar trend with variation in referral rates varying across practices (figure 8).

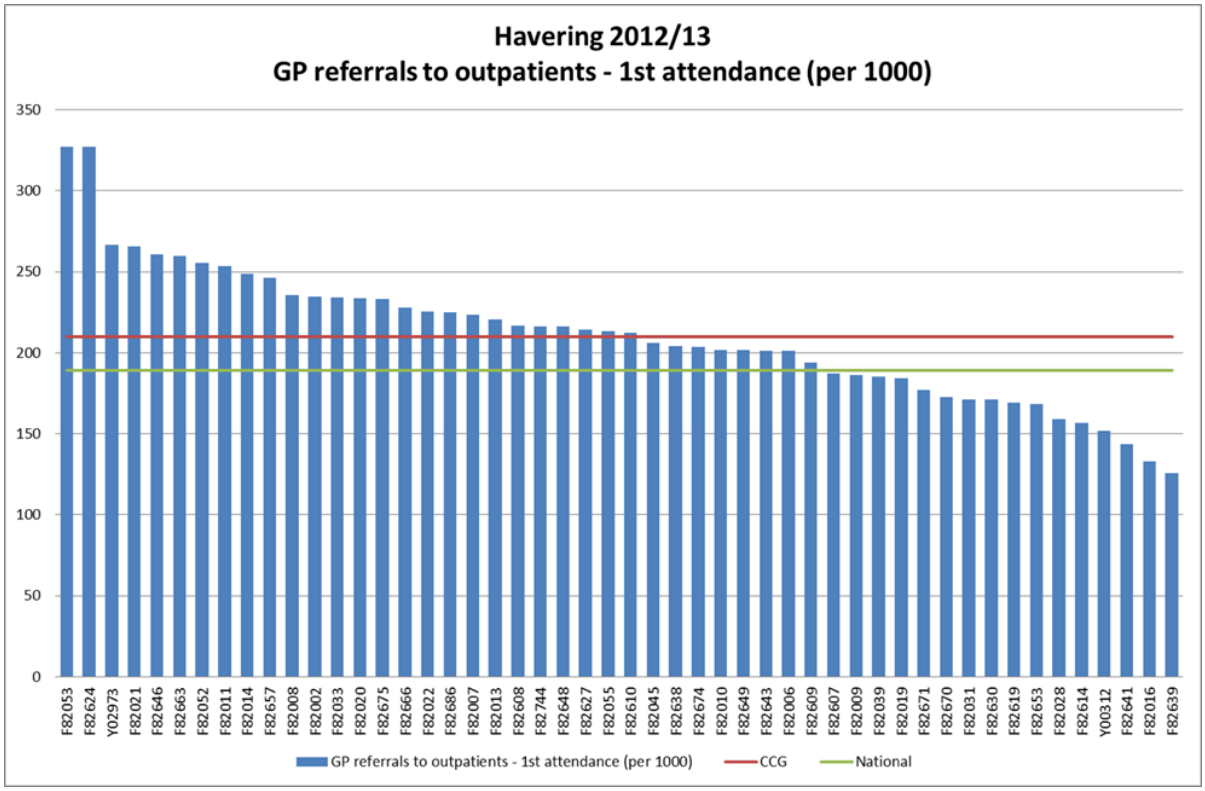


Figure 6. GP referrals to outpatients, first attendance by practice per 1,000 population

3.3 GP and stakeholder perspectives

We have consulted with patient representatives, general practitioners, practice managers, pharmacists, nurses, community and mental health services (NELFT), acute services (BHRUT), the local authority, NHS commissioners and Care City. We have also had conversations with primary care and workforce leads at NHS England London. Local stakeholders have identified issues with primary care as it is now, and potential solutions. There is wide recognition that transformation in primary care is both necessary and desirable.

A full thematic analysis of feedback is available from the primary care transformation team. The key themes are shown below:

Challenge	Aspiration	Solutions offered
The system is fractured – we work in silos and there is a lot of inefficiency and duplication	We want integrated health and wellbeing services that meet our populations' physical, mental and social care needs	• We want more focus on prevention • We need to help patients to self-care • Care should be close to home • Links and handovers between primary, community, secondary and social care should be seamless • To improve quality and reduce costs we should align incentives across providers.
Demands and expectations of GPs are too high	We need to re-define the role of the GP in relation to the rest of the primary care team	• GPs want to retain overall responsibility for their patients but not feel like they have to do everything • We want GPs to be able to delegate work/decisions to other members of the primary

		care team where appropriate • We want GPs to have more time for complex, planned and preventative work • We want the benefits of collective working but also need to balance that against the desire for GP autonomy.
Our workforce is stretched and the workload is getting bigger	There are ways we could tackle our workload and workforce challenges	• We could share staff • We could pilot new care pathways and ways of working • By enhancing people's skills we could enable more sharing of the workload • Shared education and training would help team working and build relationships between professionals • We could train hybrid health and social care workers • Building communities of practice and support across professions would reduce feelings of isolation and allow us to share knowledge • Sharing back office functions would cut down on work.
We are committed to our patients and do some things really well	We want to build on what already works	• We want to roll out the successful pilots we already have • We want to keep what works well.
Poor use of technology and low quality facilities makes our work harder	To do our jobs well we need fit for purpose buildings and good IT	• We need good IT and digital platforms to improve self-care and access for patients • We need integrated IT to improve quality and reduce workload.

4 Primary care strategic options

4.1 Requirements

In summary, the drivers for change described in the previous section give us a set of requirements a new primary care model must aim to meet. These are:

Delivery

- Meet the health needs of the diverse, growing and ageing populations in its various local communities
- Contribute substantially to the improvement of health outcomes for these populations and the reduction of health inequalities overall
- Meet national and regional quality standards for primary care, ensuring care is accessible, coordinated and proactive
- Increase capability/capacity to deliver the majority of patient care – planned, mental health and urgent – out of hospital with a focus on prevention, reducing demand for acute care and enabling savings of £400 million across BHR.

Patient experience

- Patients can continue to benefit from a relationship with their local GP
- Patients receive a joined-up, cost-effective care service with unnecessary duplicate assessment and treatment avoided.
- Patients find it easier to access appropriate primary care

General practice

- Productive GP practices can retain their autonomy and have a financially sustainable future
- GPs have the time they need to provide quality patient care
- The time and effort spent by GPs and practice colleagues on administrative tasks is minimised
- The respective roles and responsibilities of GP practices and all local care providers in delivering care are clearly defined and consistently applied day-to-day by all parties.

Workforce

- The career offer and working environment for GPs in Barking and Dagenham are sufficiently compelling to retain existing GPs and attract new enough recruits.

Infrastructure

- GPs and their fellow professionals can rely on IT to present the information about their patients that they need at the point of care to make the best decisions for patients
- Care is delivered in premises that are fit for purpose in a way that makes the best use of existing assets.

4.2 Strategic options

We have identified five possible options for the transformation of primary care in Havering over the coming five years:

1. “Do nothing” – retain the existing model at current levels of funding.
2. Retain the existing model and increase funding.
3. Invest in improving the quality and productivity of general practice and make it sustainable.
4. Extend primary care incrementally to become a place-based model of care, whereby general practice and other primary and community-based providers collaborate to deliver proactive, joined-up care out of hospital for a local population.
5. Building on the Five Year Forward View, move directly to merging the provision of general practice and community-based care and create a new form of provider, such as a multi-speciality community provider.

Our analysis in section three demonstrates that option one is not sustainable.

Option two is neither clinically sustainable nor financially viable. BHR has a system wide budget gap of over £400m, and there is no additional funding available in the system beyond funding potentially released through a proportional reduction in acute hospital care.

The current primary care model therefore needs to change. A focus on improving general practice (option three) meets a number of the requirements above, but is not sufficient to create the capability and capacity needed to deliver the majority of patient care, or to transform care so it is joined-up and cost-effective with unnecessary duplicate assessment and treatment avoided. This would require closer integration of general practice with other primary and community-based care (option four).

Our recommendation is a vision which combines the strengthening of general practice (option three), maintenance of the patient-GP relationship and the continued autonomy of practices, with the extension of primary care to become place-based care (option four).

Experience of collaborative working in a virtual team may, in time, build a case to move to new forms of provider configuration (option five), but change should be made incrementally by local care professionals with a focus on what will improve services for patients.

5 The vision for primary care in Havering

5.1 Vision for primary care

The CCG's vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. This will involve the establishment of geographical localities of 50-70,000 population within Havering as the basis of place-based care. Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The locality-based care model has at its foundation highly productive GP practices working collaboratively to deliver care, free up GP time and reduce administrative costs, making best use of available IT solutions. General practice will lead a highly effective extended locality team of community, social care, pharmacy, dental and ophthalmology professionals and the voluntary sector providing local people with the majority of their care. With input from local patients, this team will decide local pathways, how the care workload is shared, and where care is delivered from, in line with standards set and common assets managed at the BHR system level.

Collaborative working will include GPs deciding how GP practices will work collectively across localities to offer services to patients both within routine and extended opening hours, as defined by the strategic commissioning framework standards, and how collective working to manage workload will create more time for extended appointments. Localities will also decide what blend of services best meet local need and standards, for example the number of appointments available with GPs and other health professionals, and where those appointments will be offered (e.g. GP practices, hubs). To see how locality-based care will meet each strategic commissioning framework standard, see Appendix A: Strategic Commissioning Framework delivery plan.

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. In 2021, provision may continue in the form of an alliance of autonomous providers. Alternatively, by then, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

A system-wide programme will be established to refresh the roles and mix of professionals needed for locality-based care and to develop the career packages needed to sustainably attract and retain the GPs, nurses and healthcare assistants needed.

With the balance of care delivery shifting away from hospital care, a greater share of the existing funding envelope will fall to general practice and fellow locality team providers. In time, it is likely that contractual arrangements will change to incentivise population-level outcomes rather than reward provider activity.

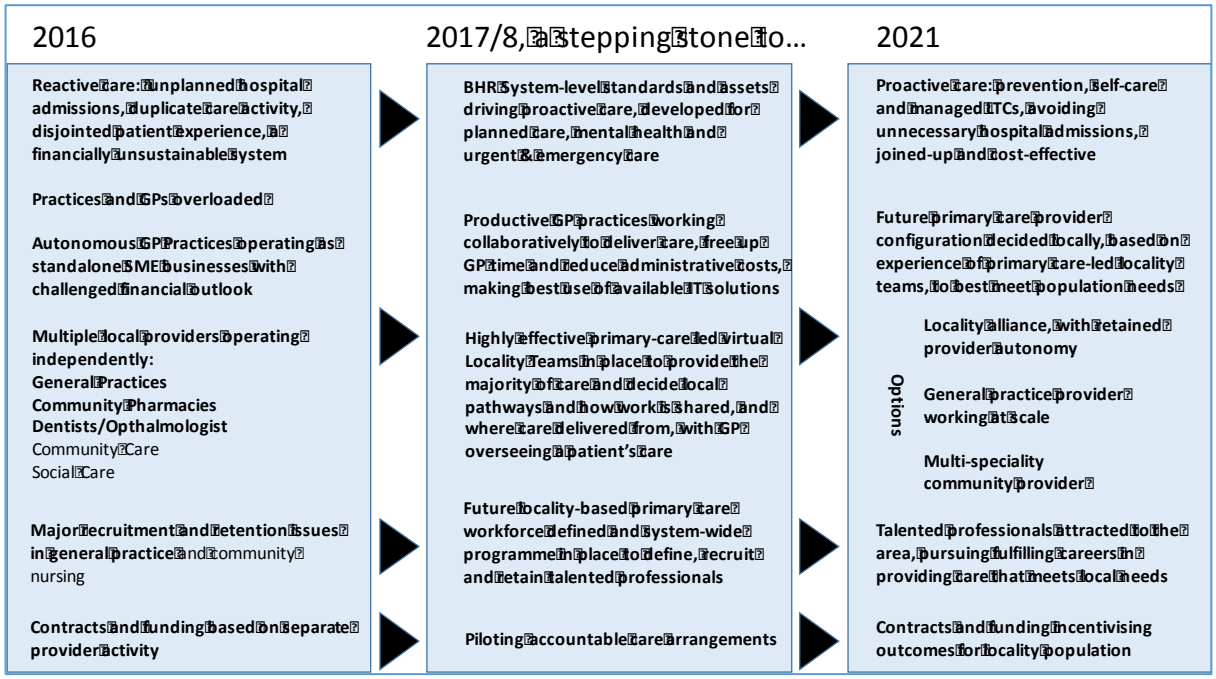


Figure 9. Milestones in journey towards achieving the vision

5.2 What is place-based care?

The King's Fund proposes place-based care as a way to create an environment where health care organisations can effectively work together towards improving health outcomes for the populations they serve. By pooling their resources, providers are freed from the pressure to focus on their own services and organisational survival to the potential detriment of other organisations within the health economy. In place-based care, providers collaborate to manage pooled resources, enabling them to consider the whole health economy when making decisions and to better use resources to meet their local populations' needs. Place-based care is not about top-down change, it's about enabling local systems of care to develop ways of working that effectively meet population need. The King's Fund's framework for developing place-based models of care will be used to develop the model in Havering. More details on this framework are in Section 6.4.3.

Evidence advanced by the King's Fund, drawing on examples from New Zealand, Chenn Med, is that place-based care works best with a population of 50-70,000 people. Havering has a history of working in clusters of 25-50,000 population, so it is proposed that existing clusters (see Appendix B) are reconfigured into localities of 50-70,000 and that place-based care be established within these new locality boundaries.

5.3 How will place-based care in a Havering locality work?

The vision for general practice-led, locality-based care is summarised in figure 10 below. As now, it is founded on GP practices.

Providers and professionals working collaboratively

The locality-based care model comprises multiple layers, operating in parallel:

- Individual GPs, supporting, treating and referring patients on their list, taking, where appropriate, oversight of their care across the system, equipped with the information they need to do so
- Productive GP practices, effective at managing and prioritising their workload, using the full resources of the practice and making best use of IT solutions to free up GP time for patient care
- GP practices working within collaborative arrangements to deliver primary medical and additional services and to manage administrative activity more cost-effectively; existing federation arrangements may offer a starting point for this
- General practice leading an extended multi-professional team of community, social care, pharmacy, dental, ophthalmology and voluntary sector services.

The team in a locality will be sufficiently small (averaging circa 100 team members) to allow the formation of trusted working relationships between clinicians and care workers from different organisations and professional backgrounds, which will be important in improving care quality, patient experience and productivity. The inclusion of patients in that team of 100 will be key for the co-design of services with the population they serve.

It is assumed initially that general practice and fellow providers will come together in a virtual team, with the option to evolve into more formal organisational structures for collaborative working based on experience from delivering care collaboratively.

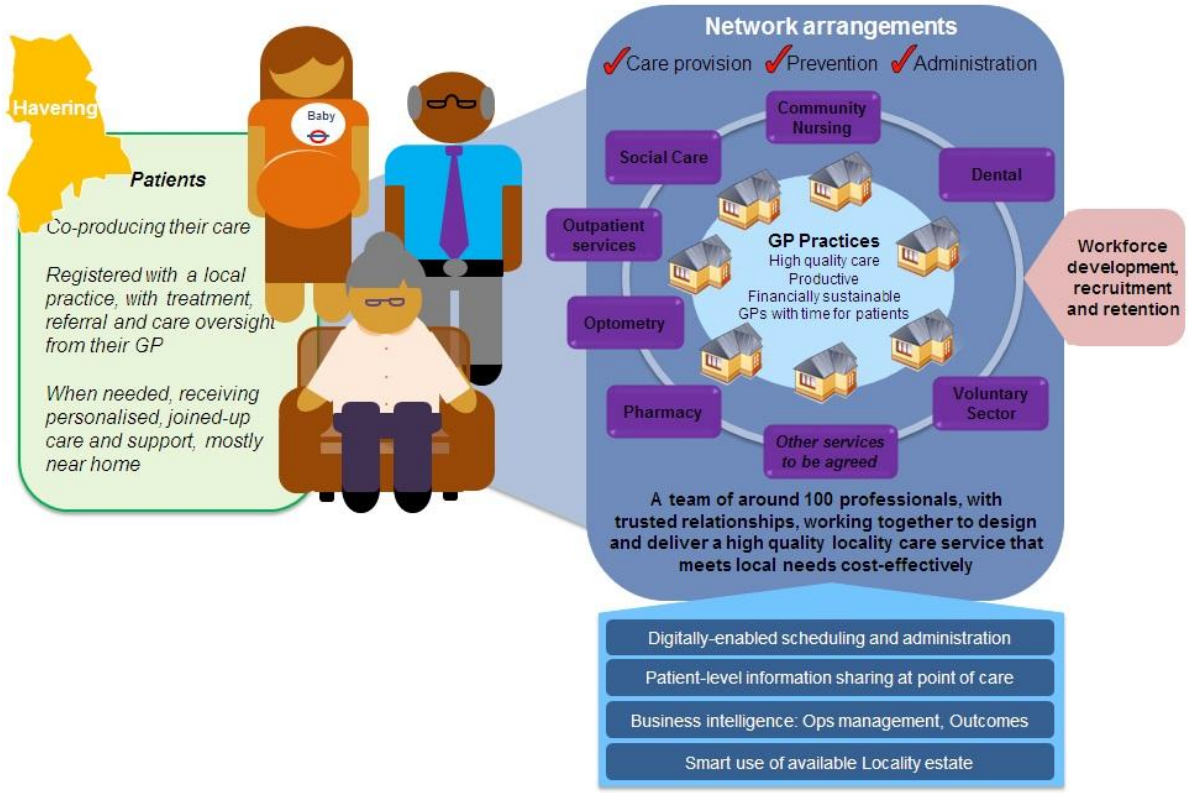


Figure 10. General practice-led locality-based care

Building a locality strategy and plan

To ensure equity and quality of care, localities will need to provide services which meet NHS England's strategic commissioning framework quality standards, and with BHR ambitions set

within a formal quality improvement framework with evaluation via the system's agreed primary care transformation dashboard (Appendix C: Primary care transformation dashboard indicators

Primary care Indicator	Item	Performance Indicator	Description	Source
Diabetes	Proactive Care	Diabetic retinal screening uptake	The proportion of those offered diabetic eye screening who attend a digital screening event	
	Treatment	% Blood pressure of 140/80 mmHg or less	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.	
		% Cholesterol of 5 mmol/l or less	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	
		% HbA1c is less than 59 mmol/mol	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months.	
		% of newly diagnosed referred to education programme	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	
	Outcome	Admissions due to diabetes	Rate per 1,000 population aged 17+ years	HSCIC
		Preventable sight loss - diabetic eye disease	New Certifications of Visual Impairment (CVI) due to diabetic eye disease aged 12+, rate per 100,000 population. The numerator counts for this indicator includes sight loss due to diabetic eye disease as the main cause or if no main cause as a contributory cause. (These are not counts of diabetics with visual impairments due to any cause)	PHE
		Emergency hospital admissions: diabetic ketoacidosis and coma	Emergency hospital admissions: diabetic ketoacidosis and coma, indirectly age standardised rate per 100,000 persons	HSCIC
		Years of life lost due to mortality, males	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, males	
		Years of life lost due to mortality, females	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, females	
		Diabetic foot amputation	No. of hospital admissions per 100,000 population related to diabetic amputations	SUS/HES
COPD	Proactive Care	Smoking cessation uptake	Crude rate of successful four week quitters per 100,000 population aged 16+ years	PHE
	Treatment	Bronchodilator spirometry	COPD002: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	HSCIC
		Health care review	COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months	
		Smokers with COPD diagnosis	% of patients referred to stop smoking clinic with denominator as total number of smokers with COPD diagnosis	Health Analytics
		Patients with MRC 3 and above	The % of patients with MRC score 3-5 referred for pulmonary rehabilitation / total number of patients with MRC 3 and above	
		COPD with self management plan	% of patients with severe or very severe Copd who have self management plan/ total number of patients with severe or very severe	
		Smoking prevalence	Percentage of COPD patients who are recorded as currently smoking	Health Analytics
		COPD severity	Mild COPD, confirmed COPD patients with latest predicted FEV1 ≥80%	
			Moderate COPD, confirmed COPD patients with latest predicted FEV1 ≥50% <80%	
			Severe COPD, confirmed COPD patients with latest predicted FEV1 ≥30% <50%	
			Very severe COPD, confirmed COPD patients with latest predicted FEV1 <30%	
	Outcome	Emergency Admissions due to COPD	Rate per 100 patients on the disease register	HSCIC
		Under 75 years of age mortality rate from respiratory conditions considered to be preventable	Age-standardised rate of mortality considered preventable from respiratory disease in those aged <75 per 100,000 population	PHOF
Cancer	Proactive Care	Bowel Screening Uptake	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	HSCIC
		Percentage of cancers detected at stage 1 and 2	Early Diagnosis and treatment of cancer	
	Treatment	Two Week Wait Referrals	Percentage of two week wait referrals who have been seen by a specialist within two weeks of an urgent referral by their GP for suspected cancer	Cancer Commissioning Toolkit
			Number of two week wait referrals (TWR) with cancer diagnosis	
	Outcome	Premature mortality from all cancers	Standardised rate of premature deaths (<75 years old) per 100,000 population	PHE
		Premature mortality from lung cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from breast cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from Colorectal cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Emergency admissions due to cancer	Direct standardised rate per 100,000	HES
Cardiovascular Disease	Proactive Care	NHS Health Check uptake	Cumulative % of uptake amongst eligible population	PHE
		Atrial Fibrillation	AF002: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS2 score is greater than 1), NICE 2011 menu ID: NM24	HSCIC
	Treatment	Atrial Fibrillation	AF004: In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy, NICE 2011 menu ID: NM46	HSCIC
		Coronary Heart Disease	CHD002: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	
			CHD003: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less	
			CHD005: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	
		Hypertension	HYP002: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	
	Outcome	Heart Disease and Stroke	Premature mortality, rate per 100,000	Healthier Lives, Mortality Rankings - PHE
		Stroke, emergency hospital admissions	Emergency hospital admissions for stroke, indirectly age standardised rate per 100,000, all ages	HSCIC
		Emergency admissions for Hypertension patients	Emergency hospital admissions per 100 individuals on Hypertension LTC list	Health Analytics

Primary care Indicator	Item	Performance Indicator	Description	Source
Mental health	Proactive Care	New diagnosis of depression who have had a review	DEP002: The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis, NICE 2012 menu ID: NM50	HSCIC
		Dementia diagnosis rate	The Diagnosis rate indicates the proportion of patients with dementia on a practice list or within a group who have a diagnosis of dementia. The total number from the aNDPR, and the number with a diagnosis on the QOF dementia register.	HSCIC
		Early interventions, psychosis	New cases of psychosis served by Early Interventions team, annual rate per 100,000 population	PHOF
	Treatment	Access to community mental health services by people from Black and Minority Ethnic (BME) groups	Crude rates per 100,000 population	HSCIC
		Proportion of adults in contact with secondary mental health services in paid employment	The measure (percentage of adults) is intended to measure improved employment outcomes for adults with mental health problems. Employment is a wider determinant of health and social inequalities	
		Blood pressure recorded	MH003: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17	
		Improving Access to Psychological Therapies (IAPT)- Referrals	The number of people who have been referred to IAPT for psychological therapies during reporting period.	NELFT
		Improving Access to Psychological Therapies (IAPT)- Recovery	The number of people who have completed treatment and are moving to recovery	
		Blood Glucose or HbA1c recorded	MH005: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months, NICE 2011 menu ID: NM42	HSCIC
	Outcome	Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over	Indirectly age and sex standardised ratio of unplanned readmissions to a mental health service	HSCIC
		Emergency hospital admissions: schizophrenia	Indirectly age (15-74) standardised rates	
Learning Disabilities		Ldis Health Check uptake	% of QOF recorded LD population who have had LD health check in last 12 months	Health Analytics
GP Survey	ED 1	Rating of GP giving you enough time		GPPS
		Rating of GP listening to you		
		Rating of GP explaining tests and treatments		
		Rating of GP involving you in decisions about your care		
		Rating of GP treating you with care and concern		
		Rating of nurse giving you enough time		
		Rating of nurse listening to you		
		Rating of nurse explaining tests and treatments		
		Rating of nurse involving you in decisions about your care		
		Rating of nurse treating you with care and concern		
	ED 2	Overall experience of GP surgery		GPPS
	ED 3	Overall experience of making an appointment		GPPS

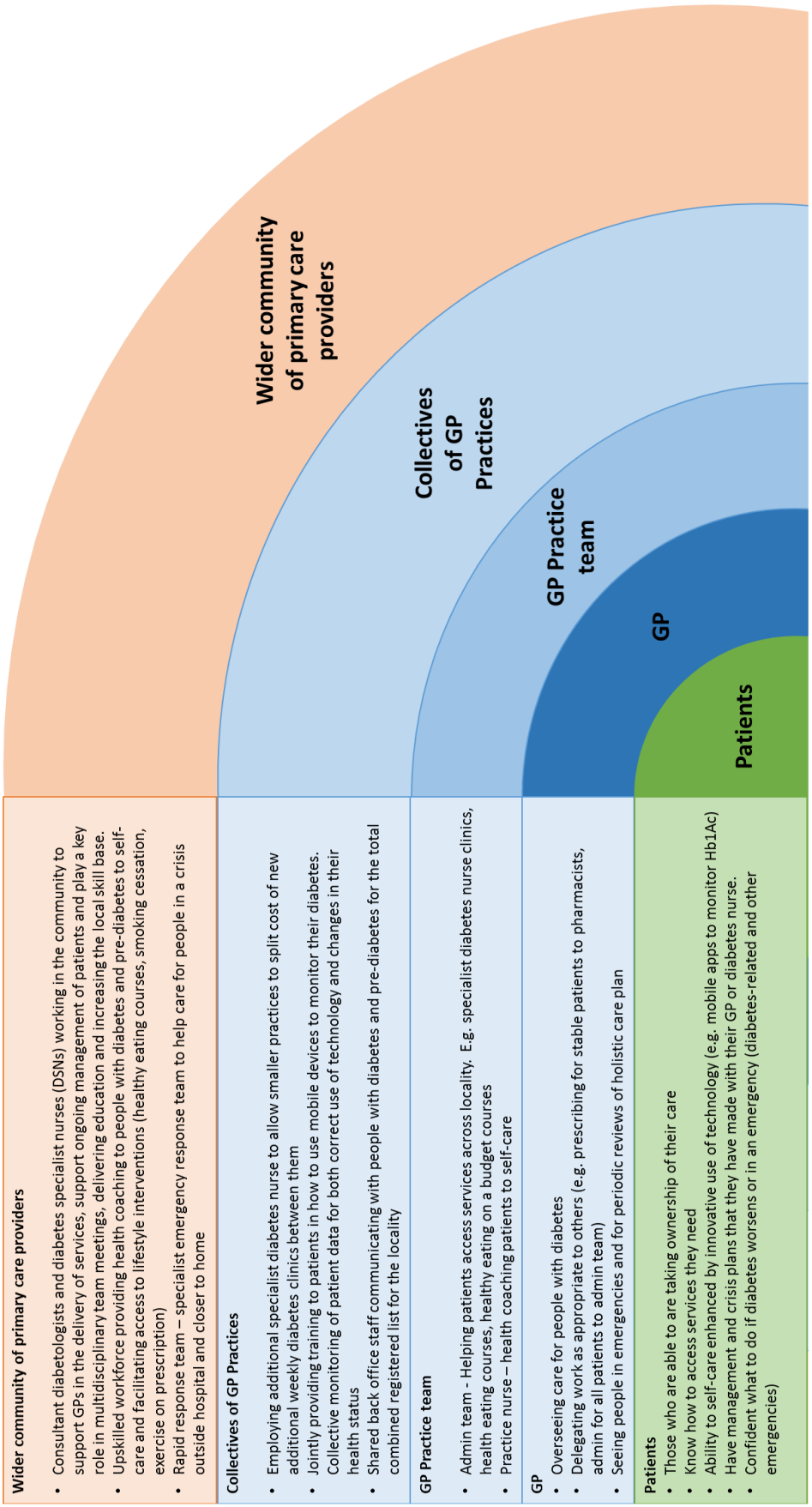
). Within this framework, locality teams will develop a shared strategy and plan to meet the needs, priorities and preferences of the population they serve. They will decide what resources will best meet local health needs, and the specific health outcomes they want to target and track.

Localised pathway design

Pathway design within each locality will be informed by BHR standards for pathways for preventative, planned, urgent and mental health care. Within these standards, localities will be supported to design the pathways that work best for their population. Pathway design at locality level will include:

- Deciding the division of responsibility for delivery of primary care services across GP practices individually, GP practices collectively and the extended team
- Thresholds and protocols for referral to, and discharge from local hospital services
- The relative proportion of GP practice appointment time to be made available for prevention, planned and unplanned care.
- How the locality will utilise the planned new urgent and emergency care ‘click, call, come in’ capacity as part of its urgent care offer
- How care across providers is joined up around the patient
- How providers all play to their strengths
- How quality is assured.

Figure 11: example of how the mix of services might be distributed across the locality team



Enablers and support

BHR CCGs will provide investment and support in the enablers of this vision for primary care-led locality working. They will:

- Provide each locality with dedicated resources to support the development of locality working.
- Identify solutions for the recruitment, retention and development of the GP workforce, as well as nursing, pharmacists and practice management. Other roles, including primary care healthcare assistants, may need to be developed.
- Develop funding and contractual arrangements for primary care and the wider system to incentivise joined-up care, prevention and avoidance of avoidable hospital admissions.
- Enable GPs and the extended primary care team to operate from fit-for-purpose premises, making best collective use of local public service estates.
- Support both patients and their care providers to be confident users of information and IT solutions that enable self-care, care scheduling, joined-up care planning and management, and safe clinical decision-making.

At the same time, the financial sustainability of the system will be enhanced through the de-duplication and appropriate automation of administrative functions, releasing more patient-facing time.

Local authority partners

- Social care services will make up a core part of locality-based teams
- Public health will contribute in a number of ways:
    - input into needs assessments for each locality
    - map the current social capital available within each locality
    - commission services that focus on prevention of ill health
    - evaluate the impact of prevention on care capacity.

Evolution of the way providers are organised and work together

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. Provision may continue in the form of an alliance of autonomous providers. Alternatively, by 2021, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider. Local authorities will have joint oversight of the evolution of the system so it continues to meet population need.

5.4 What is the vision for workforce in general practice and the locality?

Throughout our stakeholder interviews, there was a shared vision of integrated primary, community and social care working at a locality level with the patient and GP in the centre.

This strategy, therefore, makes recommendations for the primary care workforce for the first two years whilst the landscape becomes clearer with other strategies and initiatives. These recommendations will create the framework for a more engaged, mature and agile locality-based primary care team empowered to "sense and respond" in a fast-changing world.[6] This will allow benefits from working as part of BHR but will also be locally driven.

[6] Frederic Laloux: Reinventing Organizations: A Guide to Creating Organizations Inspired by the Next Stage of Human Consciousness (Nelson Parker,2014).

As the vision is very much about empowering localities to co-design and deliver locally appropriate solutions, we have set out a range of potential options proposed by stakeholders for workforce development within locality settings. Localities can choose to adopt solutions that suit their population's and workforce's needs. These are set out in Appendix D: Workforce development in primary care.

5.5 What would locality-based care mean for a GP practice in 2018?

Different ways of working will develop within each locality, but GPs will see key changes in their day to day working across Havering take place over the next two years.

1. GP practices will work more productively and free up GP time to provide and oversee patient care.

I'm a Practice Manger for quite a big practice (nine FTE GPs). I did a bit of work with one of our partners looking at the activity in our practice using a tool developed by the RCGP, which we found out about at one of the locality support sessions. I found the tool really helpful, not least because while everyone at our practice feels stretched and that things could be more efficient, they all have different opinions about what the problem is! Having the information about how we were spending our time in black and white made it a lot easier to agree what we should focus on, and ways we could change it.

We realised that a lot of GP time was spent on patients that could be seen by someone else in the practice. For example, GPs were doing routine blood pressure checks that could have been done by the nurse; hospital referral chasing that could have been done by reception; repeat prescriptions could have been done by our admin team. We talked through a couple of options that we'd gone through at a locality workshop and decided we would try 'process triage' at our practice. That means getting reception to ask what appointments were for and directing the routine checks, repeat prescriptions, coughs etc to alternative members of staff or the pharmacy. Of course, if a patient doesn't want to say why they want a GP appointment, we don't push them to say, it's just where they are happy to give that information. It's also not infallible; sometimes patients do reveal they have another problem which needs GP attention during their nurse appointment. Even taking all that into account, we managed to move about 10-15% of our GPs' workload onto other members of the practice team. That frees up about a day a week of GP time that can be spent on more valuable work.

2. Collaborative working between GP practices in localities and with the extended team of care professional will become established, raising quality and increasing capacity for locality care services and helping reduce the cost of administration.

I'm a partner in a small practice and, like many practices, we have a lot of patients with diabetes. A specialist nurse helping to care for these patients would really improve these peoples' care, but we don't have the resources to employ a full-time specialist nurse, and have never been able to recruit one on a part-time basis. Because the practices in our locality have all outsourced our payroll and HR through the same company, it's been easy to join up with two other small practices to create a full-time role for a specialist diabetes nurse that we share between us. We share the cost of her salary, and all our patients get the benefit of specialist nursing. Our nurse likes the variety and was attracted by the full time job close to home. Our practices are close together so it's similar for her in terms of travel, and she's never working too far away from her son's nursery either.

We don't just outsource as a locality though; we also share work between our existing staff. We realised there are a lot of tasks that we didn't want to outsource, but that didn't

make sense for every practice to do its own. Our practice managers have divided up this work we all do between them and now focus each team on doing one thing (e.g. call-recall) really well for the whole locality.

3. Clear boundaries between primary care and acute hospitals, with good handovers between teams.

I used to spend hours chasing up information about my patients that had been discharged from hospital, making sure I knew what care needed to be in place and that it was happening. It was very often reactive, non-medical work, that was draining and frustrating. Having better information flows with our local hospital has improved things a lot. Joined-up IT means I have much more of the information I need to manage patients post-discharge. Reducing the administrative burden associated with discharged patients means I have more time to focus on planned care. For example, working on emergency plans with those patients who are likely to require acute care when their condition deteriorates. By having those plans in place with patients, and other services they will need, we can make the transition between primary and secondary care much better for those patients.

4. A programme will be put in place to recruit, develop and retain a primary care workforce suited to delivery in a place-based model in Havering.

After years of trying, six months ago I finally recruited a new salaried GP to my practice and it's made a huge difference. Before she started I'd been reliant on locums and working myself into the ground. I used to regularly think to myself 'I'm a GP in my prime, I'm highly skilled, do I really want to do this for another 20 years when I could have a much, much nicer life in Australia?!'. Having another full time GP that's committed to the practice and the patients has really helped take some of that pressure off.

I think the recent changes have helped make our borough an attractive option for newly qualified GPs, when they wouldn't have considered it a few years ago. Now we're getting a reputation as the top place in London for innovation, what with the Vanguard and work on integration. She wanted to work somewhere where she would definitely be developed, on top of getting experience in all the multiprofessional working. It also helps that the CCG have got a bit slicker at marketing the area - good house prices compared to the rest of London and so on – as well as the work we do.

5. Increasingly, reliable IT solutions will enable joined-up patient care and the automation of administrative tasks, and locality-based providers will adopt and use them with confidence.

I knew that joined-up IT would release a significant amount of time that my receptionists used to spend printing and scanning paper documents. What I hadn't really expected was the difference it's made in terms of building trust in my colleagues outside my practice, and the benefits that has brought me in my job as a GP. It's not just that I started to build relationships with them in joint IT training sessions, or during Skype MDT meetings. Having shared records where we can access the information we need means I can easily see what community nursing, pharmacies, social care etc are doing to care for my patients. For example, if a patient needs a home visit after coming out of hospital, I can

see when it's happened, what the outcome was and who is doing what. I don't have to hunt for that information, or call to double-check. It's just there. It means that I can really focus on what I need to do as a doctor for my patients, keep an overview of their care, but not feel like I have to do everything myself to be sure it will get done.

5.6 What would be the benefits of locality-based care for patients?

Across primary care there will be an overall improvement in quality of primary care in Havering, and a reduction in the variation of quality between GP practices. Patients will benefit from care that is more proactive, accessible and coordinated, as out outlined in the patient offer of the strategic commissioning framework. Their experience will be of an integrated service that supports and improves their health and wellbeing, enhances their ability to self-care, increases health literacy, and keeps people healthy. Primary care will be personalised, responsive, timely and accessible, and provided in a way that is both patient-centred and coordinated.

Practices across Havering will show improvement in the quality of treatment for key cancer, COPD, diabetes, mental health and patient satisfaction indicators (including four patient access indicators), as measured by progress against baseline in the primary care transformation dashboard (Appendix C: Primary care transformation dashboard indicators

Primary care Indicator	Item	Performance Indicator	Description	Source
Diabetes	Proactive Care	Diabetic retinal screening uptake	The proportion of those offered diabetic eye screening who attend a digital screening event	
	Treatment	% Blood pressure of 140/80 mmHg or less	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.	
		% Cholesterol of 5 mmol/l or less	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	
		% HbA1c is less than 59 mmol/mol	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months.	
		% of newly diagnosed referred to education programme	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	
	Outcome	Admissions due to diabetes	Rate per 1,000 population aged 17+ years	HSCIC
		Preventable sight loss - diabetic eye disease	New Certifications of Visual Impairment (CVI) due to diabetic eye disease aged 12+, rate per 100,000 population. The numerator counts for this indicator includes sight loss due to diabetic eye disease as the main cause or if no main cause as a contributory cause. (These are not counts of diabetics with visual impairments due to any cause)	PHE
		Emergency hospital admissions: diabetic ketoacidosis and coma	Emergency hospital admissions: diabetic ketoacidosis and coma, indirectly age standardised rate per 100,000 persons	HSCIC
		Years of life lost due to mortality, males	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, males	
		Years of life lost due to mortality, females	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, females	
		Diabetic foot amputation	No. of hospital admissions per 100,000 population related to diabetic amputations	SUS/HES
COPD	Proactive Care	Smoking cessation uptake	Crude rate of successful four week quitters per 100,000 population aged 16+ years	PHE
	Treatment	Bronchodilator spirometry	COPD002: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	HSCIC
		Health care review	COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months	
		Smokers with COPD diagnosis	% of patients referred to stop smoking clinic with denominator as total number of smokers with COPD diagnosis	Health Analytics
		Patients with MRC 3 and above	The % of patients with MRC score 3-5 referred for pulmonary rehabilitation / total number of patients with MRC 3 and above	
		COPD with self management plan	% of patients with severe or very severe Copd who have self management plan/ total number of patients with severe or very severe COPD	
		Smoking prevalence	Percentage of COPD patients who are recorded as currently smoking	Health Analytics
		COPD severity	Mild COPD, confirmed COPD patients with latest predicted FEV1 ≥80%	
			Moderate COPD, confirmed COPD patients with latest predicted FEV1 ≥50% <80%	
			Severe COPD, confirmed COPD patients with latest predicted FEV1 ≥30% <50%	
			Very severe COPD, confirmed COPD patients with latest predicted FEV1 <30%	
	Outcome	Emergency Admissions due to COPD	Rate per 100 patients on the disease register	HSCIC
		Under 75 years of age mortality rate from respiratory conditions considered to be preventable	Age-standardised rate of mortality considered preventable from respiratory disease in those aged <75 per 100,000 population	PHOF
Cancer	Proactive Care	Bowel Screening Uptake	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	HSCIC
		Percentage of cancers detected at stage 1 and 2	Early Diagnosis and treatment of cancer	
	Treatment	Two Week Wait Referrals	Percentage of two week wait referrals who have been seen by a specialist within two weeks of an urgent referral by their GP for suspected cancer	Cancer Commissioning Toolkit
			Number of two week wait referrals (TWR) with cancer diagnosis	
	Outcome	Premature mortality from all cancers	Standardised rate of premature deaths (<75 years old) per 100,000 population	PHE
		Premature mortality from lung cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from breast cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from Colorectal cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Emergency admissions due to cancer	Direct standardised rate per 100,000	HES
Cardiovascular Disease	Proactive Care	NHS Health Check uptake	Cumulative % of uptake amongst eligible population	PHE
		Atrial Fibrillation	AF002: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS2 score is greater than 1), NICE 2011 menu ID: NM24	HSCIC
	Treatment	Atrial Fibrillation	AF004: In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy, NICE 2011 menu ID: NM46	HSCIC
		Coronary Heart Disease	CHD002: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	
			CHD003: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less	
			CHD005: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	
		Hypertension	HYP002: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	
	Outcome	Heart Disease and Stroke	Premature mortality, rate per 100,000	Healthier Lives, Mortality Rankings - PHE
		Stroke, emergency hospital admissions	Emergency hospital admissions for stroke, indirectly age standardised rate per 100,000, all ages	HSCIC
		Emergency admissions for Hypertension patients	Emergency hospital admissions per 100 individuals on Hypertension LTC list	Health Analytics

Primary care Indicator	Item	Performance Indicator	Description	Source
Mental health	Proactive Care	New diagnosis of depression who have had a review	DEP002: The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis, NICE 2012 menu ID: NM50	HSCIC
		Dementia diagnosis rate	The Diagnosis rate indicates the proportion of patients with dementia on a practice list or within a group who have a diagnosis of dementia. The total number from the aNDPR, and the number with a diagnosis on the QOF dementia register.	HSCIC
		Early interventions, psychosis	New cases of psychosis served by Early Interventions team, annual rate per 100,000 population	PHOF
	Treatment	Access to community mental health services by people from Black and Minority Ethnic (BME) groups	Crude rates per 100,000 population	HSCIC
		Proportion of adults in contact with secondary mental health services in paid employment	The measure (percentage of adults) is intended to measure improved employment outcomes for adults with mental health problems. Employment is a wider determinant of health and social inequalities	
		Blood pressure recorded	MH003: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17	
		Improving Access to Psychological Therapies (IAPT)- Referrals	The number of people who have been referred to IAPT for psychological therapies during reporting period.	NELFT
		Improving Access to Psychological Therapies (IAPT)- Recovery	The number of people who have completed treatment and are moving to recovery	
		Blood Glucose or HbA1c recorded	MH005: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months, NICE 2011 menu ID: NM42	HSCIC
	Outcome	Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over	Indirectly age and sex standardised ratio of unplanned readmissions to a mental health service	HSCIC
		Emergency hospital admissions: schizophrenia	Indirectly age (15-74) standardised rates	
Learning Disabilities		Ldis Health Check uptake	% of QOF recorded LD population who have had LD health check in last 12 months	Health Analytics
GP Survey	ED 1	Rating of GP giving you enough time		GPPS
		Rating of GP listening to you		
		Rating of GP explaining tests and treatments		
		Rating of GP involving you in decisions about your care		
		Rating of GP treating you with care and concern		
		Rating of nurse giving you enough time		
		Rating of nurse listening to you		
		Rating of nurse explaining tests and treatments		
		Rating of nurse involving you in decisions about your care		
		Rating of nurse treating you with care and concern		
	ED 2	Overall experience of GP surgery		GPPS
	ED 3	Overall experience of making an appointment		GPPS

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Issues around patient access will be addressed by providing seven day primary care, with integrated IT allowing appropriate sharing of their records between services so that they receive high quality care, no matter where they are. Joined-up services and shared records will enhance patients' confidence in primary care, reduce their reliance on their GP where other professionals could help them, and reduce their frustrations around having to repeat their story to different professionals.

The locality model will also allow patients that would previously have been treated in secondary care to be treated closer to home, for example by bringing consultants out of hospitals and into community clinics hosted in hubs.

Localities will actively engage with the population they serve, with the priorities and preferences of patients feeding into the locality vision and patients involved in the co-design of services with professionals.

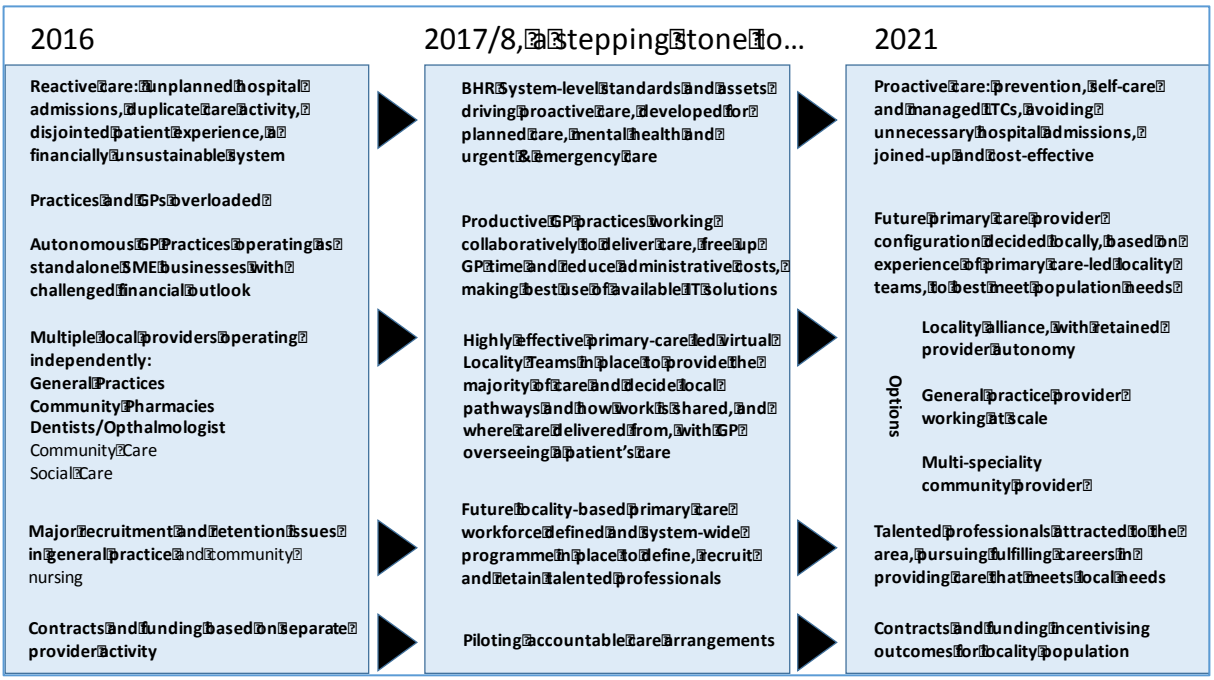
6 The transformation needed in primary care

6.1 What is the transformation needed?

Within the next five years, care for Havering residents will move from reactive to proactive, with a focus on prevention, support for self-care, active management of long term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

This will be achieved by:

- Improving the productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care
- Introducing/extending collaborative working between GP practices on care delivery and administration
- Transforming further how care is provided and organised in each locality, combining professionals in general practice with those in other primary and community-based health and social care providers into an extended team which provide a joined-up service for the majority of patients' care, with GPs overseeing care for their patients
- Developing BHR system strategies for planned care, mental health, urgent and emergency care and prevention, which establishes common standards and services for the BHR population, including defining standards regarding increasing access for those who are not currently accessing primary care.
- Locality teams working within this framework to decide local pathways, how work is shared and where care is delivered from, to best meet the needs of their population
- Locality teams having the governance, resources and business intelligence to monitor delivery, learn from experience and continuously improve their care quality and cost-effectiveness
- Locality teams are competent at capacity planning, enabling them to effectively design new ways of working taking into account how time spent on secondary prevention can free-up time currently spent on patients who have been discharged after an emergency admission.
- Developing a sustainable workforce for general practice and locality working
- Aligning contractual and funding arrangements with the achievement of population outcomes.



6.2 What will be the outcomes of the transformation?

Operating effectively, locality teams delivering the majority of care, working within the BHR standards framework, should achieve a range of outcomes:

- Reduction in unnecessary duplicate assessments and diagnostic tests
- Enhanced outcomes at individual patient and locality population levels
- Better targeting of local resource to locality health needs
- Increased support for individuals' self-management
- Enhanced life expectancy
- Better access to the right urgent care services
- Reduced unplanned A&E attendances and emergency admissions
- Reduced re-admissions to hospital.

In addition, there are outcomes specifically related to general practice:

- Enhanced patient satisfaction with the general practice service
- Continued high levels of access to GP practice services
- Proportional increase in GPs' patient-facing time
- Improved productivity and financial sustainability of GP practices
- Improved morale, teamworking and patient focus amongst locality-based staff
- Quality and financial benefits realised from investment in digital, IT and business intelligence solutions.

These will all contribute to improved outcomes for patients, which will be monitored via the primary care transformation dashboard (see Appendix C: Primary care transformation dashboard indicators

Primary care Indicator	Item	Performance Indicator	Description	Source
Diabetes	Proactive Care	Diabetic retinal screening uptake	The proportion of those offered diabetic eye screening who attend a digital screening event	
	Treatment	% Blood pressure of 140/80 mmHg or less	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.	
		% Cholesterol of 5 mmol/l or less	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	
		% HbA1c is less than 59 mmol/mol	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months.	
		% of newly diagnosed referred to education programme	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	
	Outcome	Admissions due to diabetes	Rate per 1,000 population aged 17+ years	HSCIC
		Preventable sight loss - diabetic eye disease	New Certifications of Visual Impairment (CVI) due to diabetic eye disease aged 12+, rate per 100,000 population. The numerator counts for this indicator includes sight loss due to diabetic eye disease as the main cause or if no main cause as a contributory cause. (These are not counts of diabetics with visual impairments due to any cause)	PHE
		Emergency hospital admissions: diabetic ketoacidosis and coma	Emergency hospital admissions: diabetic ketoacidosis and coma, indirectly age standardised rate per 100,000 persons	HSCIC
		Years of life lost due to mortality, males	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, males	
		Years of life lost due to mortality, females	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, females	
		Diabetic foot amputation	No. of hospital admissions per 100,000 population related to diabetic amputations	SUS/HES
COPD	Proactive Care	Smoking cessation uptake	Crude rate of successful four week quitters per 100,000 population aged 16+ years	PHE
	Treatment	Bronchodilator spirometry	COPD002: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	HSCIC
		Health care review	COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months	
		Smokers with COPD diagnosis	% of patients referred to stop smoking clinic with denominator as total number of smokers with COPD diagnosis	Health Analytics
		Patients with MRC 3 and above	The % of patients with MRC score 3-5 referred for pulmonary rehabilitation / total number of patients with MRC 3 and above	
		COPD with self management plan	% of patients with severe or very severe Copd who have self management plan/ total number of patients with severe or very severe COPD	
		Smoking prevalence	Percentage of COPD patients who are recorded as currently smoking	Health Analytics
		COPD severity	Mild COPD, confirmed COPD patients with latest predicted FEV1 ≥80%	
			Moderate COPD, confirmed COPD patients with latest predicted FEV1 ≥50% <80%	
			Severe COPD, confirmed COPD patients with latest predicted FEV1 ≥30% <50%	
			Very severe COPD, confirmed COPD patients with latest predicted FEV1 <30%	
	Outcome	Emergency Admissions due to COPD	Rate per 100 patients on the disease register	HSCIC
		Under 75 years of age mortality rate from respiratory conditions considered to be preventable	Age-standardised rate of mortality considered preventable from respiratory disease in those aged <75 per 100,000 population	PHOF
Cancer	Proactive Care	Bowel Screening Uptake	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	HSCIC
		Percentage of cancers detected at stage 1 and 2	Early Diagnosis and treatment of cancer	
	Treatment	Two Week Wait Referrals	Percentage of two week wait referrals who have been seen by a specialist within two weeks of an urgent referral by their GP for suspected cancer	Cancer Commissioning Toolkit
			Number of two week wait referrals (TWR) with cancer diagnosis	
	Outcome	Premature mortality from all cancers	Standardised rate of premature deaths (<75 years old) per 100,000 population	PHE
		Premature mortality from lung cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from breast cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from Colorectal cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Emergency admissions due to cancer	Direct standardised rate per 100,000	HES
Cardiovascular Disease	Proactive Care	NHS Health Check uptake	Cumulative % of uptake amongst eligible population	PHE
		Atrial Fibrillation	AF002: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS2 score is greater than 1), NICE 2011 menu ID: NM24	HSCIC
	Treatment	Atrial Fibrillation	AF004: In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy, NICE 2011 menu ID: NM46	HSCIC
		Coronary Heart Disease	CHD002: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	
			CHD003: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less	
			CHD005: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	
		Hypertension	HYP002: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	
	Outcome	Heart Disease and Stroke	Premature mortality, rate per 100,000	Healthier Lives, Mortality Rankings - PHE
		Stroke, emergency hospital admissions	Emergency hospital admissions for stroke, indirectly age standardised rate per 100,000, all ages	HSCIC
		Emergency admissions for Hypertension patients	Emergency hospital admissions per 100 individuals on Hypertension LTC list	Health Analytics

Primary care Indicator	Item	Performance Indicator	Description	Source
Mental health	Proactive Care	New diagnosis of depression who have had a review	DEP002: The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis, NICE 2012 menu ID: NM50	HSCIC
		Dementia diagnosis rate	The Diagnosis rate indicates the proportion of patients with dementia on a practice list or within a group who have a diagnosis of dementia. The total number from the aNDPR, and the number with a diagnosis on the QOF dementia register.	HSCIC
		Early interventions, psychosis	New cases of psychosis served by Early Interventions team, annual rate per 100,000 population	PHOF
	Treatment	Access to community mental health services by people from Black and Minority Ethnic (BME) groups	Crude rates per 100,000 population	HSCIC
		Proportion of adults in contact with secondary mental health services in paid employment	The measure (percentage of adults) is intended to measure improved employment outcomes for adults with mental health problems. Employment is a wider determinant of health and social inequalities	
		Blood pressure recorded	MH003: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17	
		Improving Access to Psychological Therapies (IAPT)- Referrals	The number of people who have been referred to IAPT for psychological therapies during reporting period.	NELFT
		Improving Access to Psychological Therapies (IAPT)- Recovery	The number of people who have completed treatment and are moving to recovery	
		Blood Glucose or HbA1c recorded	MH005: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months, NICE 2011 menu ID: NM42	HSCIC
	Outcome	Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over	Indirectly age and sex standardised ratio of unplanned readmissions to a mental health service	HSCIC
		Emergency hospital admissions: schizophrenia	Indirectly age (15-74) standardised rates	
Learning Disabilities		Ldis Health Check uptake	% of QOF recorded LD population who have had LD health check in last 12 months	Health Analytics
GP Survey	ED 1	Rating of GP giving you enough time		GPPS
		Rating of GP listening to you		
		Rating of GP explaining tests and treatments		
		Rating of GP involving you in decisions about your care		
		Rating of GP treating you with care and concern		
		Rating of nurse giving you enough time		
		Rating of nurse listening to you		
		Rating of nurse explaining tests and treatments		
		Rating of nurse involving you in decisions about your care		
		Rating of nurse treating you with care and concern		
	ED 2	Overall experience of GP surgery		GPPS
	ED 3	Overall experience of making an appointment		GPPS

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6.3 How will Implementation of the transformation agenda be organised?

The transformation agenda above is multi-dimensional and, as shown in the table below, will be led from locality teams with support from a primary care transformation programme (PCTP) and adjacent planned care, mental health and urgent and emergency care transformation programmes, all at BHR system level.

Transformation theme	Vehicle
Improving the productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care	PCTP
Introducing/extending collaborative working between GP practices on care delivery and administration	PCTP
Transforming further how care is provided and organised in each locality, combining professionals in general practice with those in other primary and community-based health and social care providers into an extended team which provide a joined-up service for the majority of patients' care, with GPs overseeing care for their patients	PCTP
Developing BHR system strategies for planned care, mental health, urgent and emergency care and prevention, which establishes common standards and services for the BHR population	Adjacent BHR transformation programmes
Extending access to urgent care services	Urgent and emergency care programme

Locality teams working within this framework to decide local pathways, how work is shared and where care is delivered from, to best meet the needs of their population	Localities, with BHR adjacent programme input and PCTP organisational development support for first cycle
Locality teams having the governance, resources and business intelligence to monitor delivery, learn from experience and continuously improve their care quality and cost-effectiveness	PCTP
Developing a sustainable workforce for general practice and locality working	BHR System/ CEPN/ Care City
Aligning contractual and funding arrangements with the achievement of population outcomes.	ACO Programme

The primary care transformation programme itself will be primarily about provider development – strengthening individual practices, progressing collaborative working amongst GP practices in localities and developing extended locality teams, bringing together GPs with all local health and social care professionals to provide the majority of care for patients. To bring this to life and establish a learning culture, the approach is to draw on the CCG's strategies for planned, mental health and urgent and emergency care, and identify specific local schemes which can be used to inform development of collaborative governance and working arrangements in localities and as a proving ground in localities, ensuring they are wholly grounded in the business of local providers and the care needs of local people.

The PCTP will be directed by the Clinical Director with a portfolio for primary care and the BHR Director of Primary Care Transformation, and governed by the primary care transformation programme board who:

- Provide system wide leadership and accountability for the transformation of primary care in BHR
- Recommend the priorities for primary care strategy to the Governing Bodies of BHR CCGs and the respective Health and Wellbeing Boards
- Oversee implementation of the strategic commissioning framework for primary care transformation in London.

A programme management office (PMO) will operate at BHR system level to ensure the four BHR transformation programmes are coordinated and aligned so that localities are enabled to deliver the outcomes set out above.

6.4 Transformation plan

6.4.1 Five-year programme

Phase one	Establish effective localities, founded on productive general practice, to provide the majority of patient care	April 2016 to September 2017
Phase two	Localities deliver care to meet local needs, and line with BHR standards, and continue to evolve through learning and trial new contractual and funding arrangements	April 2017 to April 2021
Phase three	general practice and locality provider configuration, evolves where appropriate from virtual team to	April 2018 to April 2021

	alternative provider form	

6.4.2 Phase one objectives and plan

The provider development work associated with improved productivity and the design and mobilisation of collaborative general practice and locality working needs to be undertaken with strong drive but at a measured pace to ensure the work is clinically led, that participating clinicians and care workers buy in, that professional relationships form sustainably and there is the opportunity to learn from experience and adapt the model accordingly.

The implementation will need to involve a collaborative partnership between the centralised BHR/CCG team and teams in each locality. A key requirement of the new model is that the ways of working and approach within each local area should be designed by the teams working within that area. There are however some key attributes that will need to be present in all models and additionally there are synergies and benefits that can be delivered through an understanding of the models under development in all localities, which would not be identified and exploited through a purely devolved implementation approach.

The objective is that locality teams should be working at full capacity and across the full scope of primary, community and social care by September 2018.

Second-level objectives to achieve this are set out in the table below.

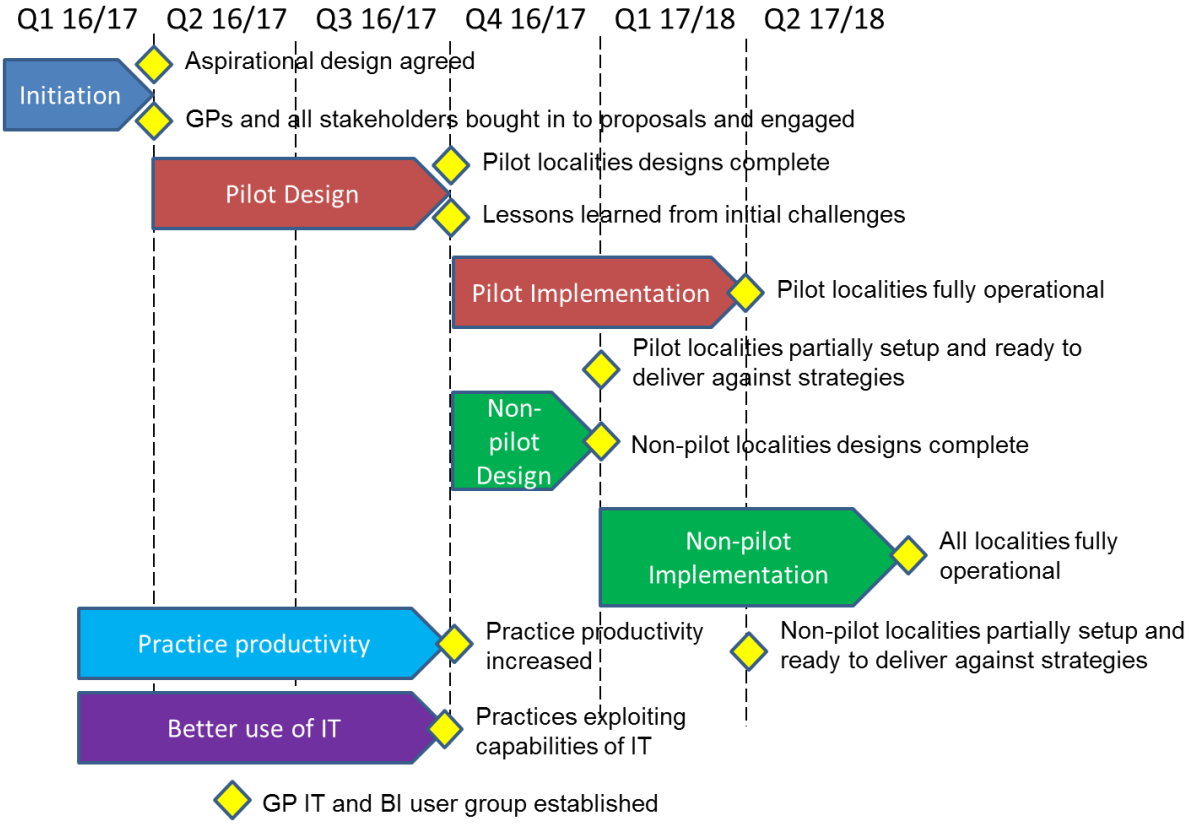
Objectives for primary care transformation phase one	
Provider development: **Practice productivity, collaborative working and locality team development**	• GPs are able to, and effective in, providing appropriate oversight for all of a patient's care • Individual GP practices are effective in managing their workload and focusing GP time where it adds most value • GP practices are clear what IT and digital solutions are available to improve productivity, have implemented them and realised the associated benefits • In each locality, each GP practice is clear on what primary care services it delivers and effective at delegating responsibility for other primary care services to other providers • Members of extended primary care teams in each locality have formed trusted working relationships with colleagues serving the same cohort of patients • Locality teams are clear what IT and digital solutions are available to enable interoperability, effective collaboration and a joined-up patient experience, have implemented them and realised the associated benefits.
Quality	• Individual GP practices sustainably meet and exceed quality standards set out in NHS England Strategic Commissioning Framework for primary care and show progress against baseline in the primary care transformation dashboard.
Locality Pathways	• Arrangements are in place and used for locality pathways to be jointly designed by a cross-section of patients, GPs and other members of the locality team • Arrangements and protocol are in place whereby locality teams work with the BHR planned care, mental health and urgent and emergency care programme to agree mutual expectations for service design, capacity assumptions and outcomes and to communicate progress,

	issues and learning • Each locality has developed and implemented a holistic plan for prevention, including the upskilling of clinicians to coach for health and the organisation of screening and immunisation services • Each locality has pathways for frail elderly patients and for those with multiple co-morbidities • Each locality has determined how the CCG's 'Click, Call, Come In' urgent care solution will be combined with urgent appointments in GP practices to provide an unplanned care service for the local population. They will have a clear plan for implementing this • Each locality has worked with Barts Health and/or BHRUT to develop and implement a full set of protocols for referral to hospital and discharge.
Governance, Intelligence and Learning	• Governance and management arrangements are established for collaborative working in general practice • Governance and management arrangements are established for locality working • Business intelligence arrangements are in place and used actively to monitor operational activity across each locality and to monitor the achievement of outcomes • Protected time is available and used by GPs and fellow locality team members to learn and develop together • Successes are identified, shared and celebrated.

While some work has been done in Havering to establish a GP federation, full implementation of the vision will require a significant change from current ways of working, and therefore it is proposed to start with a pilot. One locality will lead the way for Havering with the designs for the other localities not being started until that for the pilot locality has been completed. This will enable lessons learned from the pilot to be incorporated in the designs and planning for the other localities.

To minimise risk and allow greater chance of success, robust project and programme management arrangements will be put in place and localities will receive significant support from BHR CCGs. This is not to take away from the responsibilities and ownership of teams in localities, but to support them in the design and implementation of change.

Figure 12: key milestones for phase one



6.4.3 Programme for 2016/7

6.4.3.1 Initiation phase

An initiation phase is required to undertake the following tasks:

- Creation of a set of design principles against which all locality models should be designed. These will be based on the King's Fund: 10 principles to guide the development of systems of care in the NHS[7]
- Development of the framework of outcomes that all locality models will need to deliver as a minimum in addition to their locally identified outcomes
- Development of a business case for implementation of the new model articulating the case (costs and benefits) at all levels – system and borough, locality, GP practice
- Agreement of resources needed for implementation and how these resources will be identified
- Definition of each locality area and agreement of these, including development of locality profiles to enable localities to prioritise and plan around the needs of their populations
- Identification of the pilot locality and working with them to mobilise the project to design their new model
- Communications and engagement to gain buy-in and support from all parties across Havering who need to be involved in the design and implementation of the new model.

[7] *Place-based systems of care: A way forward for the NHS in England*. Chris Ham and Hugh Alderwick (2015) The King's Fund.

6.4.3.2 Practice productivity

A workstream will be initiated to help GP practices increase their productivity. This will be delivered through a series of workshops teaching skills and using real-life data from GPs to drive improvement. These workshops will cover:

- Theory and methods of demand and capacity modelling to support analysis of their own practices, e.g. the RCGP's *third available appointment*[8]
- Sharing modelling findings and selection of interventions to trial within their practices
- Sharing of impact and learning from changes made within practices.

This additional independent workstream will involve working with all members of the extended primary care team to help everyone understand the capabilities and make use of their existing IT.

6.4.3.3 Design phase – collaborative working in general practice and across localities

Each locality will design its new operating model, with the pilot locality taking the lead and lessons learned from the pilot feeding into the design of the other localities. This will include work on (but not limited to) the following areas:

- Processes and pathways - including business models of operation for all different areas of the operation and functions (both front and back office), the operational costs of these and the expected performance levels
- Organisation and people – the organisation structure, staffing levels, roles, skill requirements, culture etc
- Estates – how the different accommodation across the locality will be utilised to support the new operating model
- Governance – how the locality will be governed and managed
- Use of IT and information (the designs for IT and information governance will be completed at a system level to achieve economies of scale and consistency across localities).

To develop this new operating model, practitioners from different disciplines will need to come together and will follow a co-design approach. This approach will play a part in developing the organisation and creating trust and relationships between the different groups of professionals within a locality.

The implementation plan to be followed through the next phase of the implementation will also be developed. This will include in detail all of the activity that will need to be completed to move from a design on paper into live operations.

At a system level designs for IT and information governance will be completed incorporating the requirements of the emerging locality models. There will also need to be a re-design of the CCG and system-level support and management arrangements so that they are aligned with and fit-for-purpose with the new locality ways of working. This level will also have responsibility for oversight of the designs that are in development to recognise synergies and opportunities for efficiency and collaboration between localities.

6.4.3.4 Implementation phase

This phase of activity will include all the activity needed to move from a design on paper into live operations. The detail of this cannot be known until the completion of the design phase; however it will touch on all areas of the new operating model.

[8] http://www.rcgp.org.uk/rcgp-nations/rcgp-scotland/treating-access.aspx

7 Risks and assumptions

Risks

- Insufficient grassroots buy-in from GPs and other primary care professionals
- Insufficient capacity within general practice to participate
- Dependencies on other projects – IT, workforce, estates
- The pace of change demanded vs the time necessary to develop localities sustainably
- Compatibility of the strategy with main providers' strategies
- Insufficient investment in the resources to enable the programme to succeed.

Assumptions

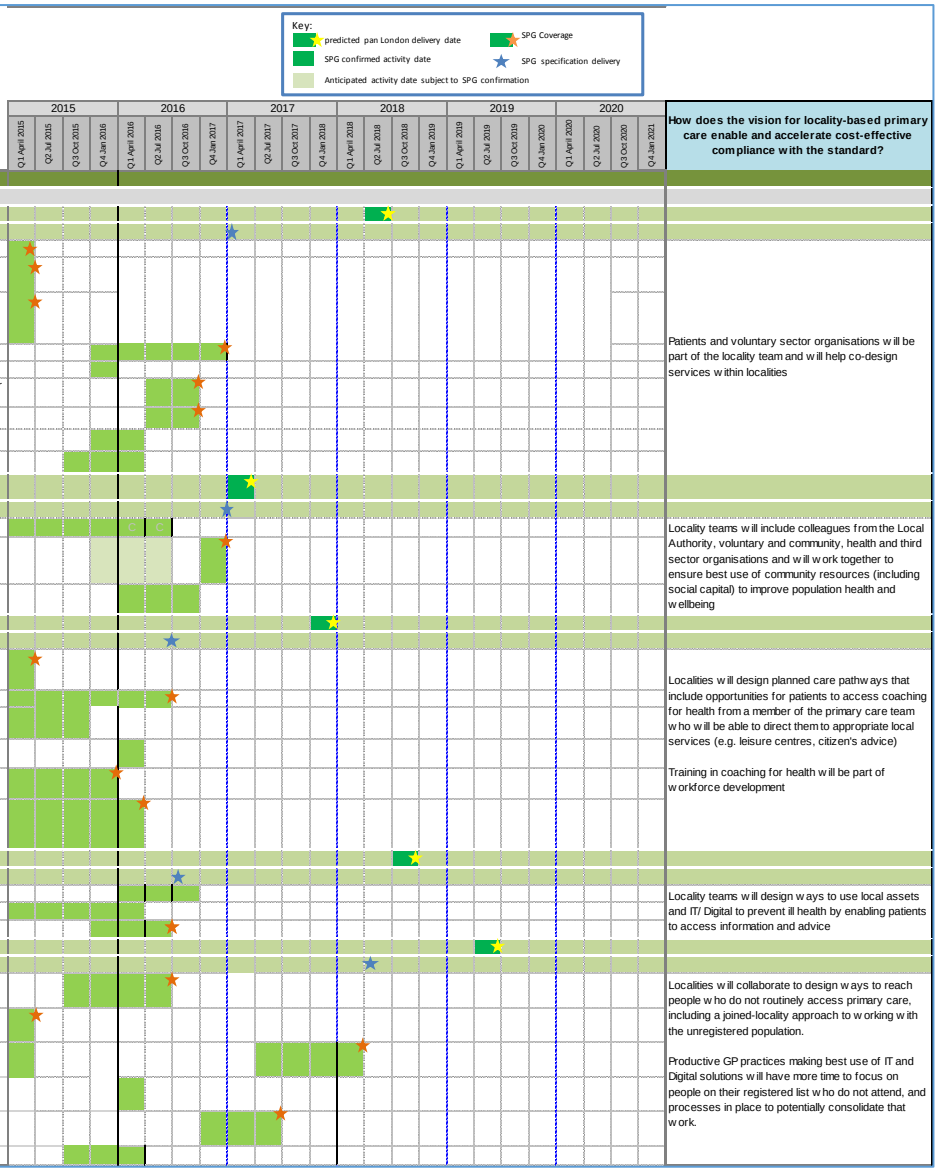
- Improving team working in localities will release significant quality and productivity benefits
- GP practices are receptive to opportunities to improve their practices
- This strategy will have top-level support regardless of whether the ACO proceeds
- Interoperable IT agenda sufficiently advanced to enable localities to provide continuity of care to patients.

Appendix A: Strategic Commissioning Framework delivery plan

Transforming Primary Care
Live SPG delivery plan

Spec	Examples of supporting activity	How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?
	Accessible Care	
A1	**Patient Choice**	
	BHR	
	Pilot access hubs as part of PMCF in place across BHR	
	Accessible care scheme to be fully defined	
	Patient record sharing functionality in place	Patient choice built into the urgent care offer designed by localities which will work alongside the BHR-wide click, call, come-in urgent and emergency care offer
	Patient records are shared across the federations and are available at the access hubs	
	Access hubs advertised via practice websites and A&E	
	Roll out of additional access hub in B&D	
	MiDoS available to patients with local asset database content loaded into the directory	Non-urgent care offering patient choice in all pathways as part of locality designs.
	Nuffield trust evaluation of success of access hub following completion of pilot stage	
A2	**Contacting the practice**	
	BHR	
	Practices have online functionality through a module within their clinical systems	
	Training of telephone triage/consultation to the federations pilot practices in BHR	
	Practice 'patient on-line' functionality in place and training delivered to allow practices to offer online availability	
	Pilot of telephone triage/consultation (12 practices)	Productive GP practices will make best use of IT and Digital solutions to simplify access and actively promote online services
	Development of BC to enhance telephone triage/consultation through a central (BHR wide) call centre	
	Federations to apply for CEPN funding to rollout telephone triage/consultation training post pilot	
	Further pilot of telephone consultations through central call centres subject to pilot success	
	Rollout of telephone consultations through central call centres subject to BC and pilot success	
A3	**Routine opening hours**	
	BHR	
	No current plans to change contracted routine opening hours, Saturday opening to be achieved via access hubs	
	Pilot access hubs as part of PMCF in place across BHR	
	Patient record sharing functionality in place	Localities will collaborate to deliver pre-bookable routine appointments with a primary health care professional within routine hours using all resources available within the locality including hubs
	Patient records are shared across the federations and are available at the access hubs	
	Access hubs advertised via practice websites and A&E	
	CCG to review requirement to open in-hours as part of federation planned and unplanned care pathway redesign	
A4	**Extended opening hours**	
	BHR	
	Pilot access hubs as part of PMCF in place across BHR, providing 6.30 - 10pm weekdays, and 12-6pm weekends	
	Walk in centres currently providing 8 - 8pm	
	Additional services providing extended opening (FOPAL, CTT team, ICM, intensive rehab service, enhanced psychiatric liaison)	
	Patient record sharing functionality in place	
	Patient records are shared across the federations and are available at the access hubs	Localities will collaborate to deliver pre-bookable and unscheduled appointments within extended hours using all resources available within the locality including hubs
	Access hubs advertised via practice websites and A&E	
	Roll out of additional access hub in B&D	
	Evaluate success of access hub following completion of pilot stage	
	Health1000 pilot in place providing care to patients with 5+ LTC who registered on the Health1000 list. Extended access is provided through on-call within the GP practice	
	Improve alignment between access hub and services such as GP OOH and WIC through CCGs urgent care strategy workplan	
A5	**Same day access**	
	BHR	
	Pilot access hubs as part of PMCF in place across BHR	
	Additional services providing extended opening (FOPAL, enhanced psychiatric liaison). CTT/IRS in place on a pilot basis pending formal establishment	
	Pilot of telephone triage/consultation (12 practices)	Effective use of the wider primary care team and utilising technology to improve access will create capacity that will allow patients who want to be seen the same day at their practice within routine hours.
	Development of BC to enhance telephone triage/consultation through a central (BHR wide) call centre	
	Federations to apply for CEPN funding to rollout telephone triage/consultation training post pilot	
	Further pilot of telephone consultations through central call centres - subject to BC and pilot success	
A6	**Urgent and Emergency Care**	
	BHR	
	CTT work across BHR and in Queens A&E	
	Urgent Care Centres in Queens & King George's run by GPs in place	
	Streamline access to services within A&E (CTT, ambulatory care, enhanced psychiatric liaison and FOPAL)	Localities will collaborate to design local urgent and emergency care offers that work alongside the click, call, come-in urgent care pathway
	Urgent care pathway development to be launched at 1 July conference	
	Urgent care strategy - workplan with milestones to be developed following conference)	
	Federation to develop business case to review new ways of working with in-hours and out of hours	
A7	**Continuity of Care**	
	BHR	
	Integrated case management (ICM) in place	
	Mainstream intermediate care pilot services (CTT-ICM/IRS)	
	Record sharing is available for MDTs with the ICM	
	Joint Assessment and Discharge team established in BHRUT to improve discharge and care planning for complex patients	In locality-based care all patients will have a named GP for care continuity and coordination, who effectively oversees the appropriate delivery of the care plan by the wider primary care team
	Unplanned admissions DES in place - optimising coordinated managed care for the most vulnerable patients in their homes	
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.	
	Patient records are shared across the federations and are available at the access hubs	

Transforming Primary Care
Live SPG delivery plan



		How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?
	Proactive Care	
	Delivery of specifications	
P1	**Co-Design**	
	BHR	
	Focus groups led by the federations with Healthwatch representation	Patients and voluntary sector organisations will be part of the locality team and will help co-design services within localities
	H1000 model developed with UCLP and patient groups linked into the design process	
	Development of the new intermediate care model (ICM, CTT, IRS) followed extensive engagement with stakeholders to determine co-design the model	
	Focus group to review central call centre initiative across the federations	
	CEPN to review workforce planning and training needs	
	Map dementia services across health, social care and voluntary sector in Havering	
	Map health services for over 75s to review the pathway alignment	
	Test impact of new operational resilience schemes	
	Development of the primary care strategy	
P2	**Developing assets and resources for improving health and wellbeing**	
	BHR	
	MiDoS developed to include local asset database	Locality teams will include colleagues from the Local Authority, voluntary and community, health and third sector organisations and will work together to ensure best use of community resources (including social capital) to improve population health and wellbeing
	Work with the local council, community and voluntary services to input into MiDoS (this is dependant on LA sign-up which is being sought through ICC and ICSG)	
	MiDoS used by ICM to locate support and care services close to peoples' homes	
P3	**Personal conversations focussed on an individual's health goals**	
	BHR	
	Risk stratification is in place to support targetting the top 1-3% for conversations	Localities will design planned care pathways that include opportunities for patients to access coaching for health from a member of the primary care team who will be able to direct them to appropriate local services (e.g. leisure centres, citizen's advice) Training in coaching for health will be part of workforce development
	Integrated case management (ICM) in place to manage the top 1%	
	Care co-ordination and Frailty training being commissioned as part of the Locality Training Fund for 2014/15	
	Review whether to roll out intervention pharmacists pilot as a QIPP scheme	
	Health1000 pilot in place providing tailored care to patients with 5+ LTC who registered on the Health1000 list.	
	Everyone counts initiative - GP Practices have been allocated CCG funds based on their list sizes with which to devise new and innovative services to support the >75s within their practice population.	
P4	**Health and wellbeing liaison and information**	
	BHR	
	MiDoS developed to include local asset database	Locality teams will design ways to use local assets and IT/ Digital to prevent ill health by enabling patients to access information and advice
	Clinicians use MiDoS	
	Patients are able to use MiDoS	
P5	**Patients not currently accessing primary care services**	
	BHR	
	Patients encouraged at walk in centres & UCC to register at a practice	Localities will collaborate to design ways to reach people who do not routinely access primary care, including a joined-locality approach to working with the unregistered population. Productive GP practices making best use of IT and Digital solutions will have more time to focus on people on their registered list who do not attend, and processes in place to potentially consolidate that work.
	Homeless patients encouraged to register at walk in centre co-located practices	
	CCG and LA to develop and implement plans to work with local schools and business around healty life styles	
	Review London Commissioned services around homeless practice/provision	
	Primary care strategy developing additional plans to target vulnerable groups	
	Queens A&E to review patients with 10+ attendances in 12 months	

Transforming Primary Care
Live SPG delivery plan

		2015				2016				2017				2018				2019				2020				How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?
		Q1 April 2015	Q2 Jul 2015	Q3 Oct 2015	Q4 Jan 2016	Q1 April 2016	Q2 Jul 2016	Q3 Oct 2016	Q4 Jan 2017	Q1 April 2017	Q2 Jul 2017	Q3 Oct 2017	Q4 Jan 2018	Q1 April 2018	Q2 Jul 2018	Q3 Oct 2018	Q4 Jan 2019	Q1 April 2019	Q2 Jul 2019	Q3 Oct 2019	Q4 Jan 2020	Q1 April 2020	Q2 Jul 2020	Q3 Oct 2020	Q4 Jan 2021	
Coordinated Care																										
	Delivery of specifications																									
C1	**Case finding and review**																									
	BHR																									
	Regular engagement with the Integrated Care Coalition (ICC)																									
	Risk stratification is in place to support targetting the top 1-3% for conversations																									Localities will collaborate to allow the efficient and effective stratification of their combined registered lists to allow identification of individuals who would benefit from coordinated care and a joint approach to working with those patients.
	Integrated case management (ICM) in place to manage the top 1%																									
	Queens A&E to review patients with 10+ attendances in 12 months																									
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list. Patients targeted through a tailored risk stratification tool focussed on patients with more than 5 LTC's.																									
C2	**Named professional**																									
	BHR																									
	Integrated Case Management in place																									Localities will design pathways for planned care that allow patient-focused, coordinated care, overseen effectively by their named GP and making effective use of the wider primary care team. This will be be enabled through shared patient records using interoperable IT systems that enhance the ability for work to be shared across the team, remove duplication of work and free GP time for planned care.
	All patients included in the ICM model have a named professional																									
	Risk stratification tools used to identify further patients at risk																									
	Unplanned admissions DES in place - optimising coordinated managed care for the most vulnerable patients in their homes																									
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.																									
C3	**Care Planning**																									
	BHR																									
	Integrated Case Management model in place																									
	Care plans developed and managed with the MDTs in ICM																									
	Patient records shared across MDTs within the ICM																									
	Data governance for patient records to enable Sharing within ICM																									
	Pilot Skype MDT with acute geriatrician in Havering																									
	Joint Assessment and Discharge team in BHR University Hospital Trust to improve discharge and care planning for complex patients																									Interoperable IT systems will allow patients' care plans to be effectively shared across the primary care so that they can access the appropriate care in all settings.
	Care co-ordination training commissioned as part of the Locality Training Fund for 2014/15																									
	Patient records shared across access hubs & federations																									
	Shared care summary being developed to pull key clinical information from sources to aid clinical decision making and improve patient experience																									
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.																									
C4	**Patients supported to manage their health and wellbeing**																									
	BHR																									
	Integrated Case Management model in place																									
	Care plans developed and managed with the MDTs in ICM																									Localities will design planned care pathways that include opportunities for patients to access coaching for health from a member of the primary care team who will be able to direct them to appropriate local services (e.g. leisure centres, citizen's advice) Training in coaching for health will be part of workforce development Locality teams will design ways to use local assets and IT/ Digital to prevent ill health by enabling patients to access information and advice
	Patient records shared across MDTs within the ICM																									
	Care co-ordination training commissioned as part of the Locality Training Fund for 2014/15 (training includes cognitive behavioural techniques to support patients to self-care).																									
	Patient records are shared across the federations and are available at the access hubs																									
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.																									
	System wide training / specific workshops through the CEPN e.g. EOL - difficult conversations for secondary care clinicians																									
C5	**Multi-disciplinary working**																									
	BHR																									
	Integrated Case Management model in place																									
	Care plans developed and managed with the MDTs in ICM																									Localities will design pathways for planned care that allow patient-focused, coordinated care, overseen effectively by their named GP and making effective use of the wider primary care team. This will be be enabled through shared patient records using interoperable IT systems that enhance the ability for work to be shared across the team, remove duplication of work and free GP time for planned care.
	Patient records shared across MDTs within the ICM																									
	Patient records are shared across the federations and are available at the access hubs																									
	Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list. Team consists of dedicated: Geriatrician, social workder, physiotherapist, occupational therapist, nurses, GP and key workers																									
	System wide training / specific workshops through the CEPN e.g. EOL - difficult conversations for secondary care clinicians																									

Appendix B: Current clusters

Appendix C: Primary care transformation dashboard indicators

Primary care Indicator	Item	Performance Indicator	Description	Source
Diabetes	Proactive Care	Diabetic retinal screening uptake	The proportion of those offered diabetic eye screening who attend a digital screening event	
	Treatment	% Blood pressure of 140/80 mmHg or less	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.	
		% Cholesterol of 5 mmol/l or less	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	
		% HbA1c is less than 59 mmol/mol	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months.	
		% of newly diagnosed referred to education programme	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	
	Outcome	Admissions due to diabetes	Rate per 1,000 population aged 17+ years	HSCIC
		Preventable sight loss - diabetic eye disease	New Certifications of Visual Impairment (CVI) due to diabetic eye disease aged 12+, rate per 100,000 population. The numerator counts for this indicator includes sight loss due to diabetic eye disease as the main cause or if no main cause as a contributory cause. (These are not counts of diabetics with visual impairments due to any cause)	PHE
		Emergency hospital admissions: diabetic ketoacidosis and coma	Emergency hospital admissions: diabetic ketoacidosis and coma, indirectly age standardised rate per 100,000 persons	HSCIC
		Years of life lost due to mortality, males	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, males	
		Years of life lost due to mortality, females	Years of life lost due to mortality from diabetes: directly standardised rate per 10,000 European Standard Population, 1-74 years, 3-year average, females	
		Diabetic foot amputation	No. of hospital admissions per 100,000 population related to diabetic amputations	SUS/HES
COPD	Proactive Care	Smoking cessation uptake	Crude rate of successful four week quitters per 100,000 population aged 16+ years	PHE
	Treatment	Bronchodilator spirometry	COPD002: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	HSCIC
		Health care review	COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months	
		Smokers with COPD diagnosis	% of patients referred to stop smoking clinic with denominator as total number of smokers with COPD diagnosis	Health Analytics
		Patients with MRC 3 and above	The % of patients with MRC score 3-5 referred for pulmonary rehabilitation / total number of patients with MRC 3 and above	
		COPD with self management plan	% of patients with severe or very severe Copd who have self management plan/ total number of patients with severe or very severe COPD	
		Smoking prevalence	Percentage of COPD patients who are recorded as currently smoking	Health Analytics
		COPD severity	Mild COPD, confirmed COPD patients with latest predicted FEV1 ≥80%	
			Moderate COPD, confirmed COPD patients with latest predicted FEV1 ≥50% <80%	
			Severe COPD, confirmed COPD patients with latest predicted FEV1 ≥30% <50%	
			Very severe COPD, confirmed COPD patients with latest predicted FEV1 <30%	
	Outcome	Emergency Admissions due to COPD	Rate per 100 patients on the disease register	HSCIC
		Under 75 years of age mortality rate from respiratory conditions considered to be preventable	Age-standardised rate of mortality considered preventable from respiratory disease in those aged <75 per 100,000 population	PHOF
Cancer	Proactive Care	Bowel Screening Uptake	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	HSCIC
		Percentage of cancers detected at stage 1 and 2	Early Diagnosis and treatment of cancer	
	Treatment	Two Week Wait Referrals	Percentage of two week wait referrals who have been seen by a specialist within two weeks of an urgent referral by their GP for suspected cancer	Cancer Commissioning Toolkit
			Number of two week wait referrals (TWR) with cancer diagnosis	
	Outcome	Premature mortality from all cancers	Standardised rate of premature deaths (<75 years old) per 100,000 population	PHE
		Premature mortality from lung cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from breast cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Premature mortality from Colorectal cancer	Standardised rate of premature deaths (<75 years old) per 100,000 population	
		Emergency admissions due to cancer	Direct standardised rate per 100,000	HES
Cardiovascular Disease	Proactive Care	NHS Health Check uptake	Cumulative % of uptake amongst eligible population	PHE
		Atrial Fibrillation	AF002: The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS2 score is greater than 1), NICE 2011 menu ID: NM24	HSCIC
	Treatment	Atrial Fibrillation	AF004: In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy, NICE 2011 menu ID: NM46	HSCIC
		Coronary Heart Disease	CHD002: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	
			CHD003: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less	
			CHD005: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	
		Hypertension	HYP002: The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less	
	Outcome	Heart Disease and Stroke	Premature mortality, rate per 100,000	Healthier Lives, Mortality Rankings - PHE
		Stroke, emergency hospital admissions	Emergency hospital admissions for stroke, indirectly age standardised rate per 100,000, all ages	HSCIC
		Emergency admissions for Hypertension patients	Emergency hospital admissions per 100 individuals on Hypertension LTC list	Health Analytics

Primary care Indicator	Item	Performance Indicator	Description	Source
Mental health	Proactive Care	New diagnosis of depression who have had a review	DEP002: The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 35 days after the date of diagnosis, NICE 2012 menu ID: NM50	HSCIC
		Dementia diagnosis rate	The Diagnosis rate indicates the proportion of patients with dementia on a practice list or within a group who have a diagnosis of dementia. The total number from the aNDPR, and the number with a diagnosis on the QOF dementia register.	HSCIC
		Early interventions, psychosis	New cases of psychosis served by Early Interventions team, annual rate per 100,000 population	PHOF
	Treatment	Access to community mental health services by people from Black and Minority Ethnic (BME) groups	Crude rates per 100,000 population	HSCIC
		Proportion of adults in contact with secondary mental health services in paid employment	The measure (percentage of adults) is intended to measure improved employment outcomes for adults with mental health problems. Employment is a wider determinant of health and social inequalities	
		Blood pressure recorded	MH003: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17	
		Improving Access to Psychological Therapies (IAPT)- Referrals	The number of people who have been referred to IAPT for psychological therapies during reporting period.	NELFT
		Improving Access to Psychological Therapies (IAPT)- Recovery	The number of people who have completed treatment and are moving to recovery	
		Blood Glucose or HbA1c recorded	MH005: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months, NICE 2011 menu ID: NM42	HSCIC
	Outcome	Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over	Indirectly age and sex standardised ratio of unplanned readmissions to a mental health service	HSCIC
		Emergency hospital admissions: schizophrenia	Indirectly age (15-74) standardised rates	
Learning Disabilities		Ldis Health Check uptake	% of QOF recorded LD population who have had LD health check in last 12 months	Health Analytics
GP Survey	ED 1	Rating of GP giving you enough time		GPPS
		Rating of GP listening to you		
		Rating of GP explaining tests and treatments		
		Rating of GP involving you in decisions about your care		
		Rating of GP treating you with care and concern		
		Rating of nurse giving you enough time		
		Rating of nurse listening to you		
		Rating of nurse explaining tests and treatments		
		Rating of nurse involving you in decisions about your care		
		Rating of nurse treating you with care and concern		
	ED 2	Overall experience of GP surgery		GPPS
	ED 3	Overall experience of making an appointment		GPPS

Appendix D: Workforce development in primary care

Solutions offered include using a greater skill mix of practitioners in primary care, offering a seamless integrated service with clear opportunities for career development for all members of the primary health care team.

Specific ideas for different members of the primary health care team are summarised below.

GPs

Attract young GPs	**Fourth year fellowships in Havering for GP trainees.** **Provide "home" (perhaps a BHR-wide employment agency) with identity, peers and support for ongoing learning, personal and professional development, parental leave, study leave, management opportunities to lead small projects and research opportunities, whether a partner, salaried or long term locum** **Plurality of provider models to include independent contractors, federations, chambers, super practices, and increased salaried working, to achieve economies of scale in management, infrastructure, and clinical resources, and to provide wider ranges of patient services.** **Become exemplars of multiprofessional working**
Attract returning GPs	By marketing package for returning GPs: ongoing support for personal and professional development, family friendly approach, parental leave and carers leave offer, easy to access Ofsted reports, Rightmove and Zoopla. Clarity on career path and ongoing development.
Attract international GPs	From Eastern Europe (via the IMG scheme) GP profile to match changing population profile. Offer IMGs a registrar-level salary while training (as they do in East Midlands) to enable senior experienced GPs to afford to come to London.
Promote sustainable model of General Practice	To promote fulfilling, rewarding and sustainable career. Become known as *the* place in London for excellent integrated care with primary, community and social care building on innovation of the Vanguard and ACO. Time to see patients and deal with issues properly Interesting variety of patients Integrated locality model of working with joint learning and co-development of services with other providers and patients. Identify, prioritise, implement and evaluate local models of QI initiatives Social prescribing Pharmacist prescribing Support older GPs with retirement planning
Market Havering as a place to live and work	Effective HASS in Havering with S75 agreements in place between LA and community provider Affordable housing (for London) Good schools Range of career development pathways identified
Opportunities in Havering as a GP	To develop as clinical leader - locality lead, clinical lead, committee chair, CCG board member To develop as educator and trainer

	To develop as a researcher (with Care City, BHRUT, UCL Partners)
Ongoing learning and development	Protected time for learning with peers both in general practice and with rest of the primary health care team Training in coaching for health Training in solution focused conversations Continue to develop skills e.g. joint injections, update on dermatology
Use workforce modelling data	Available from April 2016 from NHS England (London) to identify existing workforce. Match to current and future models of care, identify gaps and plan to address
Identify areas to prioritise and work on collaboratively	Form localities/communities of practice All GPs part of geographical network (including salaried and long term locums) Find ways to innovate/incentivise joint working e.g. • top slice secondary care services and provide network enhanced services • One HV for network of GP practices • Share services across network of practices e.g. phlebotomy, direct access physio, counsellor • Develop care pathways across the locality • Share back office functions e.g one book keeper, IT support, HR support • Autonomy to use delegated budget at locality level to meet the needs of the local population

Pharmacists

Upskill community pharmacists	In behaviour change Train as health coaches
Develop role of practice pharmacists	Medicines reconciliation Medication review Prescription management Prescription safety/concordance Acute common conditions Chronic disease management Practice performance Primary care practice research
Develop role of pharmacists to work in urgent care settings	Training in coaching for health Training in common clinical conditions Independent prescriber
Upskill to become independent prescribers	For urgent prescriptions as well as LTCs Career path to develop expertise in diabetes, asthma etc
recruit clinical pharmacists	Have “off the shelf” Havering offer, ready to advertise for new clinical pharmacists (London-wide initiative)
Recruit local pharmacists	Through local pharmacy apprentice scheme
Ongoing joint learning	With GPs and other members of the primary health care team Career paths identified
Family friendly	
Introduce Pharmacy First scheme	Free OTC medicines for patients on benefits

Nurses

Attract young nurses	Multi-agency training: acute, primary and community Key worker housing
Retain nurses	Career development pathways identified Ability to work in primary care and community care

	Supported by AHPs Part of a learning community of practice Key worker housing
Recruit international nurses	
Train nurse prescribers	To work with patients with LTC
Train nurse practitioners	To work with patients with LTC Career path e.g. community matron, specialist practice nurse
Family friendly	
Lifelong learning	Ongoing joint learning with GPs, pharmacists and other members of the primary and community health team
Optimise use of pool of nursing resource across a locality	Using practice nurses and community nurses, with links to midwives, health visitors and school nurses.
Develop specialist nurses for non-registered population	e.g HV for the homeless develop working relationship with third sector e.g. AA, narcotics anonymous

Allied Health Professionals

Recruit physician's assistants Physician associates support doctors in the diagnosis and management of patients. They are trained to perform a number of roles including: • taking medical histories • performing examinations • diagnosing illnesses • analysing test results • developing management plans. They work under the direct supervision of a doctor	London-wide scheme to train physicians assistants Have a Havering offer "on the shelf" ready to advertise when PAs graduate See patients for same-day appointments Review test results Booked appointments with patients with LTC Home visits Cryotherapy Teaching Clinical audit Maintaining practice registers Supervision of HCAs Make Havering primary care an attractive place to work by offering apprenticeships (PAs have to find £9,000 tuition fees and loans and grants are not available) NB PAs cannot gain prescribing rights as do not have registration. This is being addressed nationally.
Train generic staff to work across health and social care	Care City to provide mechanism to train generic health and social care workers to work across health and social care. Care City to host peer networks, provide mentorship and facilitate apprenticeships CEPN are developing care navigators
Family friendly	To recruit and retain
Lifelong learning	Framework for ongoing personal and professional development Career paths identified

Admin and clerical

Practice Managers Board	Could be developed to • help PMs share work between them (QOF, call-recall) • develop areas of personal expertise/sub specialisation • develop career path
Receptionists	Develop reception staff skills in signposting Career path as care navigators
Family friendly	

Lifelong learning	Opportunities to continue to learn and develop Career paths mapped out and supported