Partnership in Developing Primary Care

Dr Caz Sayer, Camden CCG Chair

Working with the people of Camden to achieve the best health for all
The Health and Social Care Act 2012 created new statutory organisations - Clinical Commissioning Groups (CCGs). These are:

1. Led by clinicians
2. Responsible for commissioning community and most hospital services

Camden CCG:
- Inner-city London borough
- Population of around 250,000
- Health inequalities linked to deprivation
Camden story – why action is needed

NEEDS
• Life expectancy gap
  11.6 years in men (CVD/Cancer)
• 2nd prevalence of SMI in England
• High proportion 19-40's
• Access to urgent care
• Poor outcomes in under 5’s
• By 2017 over 85s up 35%

UTILISATION
• Demand increasing greater than population growth
  e.g. in excess of 87,000 A+E attendances per year for Camden Registered patients

OUTCOMES
National Outcomes Framework
• Above-average results for preventing people dying prematurely
• Below-average for helping people recover and live with illness

VALUE
• 2nd highest spend per weighted population of London CCGs with variable outcomes
• Spend on acute highest in London
• Primary care spend among lowest in London but good outcomes
• Mental health spend highest in London
• Community care spend average

1. RFH
2. UCLH
3. GP Practice (37)
4. CNWL
5. CIFT
6. Camden Council
7. 3rd Sector
(CVD/Cancer)

9
8
7
6
5
4
3
2
1

1. RFH
2. UCLH
3. GP Practice (37)
4. CNWL
5. CIFT
6. Camden Council
7. 3rd Sector
(CVD/Cancer)
The Role of General practice in the English National Health Service (NHS)

General practice (the ‘jewel in the crown of the NHS’) contributes to the high ranking of the NHS in international comparisons:

1. **At level of individual patients**
   - Care for people presenting with common conditions
   - Continuity of care
   - Whole-person care

2. **At a population level**
   - Serves defined local communities
   - Focus on prevention and health education

3. **At a health system level**
   - Delivers efficient care by managing clinical risk
   - Facilitates appropriate access to specialist services and investigations
   - Advocates for patients where necessary

(Martin Marshall, NEJM 2015)

**In addition:**

- >90% consultations take place in general practices
- High levels of support and trust from the public
- Uniquely placed to improve patient outcomes
What has changed since the NHS started?

**Additional responsibilities**
- Demands/expectations - 75% increase in demand for consultations 1995-2009 (Kings Fund 2013)
- In Camden **94.5** appointments/1000 population/week (70 RCGP gold standard)
- **58,590** requests for GP appointments in 4 week data collection period (CSI)
- Variability in quality, outcomes and access between practices
- Reduced levels of resources
- Technological advances – new ways to access health advice/support (**97%** electronic records in primary care)

**Changing work-force**
- 2013-**29%** generalists, **71%** specialists
- Many part-time
- **15%** decrease in applications for GP training, increasing early retirement
- Balancing the demands for access and unscheduled care - in Camden **85%** urgent care delivered by general practice
- Increasing work-load as care shifts to the community - **40%** increase in GP work-load compared with 1995 (ONS)

**Changing demographics**
- **35%** increase in >85yr olds by 2017
- 1 in 7 population in Camden with a long-term condition
- Co-ordinating care for increasingly complex patients
- Limited support from other parts of the system
- Medical advances - diagnostics, treatments etc.

**Reduced levels of resources**
- Overall spending on NHS up 18% since 2005 but proportion allocated to general practice reduced by **8%** in same period
- General practice in 1948 = **33%** total budget of NHS-In 2013/14 = **8%**
Pressures on Primary Care

Camden CCG GP Workforce

Practitioners
(excluding retainers & registrars)

The September 2014 figures showed Camden CCG had:

- 168 Full Time Equivalent GPs
- This was a headcount of 174
  - 152 are Full time
  - 110.75\, Full time
  - 11\, 0.5 - 0.75

There are more females than males in the workforce.

A relatively young workforce comparatively

17.8\% of the Camden GPs are under 35, compared with 15.6\% London wide and 12.8\% nationally.

21.3\% of the Camden GPs are over 55 years of age, this is lower than England and London.
Key partnerships to support and develop primary care

1. Commissioners support to primary care:

- Understanding and supporting the practices with data through peer-review, data collection to see what is happening in the system e.g. peer review and score-cards
- Incentives e.g. Innovations fund
- Camden Clinical Assessment Service-support to GPs re evidence-based pathways and referral thresholds
- GP web-site- pathways, referral support tools, pod-casts
- GP education events- all clinicians in practice, mandatory training and evidence-based new services
- Approx. GP 20 Clinical Leads working with practices
- Medicines management support
Key partnerships to support and develop primary care

2. Through partnerships with other health and Social care providers
   • Community and acute providers to support management of those with Long-term conditions
   • Community, acute and social care to support management of the frail and elderly
   • Mental health services - the Team around the Practice

3. Between practices themselves developing a GP federation - that can support each other through shared work-force and resources to reduce variability between practices and ensure access to enhanced primary care for all patients

4. With patients and users - ’consumer’ focus around innovations/technology/choice (disruptive innovation)
Healthcare contacts for children and young people

The chart visualises Children and Young People’s contacts with different aspects of acute care, Primary Care and CNWL.

A large number of contacts for children and young people are with CNWL and Primary Care.
Urgent Care – ‘in-hours’ 9th September 2013

- Home
  - 253,000 Registered population
  - 1,632 Calls for same day GP apt

- A&E
  - 180 Attendances
  - 166 Self referral, emergency services etc.
  - 14 From GP
    - 1 (1%) Band 1
    - 17 (9%) Band 2
    - 65 (36%) Band 3
    - 62 (34%) Band 4
    - 35 (19%) Band 5

- Admissions from A&E
  - 31 Admissions from A&E (17% of attendances)

- GP
  - 952 (58%) Same day face to face
  - 363 (22%) Called back, no apt
  - 230 (14%) Subsequent day apt
  - 87 (5%) Not accommodated with apt or call

Home

Who attend A&E?

<table>
<thead>
<tr>
<th>Age</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>11.2%</td>
<td>11.1%</td>
<td>11.1%</td>
<td>10.0%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Under 18</td>
<td>21.6%</td>
<td>21.2%</td>
<td>21.0%</td>
<td>19.7%</td>
<td>20.9%</td>
</tr>
<tr>
<td>18 - 40 years</td>
<td>38.9%</td>
<td>38.7%</td>
<td>39.0%</td>
<td>40.0%</td>
<td>39.1%</td>
</tr>
<tr>
<td>40 - 65 years</td>
<td>23.7%</td>
<td>24.1%</td>
<td>24.1%</td>
<td>24.6%</td>
<td>24.1%</td>
</tr>
<tr>
<td>Over 65</td>
<td>15.8%</td>
<td>16.1%</td>
<td>15.9%</td>
<td>15.7%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Over 75</td>
<td>9.1%</td>
<td>9.3%</td>
<td>9.1%</td>
<td>9.1%</td>
<td>9.2%</td>
</tr>
</tbody>
</table>

Please note that the percentages will not total 100 as over 75 is a subset of the over 65s and the under 5s a subset of the under 18s.

Under 5s account for 10.9% of A&E Attendances in the last 4 years.

A 5% reduction in attendances for the under 5’s would see a reduction of approximately 465 attendances per year.

Although the A&E attendance profile is comparable to the demographic profile, it could be said that it should not be comparable as acuity changes with age. A 25-29 year old has a 10% chance of attendance becoming admission whilst a 65-69 year old has a 30% chance.

There has been very slight shifts in the percentages seen in each age category but no significant shifts.

There is also a large cohort for 18 to 36 year olds. It would be interesting to identify whether this is access to primary care or perception of access.
Holborn Medical Centre Appointment Triage Innovation Bid

We aimed to improve our on the day patient access by offering a GP-led telephone triage system.

We also aimed to help manage all requests for urgent and routine GP appointments, and to facilitate a reduction in A&E attendances for conditions that could be managed in primary care.

- The triage doctor was available to respond to immediate queries and requests as the patients dialled in.
- Patients were invited immediately into surgery or signposted to a more appropriate service.
- ‘On the day’ access (either telephone or face to face) was greatly improved.
- We also facilitated a second GP session for patients that needed to be seen on the day, and were booked in by the telephone triage GP.

We analysed our patient experience with a questionnaire, where the main results can be seen in the graph on the right. We also looked at the satisfaction level of our patients in regards to our new triage system. This was an average of 4 out of 5 (where 1 is poor and 5 is excellent).

The graph above shows that there was a reduction in our patient A&E attendances, despite an increase in list size.

We achieved:
- Increased patient satisfaction
- Increased staff satisfaction
- A streamlined appointment and triage system
- Reduced A&E admissions
- Reduction of safety concerns
- Value for money benefits

Bar graph to show the difference in the overall number of visits to A&E and the number of patients who visited A&E in March 2013 compared with March 2014

Bar graph demonstrating patient experience with the appointment triage system during this pilot
Holborn Medical Centre Appointment Triage Innovation Bid

### Practice - COPD and Hypertension Indicators

**Monthly Trend**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>List Size</td>
<td>14,323</td>
<td>14,293</td>
<td>14,291</td>
<td>14,332</td>
<td>14,287</td>
<td>13,561</td>
<td>14,357</td>
<td>14,313</td>
<td>14,330</td>
<td>14,344</td>
<td>14,339</td>
<td>14,501</td>
<td>14,560</td>
<td>14,239</td>
<td>14,259</td>
<td>14,250</td>
<td>14,249</td>
</tr>
<tr>
<td>Numbers of people on practice COPD register</td>
<td>159</td>
<td>156</td>
<td>159</td>
<td>160</td>
<td>162</td>
<td>154</td>
<td>161</td>
<td>161</td>
<td>165</td>
<td>174</td>
<td>172</td>
<td>173</td>
<td>179</td>
<td>180</td>
<td>181</td>
<td>180</td>
<td>182</td>
</tr>
<tr>
<td>Percentage of population in practice COPD register</td>
<td>1.11%</td>
<td>1.09%</td>
<td>1.11%</td>
<td>1.12%</td>
<td>1.13%</td>
<td>1.11%</td>
<td>1.12%</td>
<td>1.12%</td>
<td>1.15%</td>
<td>1.21%</td>
<td>1.20%</td>
<td>1.20%</td>
<td>1.24%</td>
<td>1.26%</td>
<td>1.27%</td>
<td>1.26%</td>
<td>1.23%</td>
</tr>
<tr>
<td>Numbers of people meeting NICE criteria who have had handed sputum/symptom screening</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Numbers of people with COPD in high risk groups who have had COPD review on local template</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Numbers of people on COPD register who are confirmed by 4 week quitters (or change in status measured by CO monitoring)?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number with (High Risk) COPD referred to pulmonary rehabilitation</td>
<td>29</td>
<td>24</td>
<td>28</td>
<td>30</td>
<td>31</td>
<td>32</td>
<td>36</td>
<td>38</td>
<td>41</td>
<td>44</td>
<td>43</td>
<td>45</td>
<td>47</td>
<td>52</td>
<td>52</td>
<td>55</td>
<td>56</td>
</tr>
<tr>
<td>Percentage of people with COPD who have had Flu Vaccination</td>
<td>78.4%</td>
<td>80.1%</td>
<td>81.8%</td>
<td>85.6%</td>
<td>88.4%</td>
<td>87.7%</td>
<td>87.0%</td>
<td>87.0%</td>
<td>86.1%</td>
<td>85.6%</td>
<td>85.5%</td>
<td>85.5%</td>
<td>89.4%</td>
<td>86.9%</td>
<td>87.8%</td>
<td>87.8%</td>
<td>87.9%</td>
</tr>
<tr>
<td>Numbers of people on practice hypertension register</td>
<td>1,048</td>
<td>1,046</td>
<td>1,052</td>
<td>1,059</td>
<td>1,059</td>
<td>1,022</td>
<td>1,060</td>
<td>1,053</td>
<td>1,059</td>
<td>1,061</td>
<td>1,120</td>
<td>1,130</td>
<td>1,137</td>
<td>1,148</td>
<td>1,145</td>
<td>1,142</td>
<td>1,141</td>
</tr>
<tr>
<td>Percentage of population in practice Hypertension Register</td>
<td>7.32%</td>
<td>7.32%</td>
<td>7.36%</td>
<td>7.32%</td>
<td>7.41%</td>
<td>7.37%</td>
<td>7.39%</td>
<td>7.36%</td>
<td>7.39%</td>
<td>7.40%</td>
<td>7.81%</td>
<td>7.87%</td>
<td>7.91%</td>
<td>8.05%</td>
<td>8.03%</td>
<td>8.01%</td>
<td>8.01%</td>
</tr>
<tr>
<td>Numbers of people on practice hypertension register with (Lates BP 140/90 who have had 24 hour BP test (or 3 BPs)?</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>9</td>
<td>14</td>
<td>16</td>
<td>5</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Number of people on hypertension register with BP to target (under &lt; BP 140/90)</td>
<td>685</td>
<td>674</td>
<td>676</td>
<td>679</td>
<td>688</td>
<td>692</td>
<td>715</td>
<td>709</td>
<td>714</td>
<td>719</td>
<td>738</td>
<td>750</td>
<td>764</td>
<td>751</td>
<td>740</td>
<td>728</td>
<td>724</td>
</tr>
<tr>
<td>HIT.1a</td>
<td>56</td>
<td>45</td>
<td>78</td>
<td>61</td>
<td>68</td>
<td>80</td>
<td>51</td>
<td>51</td>
<td>50</td>
<td>59</td>
<td>67</td>
<td>57</td>
<td>41</td>
<td>34</td>
<td>35</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td>Number of people who’ve had home monitoring testing in accordance with local policy, whose BP is ≥ 140/90 in the last 2 yrs</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>

**At the end of February 2015,**

**Caversham group practice** has a list size of **14,249** and COPD prevalence of **1.28%** (182).

The practice has 87.91% of people with COPD who have had Flu Vaccination.

**Instructions:**

The table above shows monthly trends for the practice selected in the main dashboard. Select the Disease Area in the dropdown provided at the top right-hand corner to change the list of indicators.

The map shown on the left-hand side shows all the practices in the locality. Size of the bubble represents the indicator value relative to other practices in the locality. The Practice selected in main dashboard is highlighted on the map. Use the Indicator dropdown to select the indicator. Hover on the circles to see more details.
Camden has done well to keep the number outpatient referrals steady and its A&E attendances increasing only in line with the overall national trend. Other CCGs that have lowered their OP referrals, such as Haringey, have seen a dramatic increase in A&E attendances.
Service Model

Tier 4: Secondary Care

Tier 3: Community

Tier 2: Primary Care

Tier 1: Primary Care

Diabetes IPU
All patients with a diabetes diagnosis over 18 years registered with a Camden GP

Supporting Primary Care in Management and Care Planning

Diabetes IPU Clinical Establishment

• DSNs
• Podiatry
• Dietetics
• Psychology
• Consultant Sessions
Identifying People at Risk

**Did it work?**

### Impact in 12 months on emergency contacts (EM admissions and AE attendances)  
(LTCs + Frailty) Vs Other Conditions*

**Number of Emergency Contacts 12 months before** | **Number of Emergency Contacts 12 months after**
---|---
**LTCs and Frailty** | 2,605
**Other Conditions** | 2,775

* 'LTC & Frailty' include Patients with one or more of Diabetic medicine, CKD, COPD, CHD, Heart Failure and Frailty but do not have any other conditions.

* Other conditions include patients with one or more of conditions Asthma, Peripheral Arterial Disease, Stroke and TIA, Atrial Fibrillation', Palliative Care, Rheumatoid Arthritis, Hypothyroidism & Hypertension but do not have the five LTCs or Frailty.

<table>
<thead>
<tr>
<th>Numbers on LTC Registers</th>
<th>Date of extract</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2013</strong></td>
<td><strong>2014</strong></td>
</tr>
<tr>
<td>CKD</td>
<td>5000</td>
</tr>
<tr>
<td>COPD</td>
<td>2900</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8500</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>1400</td>
</tr>
<tr>
<td>Hypertension</td>
<td>21500</td>
</tr>
</tbody>
</table>

Nov Dec Jan Feb Mar Apr May Jun Jul Aug
Outcomes Achieved in Long Term Conditions

- **5.5** strokes prevented
- **9% increase** in people with Atrial Fibrillation started on anticoagulation medication since October 2013 (5.5 strokes prevented)
- Increased number of people with Heart Failure on evidence based medication
- **1000** more people identified with hypertension (November 13 – July 14)
- Increased proportion of people with a BP of less than 140/90
- **6.9%** improvement in the number of Diabetic patients with an HbA1C of <75mmol/mol in one year (proxy measure for improved outcomes)
- **7.4%** reduction in Diabetes admissions from April 2013-April 2014
- **16%** increase in dementia diagnosis rate in 2 years now **67%** in 13/14 with increased referrals and investment in Memory service
- **19.9%** successfully completed drug addiction treatment 13/14 (49% increase on previous year, 5%>national)
- **6%** increase access to ETOH treatment-42% increase in successful completion
Evaluation Outcomes

Underlying Assumption: Population clearly defined using Edmonton Frailty score or similar

Outcome Hierarchy for Frail Elderly:

Tier 1
- Survival

Tier 2
- Time to recovery, maintenance of return to normal activities

Tier 3
- Sustainability of recovery or health over time

Health Status Achieved or Retained
- Degree of recovery / health

Process of Recovery
- Disability of care or treatment process (e.g., treatment-related discomfort, complications, adverse effects, diagnostic errors, treatment errors)

Sustainability of Health
- Long-term consequences of therapy / lack of (e.g., care-induced illnesses)

Tier 1
- Mortality Measure: Six months might not be a good measure, but 1, 3 and/or 5 years could be a better measure for this population. Longer time periods may be less valuable. Not necessarily a single measure
- Appropriate duration for mortality measure should include durations around the current mean survival for this patient population

Tier 2
- Number of days spent at home / not spent in hospital (e.g., Proportion in (6) month period)
- Measure extent patients feel care is co-ordinated
- Measure extent patients feel they are reliant on carers or relatives over time
- Measure extent patients feel they are receiving care that is being received if there are multiple long term conditions
- Number of case load / case management referrals (e.g., post admission)

Tier 3
- Measure extent patients feel they are receiving care that is being received if there are multiple long term conditions
- Number of carers/carer hours required per (week), over time
- Number of outpatient appointments per (month/annum) over time

Caseload Specific
The chart above shows the days spent at home 6 months prior to case management and the days spent at home 6 months post case management, a T-test analysis shows that these results are statistically significant.

The reduction in acute activity following case management and review by the frailty multi-disciplinary team – is shown above right.

All patients over 60
These charts present A&E attendance and admissions trends for the CCG over 60 population.
Directly standardised percentage of people who feel supported to manage their long-term condition
GP Patient Survey (GPPS) (HSCIC)

Working with the people of Camden to achieve the best health for all
What has been achieved through partnerships?

- **Increased numbers of patients identified with disease**
- **Supported evidence-based decision-making** that has improved patient outcomes and reduced costs e.g. through better medicines management, enhanced care for those with long-term conditions and the frail elderly
- **Extended access to primary care** for both urgent and chronic disease management
- **Improved patients’ experience** of living with disease
Future State

Upscale:
1. Extend approach to all chronic conditions
2. Wider geographical coverage
3. New structures/contracts to deliver new models

Key messages:
1. Integration of the whole system to deliver improved outcomes to populations and individuals
2. Measurement and evaluation drives quality and adoption
3. The clinical case for change can happen at pace