Primary Care Access Update

Enfield Borough Partnership

Background – NCLICB Priorities for Enfield

Enfield is home to around 334,000 people. It is the northernmost London borough and has a very diverse population, with around 40% of residents coming from Black, Asian and Minority Ethnic (BAME) backgrounds. Enfield has relatively high proportions of children and young people under the age of twenty – higher than both the London and England averages.

There are a number of local health challenges and health inequalities which we are seeking to address in the borough:

- Diabetes prevalence in Enfield is the second highest of all London boroughs, and is above both the regional and England average.
- 5% of adults over 65 have been diagnosed with dementia – the highest prevalence in London, and higher than the rate for England.
- Children in Enfield are more likely to be overweight or obese than in London and England generally – the prevalence of children carrying excess weight in Year 6 is the third highest of the 32 London boroughs.
- 58% of adults in Enfield are overweight or obese as of 2019/20 – above the London average of 56%

Our key priorities as a borough partnership:

- Increasing the uptake of vaccines and immunisations (in particular childhood immunisations and flu, Covid-19 vaccinations).
- Improving mental health and wellbeing.
- Improving the health and wellbeing of children, young people and families.
- Improving access, disc.
- Discharge & crisis services.
- Developing neighbourhoods – and integrated models of care / pathways for delivery.
- Digital inclusion, and other means of addressing social isolation.
- Joining up health and care workforce development, including employment support & jobs for local people.
- Tackling inequalities – via NCL inequalities fund, other local resources (e.g. community chest fund).

Primary Care Access Highlights

Overall the number of core primary care appointments offered in NCL continued to rise (plus appointments from at scale services and winter plans) throughout autumn i.e. September – November

At the same time, NCL practices continued the overall trend of increasing the proportion of appointments delivered face to face. There is no defined optimal blend of appointment type, so this should be / is tailored to the needs of local registered populations.

This picture changed with the onset of winter (from December onwards). Trends in activity have been impacted by a highly challenging winter period with many indicators in the dashboard demonstrating a shift as measured against the autumn view. The snapshot set out in the table shows between November and December 'core' appointment numbers decreased along with the proportion of f2f appointments. The proportion of appointments delivered same day increased. It should be noted that NCL practices continue to provide a high percentage of same day appointments

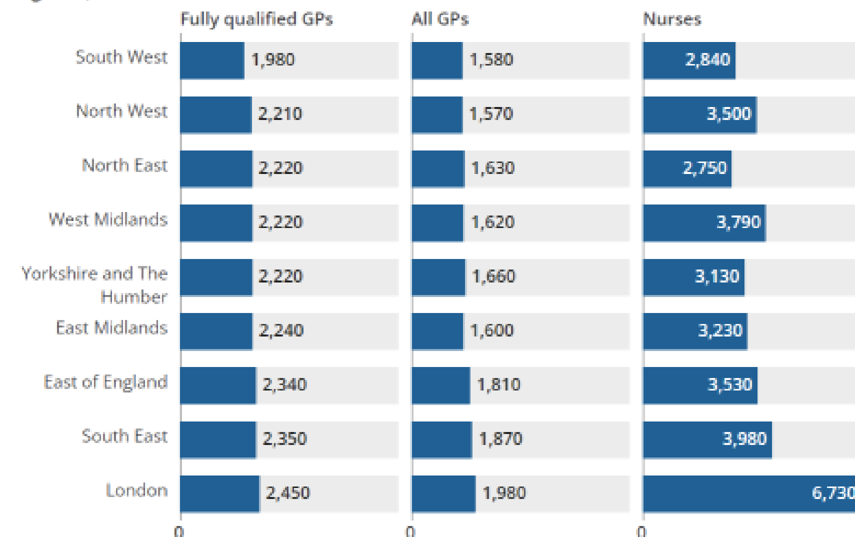
	Sep '22	Oct '22	Nov '22	Dec '22
Core primary care appointments	635,734	697,242	700,259	590,561
% face to face appointments	63%	67%	65%	56%
% same day appointments	47%	45%	48%	53%

General Practice Investment (Core & Enhanced Provision)

- Enfield's delegated budget stands at £37,791,000 for 22/23, £115.16 per weighted payment. This is largest across all 5 boroughs.
- Beyond delegated budget for core provision, Enfield invests a further approx. £10,000,000 on additional/enhanced services, namely Extended Access, Enfield Single Offer, Long Term Conditions.
- This is comparable to the investment made within other boroughs.

Workforce Challenges

- As of December 2022, there were 205 individuals (headcount) fully qualified GPs working in Enfield, with the number of GP partners declining significantly over that time.
- There are 0.44 fully qualified GPs per 1,000 patients in England – down from 0.52 in 2015. In Enfield there are 0.63 fully qualified GPs per 1,000 patients. Headcount ratio has remained static since 2015. While head counts highlight a better ratio in Enfield to England, London in general, as presented by the chart, has the largest GP to Patient ratio when observing full-time equivalent. Enfield has a further acute local challenges, that 30% of our qualified GPs are over 55. Nationally there has been signs that post covid has seen a marked increase the number of GPs leaving the profession.
- Since 2017, the number of GPs working full time hours or more in GP practice-based settings has been steadily decreasing.
- At the same time, the number of GPs choosing to work less than full-time has been climbing. This is likely because doctors are, understandably, moving towards working patterns that allow them to better control their hours and workload in order to reduce stress, ill-health and burnout and to improve work-life balance.
- Although these GPs may be working less than one FTE on paper, in reality 'part time' as a GP very often means working a number of additional unpaid hours just to get through the large numbers of appointments and essential patient follow-up (administrative) work.



Further surveying of GPs have identified a number of local issues relating to Enfield:

- An increase in the number of duplicate correspondences to General Practice. approx. 20% of all letters received are duplicate and continue to take up significant resource to manage.
- Limited access to community provision

Key Highlights

- Ensure people can more easily contact their GP practice (by phone, NHS App, NHS111 or online).
- Transfer lower acuity care away from both general practice and NHS 111 by increasing pharmacy participation in the Community Pharmacist Consultation Service.

NHS England will publish the General Practice Access Recovery Plan in the new year which will provide details of the actions needed to achieve the goals above. In addition, once the 2023/24 contract negotiations have concluded

Local Initiatives

Enfield Borough Partnership

Improve practice telephony

Getting through on the phone is fundamental to primary care access.

No.	Initiative	Description and update
i.	Move to cloud-based telephony	NCL ICB has supported the development of cloud-based telephony in practices, many practices have invested independently. A number practices have invested in new telephone systems over the past twelve to eighteen months. NCLICB is supporting a further wave of practices to move to cloud-based telephony using Winter Access Funding. Enfield has targeted the larger practices to support a migration to VOIP telephony systems. Medicus Health Partners is on target to exceed 1 million telephone calls over the year, routinely receiving more than 20,000 calls per week, around 1000 calls each day between 8:00 – 9:00. The business analytic tools are enabling practices better respond to telephone access. We anticipate only a single GP Practice will remain on an older phone solution and will migrate at the end of their existing contract
ii.	Improvements to telephone procedures	A Healthwatch report identified best practices principles that could make a difference if applied consistently across practices. These included: an automated queuing system, a message of less than a minute recorded in a human voice and a callback option for a patient who does not want to wait on the phone. Enfield is supporting the implementation of these principles.

Improve practice telephony

Getting through on the phone is fundamental to primary care access.

No.	Initiative	Description and update
iii.	Follow-through on quantitative and qualitative research	The national Ipsos-Mori survey includes a specific question on ease of getting through on the telephone and there is a correlation between high patient satisfaction on this question and overall satisfaction. In Enfield Ipsos-Mori results are reviewed at the joint Clinical Director forums, local actions are addressed at the weekly PCN liaison meetings. We encourage Practices to discuss survey results a PPGs meeting to consider different approaches to improve overall patient satisfaction of GP services.

Enhance digital access

NCLICB is taking forward a number of measures to improve digital access.

No.	Initiative	Description and update
i.	E-Consult	All practices have introduced e-consult mechanisms, with a link on their practice website. Practices have worked to embed e-consult into daily working, setting aside time to review applications made on the system. Practices will choose a new e-Consult solution from October. NCLICB is setting up a procurement exercise to identify a small number of approved providers. Between 1 April 2021 and 31 December 2021, 129,420 online consultation requests were made to practices in Enfield. Enfield had the highest uptake of Online Consultations since roll out in May 2020. e-consult have since reduced in favour of face to face provision, in line with patient preferences.
ii.	Social media improvements	Redmoor have been commissioned to train practice staff in social media training. Enfield continue to focus on retiring redundant materials on websites and any unofficial social media, improve practice websites (google translator, signposting and navigation) and develop ongoing engagement with key local media outlets. Remoor will be working with Enfield to help host Patient Participation Groups utilise closed facebook pages and improve the diversity of PPG members.
iii.	Digital appointments	Most practices provide digital appointments. There is also the option of patients sending photos to support consultation.

Enhance digital access

NCL ICB is taking forward a number of measures to improve digital access for potentially vulnerable groups.

No.	Initiative	Description and update
iv.	Digital Inclusion	Enfield is collaborating with Enfield Libraries, Primary Care will signpost patients to library services where residents can both use library devices, we are also working with library staff to help educate and training residents, where this is requested in how to access and use online solutions, such as online support and NHS toolkits such as the NHS App. We hope this can be rolled out to all libraries during 23/24, and we are also scoping how the service can support residents to bring their own devices.
v.	Remote diagnostics	NCL CCG has provided a number of blood pressure machines for practices. Supporting patients to monitor their conditions at home.
vi.	BSL translation on-line	Haringey on behalf of NCLICB has commissioned BSL translation on-line service from Language Line. This service enables patients who are deaf or hard of hearing to access appointments online and also to access same day appointments because a translator doesn’t need to be booked in advance. The CCG is intending to set up a Users Group with Language Line, looking to improve the service further. In Enfield, practices are being supported to deploy a three-way video consultation model, to mitigate the challenges with interpreters not able to attend physical GP appointments.

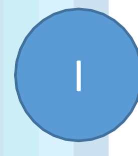
Strengthen the primary care workforce

A strong and robust primary care workforce is fundamental to providing good access. NCLICB is working on a number of measures to strengthen the primary care workforce.

No.	Initiative	Description and update
i.	Additional Roles staff	All practices are in Primary Care Networks (PCNs). PCNs then deploy additional staff; e.g. pharmacists, social link prescribers; which improves access.
ii.	Admin recruitment	Enfield and used Winter Access Funding to develop an admin recruitment programme. New staff will be recruited, supported through an induction programme and then work in a practice in East Haringey or East Enfield.
iii.	Laptops for admin staff	Both boroughs will use Winter Access Funding to buy laptops for administrative staff to work from home.
iv.	Staff resilience and comms	Training hub is running a training programme for staff on managing difficult conversations. In addition, the CCG has commissioned a Communications campaign setting out a zero tolerance approach to aggression towards staff. Enfield has invested over £60k of estates investment to support practices, to prevent and minimise the impact of verbal/physical abuse and aggression within practice settings.

Strengthen the primary care workforce

No.	Initiative	Description and update
v.	Teaching practices	Teaching practices take on GP trainees. The trainees support practice activity and are then more likely to work permanently in a practice where they trained. In Enfield a significant emphasis has been placed on increasing the number of teaching practices.



Develop the primary care estate

Developing a strong primary care estate is fundamental to: i) providing a good quality of care ii) giving patients confidence in the service and iii) attracting and retaining a primary care workforce.

No.	Initiative	Description and update
i.	Maximise existing capacity	The *Lloyd George* initiative is where health records are digitised, meaning that a room can be freed. Enfield has 17 practices in scope, 60% of the total across NCL. The programme will create, 17 additional consultation rooms, 16 virtual consultation desks and 11 clinical support desks creating a further 153,000 additional face to face and virtual contacts a year.
ii.	Develop New buildings - Haringey	Enfield opened two new state of the art GP Practices in 2021. • Alma Health Centre – situated on the newly built Alma Estate (£315m), just a few metres from Ponders End station. As well as offering GP appointments and other primary care services such as screening, contraception, micro suction for ear wax, joint injections, anti-coagulation clinics and nurse led services, the Alma Healthcare Centre has a pharmacy, a coffee shop, a research centre and offers a wide range of services. The state-of-the-art facilities also include underfloor heating and an air extraction system that provides better ventilation. • White Lodge Medical Practice – the practice have relocated from a grade II listed site from where they have delivered general practice services for over 104 years, to a new purpose build facility. The new site co-locates a NHS dental service, General Practice and Community Pharmacy. The site fully complies to BREEAM standards making this one of the most environmentally conscious practices across NCL. We have East Enfield Medical Practice and upgrades to Lincoln Road in 2023.

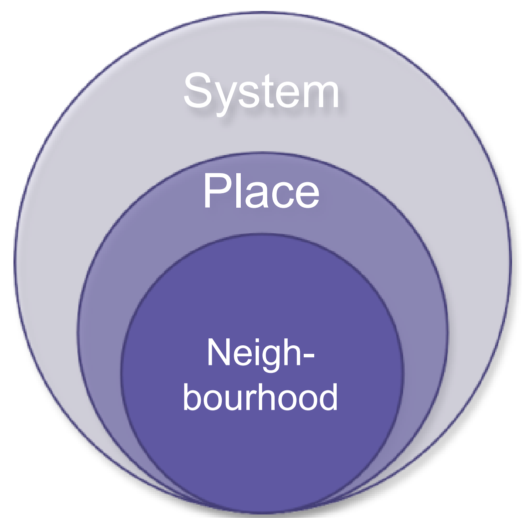
Next Steps for integrating primary care

Fuller Stocktake Report

Enfield Borough Partnership progress update

Working together for population health

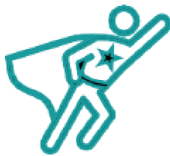
Our Population Health Strategy and key priorities will drive neighbourhood working



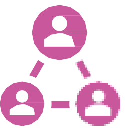
Neighbourhood:
Builds on the core of primary care networks through multidisciplinary teams delivering a proactive population based approach to care at a community level.

- Key unit of integrated care delivery for population health improvement.
- Balance proactive/preventative and reactive/episodic care.
- Multidisciplinary working.
- Close collaboration with voluntary sector partners.
- Risk stratification, case-finding, care coordination, anticipatory care and making every contact count.
- Co-produced targeted services and interventions to improve outcomes for communities.

Make brave decisions that demonstrate our collective accountability for population health
We take shared responsibility for achieving our ICS outcomes and our role as anchor institutions



Build 'one workforce' to deliver sustainable, integrated health and care services
We maximise our workforce skills, efficiencies and capabilities across the system



Support hyper-local delivery to tackle health inequalities and address wider determinants
We make care more sustainable by creating local integrated teams that coordinate care around the communities they serve

The change we need to make

Our system challenges are big; too big to assume more of the same will deliver the change we need.

We need to fundamentally change the way we work with our residents and communities. We need a new vision that will bring us together around a common purpose and approach.

The Population Health Strategy will highlight the need to move from being a collection of health and care organisations that…		To become a population health system that…		So that our residents...
are reactive and demand-driven with a high-proportion of resources focused on urgent care.	→	is needs-driven, prioritising prevention and proactive care.	→	stay well and in control of their health.
treats individual conditions not the drivers of poor health.	→	sees the whole person and takes action on prevention and the wider determinants of health.	→	feel heard and confident that their care is right for them.
are focussed on their services and part of the pathway.	→	integrates care around the person and communities.	→	feel that the system is coordinated and communicates well.
are focussed on illness and dependence.	→	works to improve life chances, prevent illness and promote physical and mental wellbeing.	→	can live more of their life in good health.

A vision for integrating primary care

At the heart of the Fuller report is a new vision for integrating primary care, improving access, experience and outcomes for our communities, which centres around:

1. Building integrated teams in every neighbourhood: bringing together previously siloed teams and professionals to do things differently to improve patient care for neighbourhood populations of 30-50,000. Incorporating teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff. Working together to share resources and information, form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.
2. Streamlining access to care and advice for people who get ill but only use health services infrequently; providing them with much more choice about how they access care and ensuring care is always available in their community when they need it.
3. Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long term conditions.
4. Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

Next Steps for Integrating Care: Fuller Stocktake Report

At the heart of the **Fuller report** is a new vision for integrating care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

1. **Streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it.**

2. **Providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to, those with multiple long-term conditions.

3. **Helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

The new vision for integrating care is bringing together **previously siloed teams and professionals** to do things differently to improve patient care for **whole populations.**

Neighbourhoods/Localities of 30-50,000, incorporating teams from

- Across primary care networks (PCNs),
- Wider primary care providers,
- Secondary care teams,
- Social care teams, and
- Domiciliary and care staff

Working together to:

- Share resources and information and
- Form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and
- Tackling health inequalities.

Development of integrated neighbourhood 'teams of teams' rooted in a sense of shared ownership for improving the health and wellbeing of the population.

Neighbourhood Development: Fuller Matrix

There are generally three types of people:

1. Those who are generally well, who don't have long term conditions. Need to risk stratify this cohort in terms of their risks of developing long term conditions, deprivation it, etc. The offer from public services is more preventative to keep them well with high levels of physical and mental wellbeing and keep them productive in society

2. Those people with one or more long term conditions who require ongoing care, not only from health service but from other organisations to help them self-manage their long-term conditions; and support them to prevent those conditions deteriorating and preventing them from getting new conditions.

	Generally well (lower continuity)	Long Term Conditions (medium continuity)	Complex Needs (high continuity)
Primary Prevention	Primary prevention – vaccination, screening, health-checks, smoking cessation…		
Ongoing Care (with prevention)		Long Term Condition Management with primary and secondary prevention	Highly personalised holistic care and support, including LTC management with primary, secondary and tertiary prevention
Reactive Care	Same-Day Care for new concerns	Same-Day Care for new concerns and exacerbations	Same-Day Care for new concerns and crises

17/01/2023 | Dr Steve Laitner 2022 - Free to use for NHS with source quoted

3. Those with complex needs including frail elderly, end of life dementia, children with complex needs, and working age adults with a mixture of mental health, drug and alcohol problems, who require a primary prevention model of care.

- Primary care struggles with providing same day care for people with new concerns, exacerbations of long-term conditions, and those with complexities, however there are some groups in society who need more continuity than others so we **need to focus on where our scarce resources should be**.

The matrix informs shaping the neighbourhood model in terms of the:

- **Who** – population health - the hierarchy of patient need in terms of health and wellbeing
- **What** we can do differently
- **How** - to include self-management, peer-to-peer support, i.e. find a different way of delivering, and therefore protect in terms of health inequalities
- **Identify our priorities including workforce requirements –develop a skilled workforce and the use of care navigators**

Further workshops planned with our partners to shape our neighbourhood approach

North Central London Integrated Care System

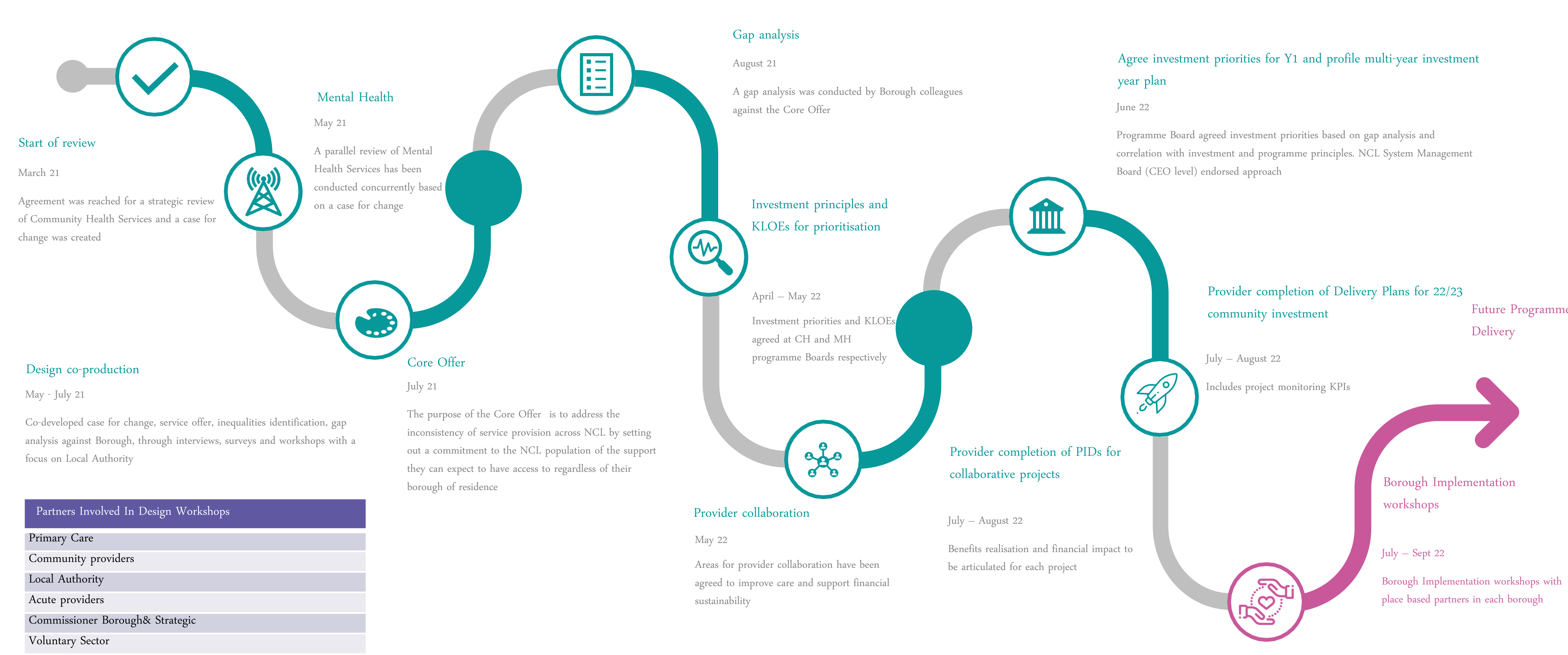
1. **Where should we FOCUS our efforts and prioritise?**
2. **What are the core FUNCTIONS required - Neighbourhood and Place – develop group sessions, peer support and required VCS support?**
3. **Informing future FUNDING/ Resourcing requirements?**
4. **What is the FORM of the Integrated Care Team?**

Enfield Community Services Review

Progress Update

The journey so far for community and mental health service reviews

Since the initial analysis was completed, extensive stakeholder engagement was conducted through the design phase of the core offer, including patient groups, providers, local authorities, and commissioners. This is set to continue as the programme moves forwards.



Partners Involved In Design Workshops
Primary Care
Community providers
Local Authority
Acute providers
Commissioner Borough& Strategic
Voluntary Sector
Residents/Users/Carers

A co-developed core offer was signed-off in Summer 2021 to address the case for change and provide equity and consistency for residents across NCL

The purpose of the core offer

The purpose of the core offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL population of the support they can expect to have access to regardless of their borough of residence.

The core offer will provide clarity to the population, clinicians and professionals in the system on what support is available, when it is available and how to access it.

The core offer contains

A description of care functions and services that should be available across NCL and how these integrate with the wider health and care system. The components of the core offer include services delivering care, as well as coordinating functions which will help navigate and integrate services for service users. The core offer describes:

- Operating hours and out of hours provision
- Response time for first and ongoing contacts (in line with national guidance)
- Access to the care function and criteria
- Description of the service, including requirements to meet best practice guidance
- Integration between the care function and other services and agencies
- Workforce capabilities required
- Point of delivery (eg. in person, virtual)

Given the system's challenging financial position, the Programme Boards agreed the following principles for allocating Year 1 investments

The below principles set out our thinking for allocating investment in the financial year 2022/ 2023

1. Delivering a proportion of it through productivity savings
2. Borough gap analysis should be used to inform decision making
3. Investment should focus on historically underfunded areas and where there are historic inequities
4. Reduce admissions and improve discharge and elective recovery to release acute costs (particularly for community investment)
5. Preventative services
6. Take into account capacity to delivery and deliverability
7. How best to support coordinating functions in order to respond to significant public and patient feedback

Proposed Programme KLOE's used for prioritisation (aligned to design principles)

1. Funding available → 2. Agree process and principles → 3. Gap analysis → 4. Priority setting → 5. Sign-off

Strategic fit	• Will this transformation project meet a gap against the full Core Offer as set out in MHSR? • Is it a national 'must do'? • Will this transformation programme support admission avoidance or by supporting prompt discharge from an inpatient bed? • Will this transformation contribute to delivering the ICB's financial strategy?
Clinical impact	• Will investment impact positively on clinical care of individual patients? • Will the investment help deliver a performance improvement in admission avoidance, ambulance handovers, A&E attendance or acute hospital flow including reductions in length of stay and discharge and their associated clinical benefits? • Does this service address a clinical gap which has been categorised as causing potential harm/risk to patients?
Health inequalities/ Inequality of access	• Could the development of this service area impact on health inequalities or inequality of access? • Will investment now impact on future delivery in terms of reducing inequalities, impacting on population health outcomes improving access and or contribute to an improved system performance? • Could this investment address historic discrepancies/inconsistences in provision between boroughs and as outlined in core service offer?
Patient experience	• Will service improve patient experience by e.g. reducing waiting times? • Will this service support responding to comments raised by residents/users as part of engagement and co-production? • Will this service contribute to supporting delivering of NCL population health improvement strategy? • Will this service support community care and supporting people to live in their homes?
Deliverability	• Can we recruit staff? • Do we have the management capacity (including clinical leadership) to support this scheme? • Aside from staff are there other investments e.g. capital or IT needed to deliver this service?
System impact	• Does delivery of this scheme provide an opportunity for releasing resources for alternative uses? (resources include staff time, estate and finance, waste and duplication)? • Does investment in this service support transformation through different ways of working including across pathways or contribute to productivity savings? • Does investment impact on system costs and is it affordable ?