ENFIELD LOCAL MEDICAL COMMITTEE MEETING

To be held at 2.45 pm on Monday 17 December 2012 in the Edward Beale Room, West Lodge Park Hotel, Cockfosters Road, Hadley Wood, EN4 0PY

PART TWO  
(OPEN)  
2.45 pm – 3.30 pm

AGENDA

1.0 Apologies

2.0 Declarations of conflicts of interest  
Members to declare any conflicts of interest in connection with any items on the agenda or in the light of subsequent debate

3.0 Minutes and matters arising not listed elsewhere on the agenda:  
3.1 Minutes of LMC Part 2 meeting on 25 June 2012 (pages 3-9)

4.0 Chief Operating Officer report including:  
• Finance update

5.0 Enfield CCG update

6.0 NCL Primary Care Strategy – local borough implementation update:  
6.1 Notes of Primary Care Strategy Implementation Board (formerly Primary Care Sub-Committee of the Health and Wellbeing Board) meeting on 15 November 2012 (pages 10-14)  
6.2 GP workforce Development – proposals for Clinical Associate posts (pages 15-31)  
6.3 Audit of GP referrals (pages 32-34)

7.0 Enhanced services  
• Matrix of schemes (pages 35-41)  
• COPD LES (pages 42-54)  
• Enhanced Access LES (pages 55-61)  
• DVT LES (pages 62-68)  
• Anticoagulation LES (pages 69-79)  
• Minor Ailments Scheme (pages 80-88)

8.0 NHS 111 and Co-ordinate my Care  
8.1 To receive an update on NHS 111  
8.2 To receive Co-ordinate my Care briefing paper (pages 89-94)  
8.3 To discuss the proposed LES for CMC (page 95)
9.0 IM&T update
To receive an update upon IT related issues in the borough

10.0 NCL Cluster and LMC Chairs Group (pages 96-105)
To receive draft and unconfirmed minutes of the meeting on 30 October 2012

11.0 Proposed meeting dates in 2013 (page 106)

12.0 Date of next meeting: 25 February 2013

13.0 Any other business
Present:  
Dr Olanrewaju Durojaiye  
Dr Sarit Ghosh  
Dr Richard Harris  
Dr Sinnappo Karthikesalingam  
Dr Patrick Keating (Chair)  
Dr Manish Kumar  
Dr Tathagata Sadhu  
Dr Pavan Sardana  
Dr Ujjal Sarkar  
Dr Ramesh Sharma

Borough/Cluster:  
Mr Sean Barnett  
Ms Jenny Bostock  
Dr Alpesh Patel  
Mr Richard Quinton  
Mr Glenn Stewart  
Dr Pete Sudbury  
Ms Sarah Thompson

Visitors:  
Mrs Priti Chavda

In attendance:  
Miss Nicola Rice, Committee Liaison Executive Londonwide LMCs

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<tr>
<th>Item no.</th>
<th>Action</th>
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<tr>
<td>1.0</td>
<td>Apologies for absence</td>
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<td></td>
<td>Apologies for absence were received from Mrs Jane Betts, Dr Tony Grewal, Mr Ray James, Mr Rob Leak, Dr Manmnder Sandhu, Dr Ron Singer and Dr Jonathan Warren.</td>
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<tr>
<td>2.0</td>
<td>Declarations of conflict of interests</td>
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<tr>
<td></td>
<td>There were no new declarations of interest.</td>
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<tr>
<td>3.0</td>
<td>Minutes and matters arising:</td>
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<tr>
<td>3.1</td>
<td>Minutes of LMC Part 2 meeting on 30 April 2012</td>
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<td>The minutes of the meeting on 30 April 2012 were agreed as a correct record.</td>
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<td>3.1.1</td>
<td>Enfield Care Home Projects (minute 3.1.1 refers)</td>
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<td>Ms Bostock, Head of Care Closer to Home was welcomed to the meeting. Ms Bostock explained that this pilot had been funded by</td>
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using money removed from the Chase Farm contract as part of the 30 day readmission programme. A multi-disciplinary team had been established in January 2012 working with four care homes and early signs indicated that there had been a significant impact on emergency admissions and A&E.

Ms Bostock advised that a questionnaire had been sent to the care homes involved in the pilot for feedback to help inform further developments and improve the service where appropriate but as there had not been a high response it was intended to send a further questionnaire out in June.

Ms Bostock confirmed that it was proposed that the scheme would be rolled out Enfield wide and it was hoped that a further five care homes would be covered in the North by the end of the financial year. It was also intended to roll out the pilot to the south of the borough and negotiations with North Middlesex Hospital about this were ongoing.

Dr Karthikesalingam noted that over the last 3 years whenever he had requested a domiciliary visit it had been turned down. Ms Bostock responded to advise that the consultant geriatrician did take referrals from general practitioners and Dr Sarkar noted that confirmation of this had been circulated to GPs.

4.0 Borough Director and borough representatives’ reports:

4.1 CCG update
Ms Thompson advised that Enfield was making good and steady progress. She reminded members that this was the final year of Enfield PCT and that it was a shadow year for the CCG. Ms Thompson further advised that Ms Liz Wise had been appointed as the Accountable Office for Enfield CCG and would be commencing in post in September 2012.

Ms Thompson noted that Enfield CCG would be applying for authorisation as part of the 4th wave in November and that Enfield was moving forward positively and learning from the experience of neighbouring boroughs. Although it was anticipated that Enfield would achieve authorisation it might be subject to conditions as it was not likely to achieve financial balance this year and there was a gap in the QIPP target.

4.2 Constitution
Dr Patel advised that the constitution was in the process of being developed and views from BMA Law were being obtained. He noted that he was due to meet with Mr Greg Cairns, Director of Primary Care Strategy with Londonwide LMCs the following day to discuss the constitution further.

4.3 Finance update:
Mr Richard Quinton reminded members that Enfield’s control total for 11/12 was an £18.1m deficit but noted that Enfield came in with a figure of £17.1m deficit. Although the position had slightly improved
he noted that Enfield still had a big deficit and faced a challenging QIPP programme of £32.9m.

He reported that the month 2 figures looked to be close to budget although there were possible overspends on the acute; UCLH, Royal Free and Barnet and Chase Farm Hospitals. He noted that a detailed analysis of work was being done in relation to UCLH with a view to save at least £2m and in the meantime he would commend that people worked as hard as possible to use local providers. Ms Thompson acknowledged that this should not compromise patient choice but suggested that GPs might wish to have informed conversations with patients about the benefits of having treatment locally.

Mr Quinton advised that as part of the QIPP programme an integrated care workshop took place on 31 May 2012 which was attended by representatives from Barnet and Chase Farm NHS Trust, BEH Mental Health Trust and the North Middlesex NHS Trust. He advised that this was a major area of work which included looking at admission avoidance, shortening stays in hospital and care closer to home. He advised that work was also being done with regard to looking to move patients into community services.

5.0 Enfield CCG update

This was discussed under item 4.1.

6.0 NCL primary care strategy – local borough implementation:

6.1 Mr Sean Barnett, Project Manager - Primary Care Development (Enfield) Primary Care NHS North Central London Cluster was welcomed to the meeting. He advised that the Enfield implementation plan would be based on local needs and he confirmed that the borough wanted to work with localities and specific GPs to identify those needs. He noted Enfield had £11m funding available over three years with £2.9m to be spent in the current financial year. He explained that this year would be about supporting the structure such as developing networks and undertook to share the implementation plan with the LMC office.

In response to a query from Dr Karthikesalingam about what was meant by networks Mr Barnett explained that networks were areas of communities and that it was likely that there would be 4 networks in line with the PLT localities but practices would be able to straddle boundaries. All residents would have access to services within the locality irrespective of whether the GP with which they were registered provided the services. Dr Karthikesalingam asked whether money would follow the patient and Mr Barnett confirmed that this would be the case. He also considered that working in this way would encourage those practices to deliver services in areas in which they have a particular interest.

Mr Barnett explained that the £2.9m funding which had to be spent this financial year would be used to create, format and support the
clinical networks. He advised that 8 GPs would be recruited as Clinical Leads. In addition it was proposed that the borough would work in partnership with UCL Medical School to offer clinical education support to enable Enfield GPs to deliver funded undergraduate medical teaching courses in their practices and to create clinical associate posts in Enfield. Mr Barnet agreed to send a breakdown of the funding available for the above to the LMC office.

Mr Barnett further reported that appropriate IT would be delivered in Enfield by December 2013 and he would encourage all practices to engage with this.

Ms Thompson asked the LMC to confirm whether it was supportive of the work being done for primary care as outlined by Mr Barnett and in the implementation plan. Dr Keating confirmed that the LMC was supportive.

Dr Sarkar advised that Dr Durojaiye had been nominated to be the LMC representative on the Primary Care Sub Committee of the Health and Wellbeing Board.

| 6.2 | Sub-committee of the Health and Wellbeing Board on Primary Care development: |
| 6.2.1 | Dr Grewal’s letter to Cllr McGowan of 3 May 2012 |
|       | It was noted that Ms Thompson would be responding to the letter. |

| 6.2.2 | Notes of meeting on 19 April 2012 |
|       | Received. |

| 6.2.3 | Summary of borough investment considered at meeting on May 2012 |
|       | Received. |

| 7.0 | Community Health Checks specification |

Mr Stewart, Assistant Director of Public Health, was welcomed to the meeting to provide a report on the community health checks specification which was being put out to tender.

In response to a query about how patients who were identified under this scheme as being at risk of developing CHD would be followed up Mr Stewart explained that the provider would send details through the N3 connection. He confirmed that the provider would be asked to put steps in place to try and stop those patients known to have CHD being checked but he acknowledged that determined patients were likely to get through the system. With regard to those patients who were not registered Mr Stewart explained that they would be offered advice on how they could register with a GP. He further noted that there was little that could be done about those patients including the homeless who consistently refused to engage with general practice. | Sean Barnett |
Dr Keating asked when the Health Checks LES would be rolled out across the borough. Mr Stewart confirmed that the borough needed to think about how it could be expanded from October onwards.

### 8.0 BEH Mental Health Trust

Dr Sudbury, Medical Director of BEH was welcomed to the meeting. He advised that the Trust had experienced an enormous surge in admissions and noted that it was not unusual for there to be no beds available for admissions in London at weekends. He further noted that two patients even had to be sent to Harrogate that week. He suggested that this increased demand could not be attributed to just the recession.

Dr Karthikesalingam put forward the view that part of the problem could be due to the rapid reorganisation of the mental health services without any appropriate care having been put in place for those patients who had dropped out of the system. Dr Karthikesalingam noted that in Enfield named psychiatrists were needed rather than GPs contacting the crisis team.

Dr Sudbury clarified that the increase in admissions was across London and was not just an Enfield problem. He advised that the National Service Framework recognised the current model of mental health service provision as best practice and the United Kingdom was recognised by WHO as the best in Europe. He advised that the mental health trust was aware that emergency response was complex and difficult and he advised that he was leading on a task group to review it. He advised that if GPs were experiencing any problems they could email him and it was agreed that an item to this effect would be included in the next Enfield LMC newsletter.

He advised that it would be necessary for primary care and mental health colleagues to work together to make the most of the funding that was available in view of the current financial position. He noted that when the IAPT service was fully set up it would have the capacity for 1 referral per GP per month and confirmed that a decision would need to be made as to how IAPT should be allocated fairly.

Dr Harris asked if the budgetary constraints were impacting on patient care. Dr Sudbury advised that they did impact on the volume of care which could be delivered and agreed that the current service could be organised better which was why services for psychosis and severe and complex mental health had been divided.

Dr Karthikesalingam expressed concern that when patients were referred to the crisis team they were sometimes assessed by mental health practitioners not all of whom had prescribing rights. He queried the appropriateness of such people being able to make diagnoses and asked what a GP should do if he or she was of the view that a patient needed to be sectioned.

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Nicola Rice
Dr Sudbury confirmed that the Crisis Team would have a role to play with this and acknowledged that there was a need to get that aspect of the Crisis Team right. Dr Karthikesalingam expressed concern about the medico legal implications of this.

Dr Sudbury noted that now the primary care strategy had been agreed the mental health trust would like to provide a link person to each practice and he would welcome further guidance about how practices would group together. He advised that he would be writing to all practices to explain what the trust had to offer.

Dr Karthikesalingam noted that five years previously there was a 12 months’ wait for psychological services which increased to an 18 month wait 3 years ago and now there was a 22 to 24 month wait. He referred to an article which appeared in the BMJ which suggested that access to psychological therapies was effective and that delays to such services could cost more money in the long run. He noted that patients in Southgate could not be referred to IAPT.

Dr Sudbury agreed that if such services were put in the right place the benefits were incontrovertible but he advised that commissioning this service was difficult when facing a £17m deficit. With regard to access for Southgate patients he noted that the mental health Trust had not made the decision as to where IAPT should be placed.

Dr Sardana referred to the proposed shift of 30-40% of mental health work to primary care and asked what assurance there was that patients could have access to mental health services within 48 hours if required. Dr Sudbury explained that this was one of the reasons why a link person would be assigned to practices.

Dr Sharma asked how GPs could take on up to 60% more work without additional funding. Dr Sudbury responded by advising that if a big impact was to be made in relation to services for psychotic patients people needed to be able to be geared up to handle such patients including tracking whether patients were taking their medication and if not to know who to call. A whole reconfiguration was needed and he hoped that the link workers would be able to help with this to a certain extent. He agreed that if there was extra work there needed to be some negotiation around how that would be funded but noted that there was a limited pot of money available and it would be up to GPs to advise BEH wanted it wanted to commission.

In response to LMC members’ concerns that clinicians were not involved in considering referrals made to INTAKE Dr Sudbury explained that Band 7 nurses were involved all of whom had received appropriate training. He explained that the reason why INTAKE had been set up was to ensure that referrals such as urgent ones did not get lost. He advised that INTAKE logged the referrals so that they could be tracked.
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<th>NCL Cluster and LMC Chairs meetings:</th>
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<tr>
<td>9.1</td>
<td>Unconfirmed minutes of NCL Cluster and LMC Chairs meeting on 24 April 2012</td>
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<td>Noted.</td>
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<td>10.0</td>
<td>Date of next meeting:</td>
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<td>29 October 2012</td>
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<td>11.0</td>
<td>Any other business:</td>
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<td>There was no other business.</td>
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ACTION NOTES

Sub-committee of the Health & Well Being Board on Primary Care Development
15th November 2012

3.00 – 5.30pm
Committee Room, Holbrook House

Present:

Dr Mo Abedi (Chair) (MA)   PEC Chair
Sean Barnett (SB) Programme Manager, Primary Care Devt
Dr Angela Lennox (AL) Deputy Medical Director, NCL
Michael Hepworth (MH) Primary Care strategy programme lead - NCL
Ray James (RJ) Director of Health, Housing and Adult Social Care LBE
Dr Lanre Durojaiye (LD) LMC representative
Dr Shahed Ahmad (SA) Joint Director of Public Health
Dr Alpesh Patel (AP) Chair CCG
Dr Sarit Ghosh (SG) PEC member & Clinical Network Lead
Gerald Alexander (GA) LPC Pharmacist
Lizzie Wallman (LW) Head of Primary Care nursing - NCL
Jan Charman (JC) BEH clinical strategy project manager
Dick Darby (DD) IT Programme Manager
Pat Whelan (PW) Interim Primary Care Project manager
Linda Crawley Enfield Borough Network Coordinator (Action Notes)

Apologies:

Liz Wise (LW) Accountable officer NHS Enfield
Julia Brown (JB) Managing Director – ECS
Robert Evans (RE) Interim Associate Director of
Siobhan Harrington (SH) Primary Care - NCL
Daniel Morgan (DM) BEH Programme Manager / SRO
John Lynch (JL) Project Manager, Primary Care Devt
Tessa Garvan (TG) Enfield LINKs
Richard Weetman (RW) Head of Primary Care Strategy
Deborah Harris Implementation and QIPP
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<tr>
<td><strong>1. Introductions and Apologies</strong></td>
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<td>MA introduced the group and noted apologies.</td>
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<td><strong>2. Declarations of interest</strong></td>
<td>ALL</td>
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<td>MA reminded all members are required to complete forms and return to Network Coordinators. Members already completing DOI for CCG will suffice.</td>
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<td><strong>3. Minutes of the last meeting</strong></td>
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<td>Minutes of last meeting 18\textsuperscript{th} October 2012 were agreed as accurate.</td>
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<td><strong>4. Matters arising</strong></td>
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<td>• Item 5 - Health checks: paper has been approved for funding</td>
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<td>• Item 5 - COPD LES: changes have been made to the paper and it has been submitted to FR&amp;Q at NCL</td>
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<td>• Item 11 - GP Workforce development: paper has been amended and resubmitted to FR&amp;Q</td>
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<td>• Item 13 - Enhanced access proposal: DM had amended and resubmitted this paper. MA commented that the project would be reviewed at 6 months with the Network Leads visiting practices to ensure additional appointments are utilised</td>
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<td><strong>5. Future programme structure</strong></td>
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<td>SB updated everyone on staff changes: Michael Hepworth has taken over from Denise Tyrrell and Siobhan Harrington is now SRO for NCL.</td>
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<td>There was concern about the effect of FR&amp;Q approvals limiting the roll out of projects and holding up the spending of monies for this year. AL responded that new facilitative finance processes are now in place so there should be an improvement. MH added that this was a one-off process in order to show checks and balances. RJ would be pleased to help in any way to ensure that monies are not lost this year because of the delays.</td>
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<td><strong>Future funding:</strong></td>
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<td>A discussion followed on these areas:</td>
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<td>• In which budget will Year 2 and Year 3 monies sit? AL responded that there is still uncertainty around this. It won’t necessarily be with the CCG because of the GP contracting process</td>
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<td>• AP confirmed that CCG funding for LES projects will be part of the CCG budget. MH reiterated that any LES projects in the strategy will receive funding for 3 years and then other funding sources will need to be found to continue them.</td>
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<tr>
<td>• The Primary care strategy has been agreed for local implementation</td>
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so is it local money and nothing to do with NHS Commissioning Board funds? Will monies identified for local projects in future years be kept locally and appear in budget in bottom line?

RJ said that it would be helpful to have a written structure and governance to clarify how funding would be apportioned and accessed in the future.

Action: MH & AP to clarify the situation for the next meeting

6. Public Health report data funding

SB raised the issue of which data sources should be funded. Network Leads were generally happy with the reports available at present, and did not want further reports at present. It was agreed that there should be a period of assessment to see what data might be required later on and what format and quality would be required.

• Blood pressure and cholesterol control by practice nurses:
  Action: Glenn Stewart to write a paper on blood pressure and cholesterol control through practice nurse intervention for the next meeting and circulate document one week before for comment.

• Haringey project on a one year apprentice training scheme for HCAs:
  Action: LW to circulate a paper on this project

7. Information Technology (IT)

DocMan: SB said that £160K had not yet formally been approved for this project. EMIS web does have a document management system within it, which isn’t as good as DocMan, but Vision has none. Few practices have DocMan at present and there will be ongoing licensing costs for surgeries after the 3 years funding stream ends.

SB proposed that funding for all surgeries who wanted DocMan should be added back into the IT programme because of the added value it would bring to in Practice management of documents which in turn leads to better patient care..

AP asked that the brief should be widened to look at other IT transcriptors

Action SB to look at other IT transcription systems

iPlato: SB reported that 85% of practices have already signed up, with only 2 or 3 not interested at present. The Network Leads will be asked to visit practices to see if they can achieve better take up.

APPROVED: Funding to be provided for practices who are signed up with other providers at a cost of £600 for 3 practices for 3 years.

EMIS update: all surgeries are now in the pipeline for changeover to the new system, with published go live dates until March 2013 and further dates to be released shortly. There had been some uncertainty around whether the training EMIS was providing was robust, which means that go live dates may not all complete until August 2013.

Action: SB would clarify if costs can be brought forward from 2013-14
to this current financial year

LD asked if QOF data would be affected by the system update and it was confirmed that it would not be affected as both systems run in parallel until it goes live. It was asked that this be made clear to surgeries.

RJ felt that programme oversight needs to be tightened and escalated.

**Action:** MA agreed to escalate programme slippage with David Thomas (project sponsor) and ask for regular updates

8. **Premises**

**Improvement grants:** surgeries who had had work approved in this round were being chased to provide 3 quotes for the work by the deadline of 15\(^{th}\) Nov

SB highlighted the fact that some may not meet the deadline.

It was noted that the East Enfield Practice had been omitted from the spreadsheet tabled at the meeting, but SB confirmed that schemes had been approved for the surgery.

**CQC audits:** reports are being sent directly to surgeries and then to the strategy team. This may highlight improvements needed which will feed in to the next round of improvement grants

9. **Childhood Obesity**

This paper had not been received in time so would be tabled at the next meeting

**Action:** LC

10. **Integrated Care**

A paper had not been received on this topic.

It was envisaged that there would be an MDT in place in one locality by the end of January, funded jointly with primary care and secondary care monies.

**Action:** SB / PW to write a paper for approval for the next meeting

11. **Governance**

**Risk log:**

001 mitigated risk should be changed from 2 (likelihood) to 1

008 mitigated risk of 16 should be red

009 unmitigated risk - as NCL are mitigating this it should go to green

**Budget:** SB highlighted the percentage of allocated funding had now fallen from 107% to 85%. This was due to the need for more projects having to go through the FR&Q approval process.

MH & AL confirmed that NCL were budget mapping for an accurate picture and removing barriers to enable projects to be fast tracked.

There was concern that implementation and delivery could now
be delayed. It was suggested that there should be a weekly meeting to check variance against progress and mitigation.

MH suggested that business cases on the NCL list could be checked through to see if any could be altered for Enfield for quick turn round. **Action MH**

**Project plan:** RJ asked that clinical schemes should be added and updated and that there should be a strand showing whether project met access, outcome or patient experience strategies. **Action: Ashley Gilmore to update**

**Matrix**
Suggested this could be used for weekly / monthly monitoring of delivery

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<th>12. Any other business</th>
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<td>• <strong>Primary care foundation update:</strong> PW said that 13 practices had attended the workshop and one had joined later. 6 practices had completed the data input and were now being given an initiative suggestion report and PW would offer to support practices in implementing changes. RJ suggested that there should be a patient representative involved in the roll out. <strong>Action: PW to give a written report for the next meeting</strong></td>
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<td>• RJ asked if there was access to a web based system of pathways for GPs. It was confirmed that the Primary Care intranet site was now available and set as the homepage at all surgeries, with this and other information readily available on it.</td>
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<td>• SG asked if RJ knew about the Harrow child obesity &amp; cholesterol and blood pressure schemes. <strong>Action: RJ to talk to public health.</strong></td>
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<td>• <strong>Change of name for this committee:</strong> AL proposed and it was unanimously agreed that this committee should now be called the “Primary Care Strategy Implementation Board” to avoid confusion with other sub committees of the HWBB. <strong>Action:LC</strong></td>
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<td>• <strong>Date of next meeting changed:</strong> to enable Liz Wise to attend the next meeting it will now take place on <strong>Friday 21 December from 1.00pm to 3.00pm in the Committee Room at Holbrook House.</strong></td>
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**Future meetings: all 3:00-4:30pm Committee Room, Holbrook House**
- 17 January 2013
- 21 February 2013
- 21 March 2013
SUMMARY:

This report provides the group with an update on the development of Clinical Associate roles. At the August 2012 meeting of the Enfield Primary Care Sub Committee of the Health and Wellbeing Board it was agreed that the role of Clinical Associate would be developed by a small task and finish group. The group have focused on:

- Defining the content of the role;
- Recruitment of the Clinical Associates (JD, Advert and Interview arrangements);
- Selection process for host practices, and;
- Contractual arrangements and cost.

This report provides an update on the work carried out and requests that the group approve the funding required to begin recruitment of the Clinical Associates.

RECOMMENDED ACTION:

The Committee are asked to:

- **NOTE** and **COMMENT** on the contents of the report;
- **APPROVE** the cost of the contract with University College London Medical School.
**Objective(s) / Plans supported by this paper:**
Principle Objective 2: To deliver the NHS North Central London QIPP Plan.

**Patient & Public Involvement (PPI):** Patient and public involvement has been sought through existing channels and meetings with patients and representative groups to inform the work that is presented to the Committee.

**Equality Impact Assessment:** Not applicable.

**Risks:** There are no new risks to be recorded.

**Resource Implications:** Financial costings are to be granted from the Primary care Strategy funds, already agreed with NCL.

**Audit Trail:** There is no audit trail for this report.

**Next Steps:** Development of a Local Enhanced Service Specification
1. INTRODUCTION

In August 2012, a small working group began to develop a proposal for a Clinical Associate Role working across University College London (UCL) Medical School and Enfield Clinical Commissioning Group. The working group have met twice. The group have discussed the recruitment of the roles, the makeup of the roles and the likely cost and associated contractual framework.

It is envisaged that Enfield will recruit 4 x wte Clinical Associates. The Clinical Associates will be aligned to practices for a 1 year period, whilst also carrying out service development and teaching roles. The posts will be funded by Enfield Clinical Commissioning Group as part of the Primary Care Strategy budget over a two year period and employed by UCL Medical School.

The remaining sections of this report describe the background to the development of the Clinical Associate Role, the approach to recruitment and selection of host practices and the finalised cost of the scheme.

2. BACKGROUND

The vision for GP workforce development was outlined as part of the Enfield Primary Care Strategy Implementation Plan, submitted to NHS North Central London at the end of May 2012 and approved in June 2012. The Enfield Health and Well Being subcommittee approved the scheme in August 2012 and the NCL Programme Board agreed with the recommendations to go ahead in September 2012 with some suggested alterations to the scheme made here.

The proposal is to recruit four Clinical Associate GPs to work in each of the four Network areas identified by the borough. The Clinical Associates will be graduate GPs who will split their week between delivering clinical sessions in an Enfield GP practice, contributing to service development across GP practices in their local Networks, delivering undergraduate medical student teaching in Enfield, whilst continuing their academic career under the support and guidance of University College London (UCL) Medical School.

By creating these posts we expect the benefits to be:

- 17,472 of additional appointment capacity offered to Enfield patients;
- Improvements in specific disease areas or clinical pathways through their service development role working across all the practices within their locality networks;
- Raising the profile of Enfield as a place for undergraduate medical students to come for training and where postgraduate GPs can access exciting roles; and
- To create greater links between undergraduate and postgraduate training and retention of skills and experience.

These two-year full time posts will comprise:

- 5 sessions of academic time (teaching/research/service development)
• 4 Clinical sessions in an Enfield general practice (one year rotations)
• 1 Professional development session
• Individually supervised research and teaching activities within the academic Department
• Formal courses related to educational theory & practice and research methods
• Mentorship and support for integrating academic and clinical practice

The posts will be available from 8 January 2013. Applicants would need to be available to start by 4th March 2013 at the latest.

This paper describes in more detail the roles of the Clinical Associates and provides information on the requirements and application of host General Practices. In addition, in Appendix A and B the group are provided with the Job Description and proposed advert for the Clinical Associate role.

3. DETAILED DESCRIPTION OF THE CLINICAL ASSOCIATE ROLES

The four Clinical Associate roles are expected to:

• Undertake service development work within their locality and for the borough to improve disease prevalence and to improve disease pathways;
• Carry out consultations for their host practice;
• Bring about a training ethos to the borough, working with University College London Medical School and local practices to encourage more practices to carry out undergraduate education;
• Undertake teaching, both at the University and in Enfield.

When discussing the proposal with local practices and senior managers, it was clear that to quickly mobilise the scheme funding would need to be provided for the roles. The roles would though need to show benefit both to practices, patients and the Clinical Commissioning Group through their service development and practice specific input. It is then anticipated that following an evaluation of the benefits of the role that the roles would form part of the Clinical Commissioning Group structures, continuing the link with UCL MS, but being part funded by local practices for their work in practices.

3.1 Clinical Roles

The Clinical Associates will carry out GP consultations and contribute to the GP practice activities. It is anticipated they will carry out four sessions in practice each week, there may be opportunities to gain experience across a range of Enfield practices throughout their 2-year contract.

Specific duties related to Clinical Practice

• To work closely with the GP primary health care team to deliver clinical care
• Provide clinical care to patients this will include consultation sessions, clinical administration, home visits, surgery meetings and on-call (excluding out of hours).
• Working with the practice clinical leads and management team support the achievement of, QOF and Enhanced services.
• Provide a focus on quality, safety and improving the patient experience.
• Ensure that clinical supervision and reflective practice is undertaken.
• Ensure an annual appraisal is completed.
• Act as a clinical champion and support the GP practice in delivering education for undergraduate students.

3.2 Locality Network Roles

Based on the priorities for the locality, the Clinical Associates will take on pathway/ service development work within their Network. An example of this may be the development of a Local Enhanced Service for COPD or practice development work in regards to COPD prevalence, case finding or chronic disease management. This is to be determined by Networks and will contribute to the delivery of the Network Implementation Plan. It is anticipated that Clinical Associates will work on different priorities with the learning replicated across neighbouring locality Networks.

Specific duties related to locality network activities

• Assist the Clinical Network Lead and Network Coordinator on the production and delivery of the Primary Care Network Implementation Plan.
• Support the Clinical Lead in engaging GPs and other stakeholders in the planning and development of new local services.
• Facilitate group workshops in developing plans for local implementation e.g. Protected Learning (PLT).

3.3 Teaching roles

With the help of an extensive network of teaching practices the University College London Primary Care Education Group within PCPH is responsible for delivering approximately 15% of the medical undergraduate programme at UCL and provides teaching in all six years of the undergraduate curriculum. The subjects taught by GPs include: core general practice, clinical skills, communication skills, general medicine, elderly medicine, dermatology, child health, women’s health and mental health in the community. With over 400 students per year this constitutes one of the largest programmes of community based undergraduate teaching in the UK. The department also offers an intercalated BSc degree in Primary Care for up to 12 students per year.

Specific duties related to teaching

• Undertake a programme of training to develop expertise in clinical and general practice education
• With supervision from senior clinical academic staff, take responsibility for defined programmes of undergraduate teaching, either in the university or general practice setting
• Develop necessary teaching related materials
• Attend and contribute to meetings and seminars
• Work collaboratively with academic & administrative members of the teaching team
• Provide reports on teaching related activities as required.

3.4 Research roles

The multidisciplinary character of the UCL Institute of Epidemiology and Health Care (which includes the Research Department of Primary Care & Population Health) is a major strength for research. Staff appointments represent general practice, health services research, cardiovascular epidemiology, infectious disease epidemiology and prevention, sexual health and HIV epidemiology and public health, medical sociology, health psychology, primary care nursing, education, and statistics. The work groups within PCPH specifically are as follows listed below and described in more detail at http://www.ucl.ac.uk/pcph/

- The Cardiovascular Diseases Group
- The Centre for Aging Population Studies
- The Primary Care Mental Health Research Group
- The E-Health Group
- The Open Learning Unit
- The Primary Care Education Group

Specific duties related to research

- Undertake training in research methods appropriate to an area of interest to the ACA, the academic department and Enfield PCT/CCG
- With mentoring and supervision, take responsibility for a defined research project (clinical, educational or service development)
- With mentoring and supervision, collect and analyse research data and write a report of and publish on the research results.
- Work collaboratively with academic & administrative members of the research team
- Attend and contribute to relevant research seminars.
- Participate in the general academic life of the department

3.5 Requirements of the Host General Practice

The choice of general practice to host these Clinical Associates is important in order to ensure that maximum benefit is gained by the Clinical Associate, the host GP practice, the locality clinical leads and member practices and the Enfield Primary Care Strategy Implementation Plan.
Culture and aspiration

The Clinical Associate is not a free ‘pair-of-hands’, but rather facilitates the host practice to achieve its aspirations of improving the accessibility and quality of primary care; in return the Clinical Associate will gain valuable clinical and primary care experience.

In particular we are looking to attract practices which have no experience of delivering undergraduate or postgraduate medical education.

Practice requirements

The practice size is not a factor, its culture and aspirations are much more important. The following GP practice attributes are required:

- A willingness to collaborate with other local practices around clinical and educational developments.
- Sufficient physical space to accommodate the academic clinical associate and to undertake medical student teaching – although this does not need to be a fixed space.
- Ability to provide clinical mentoring to the Clinical Associate.
- An agreement to support the Clinical Associate in research and development projects in line with local clinical strategy.
- Minimal or no previous experience of delivering undergraduate or postgraduate medical education.
- Payment of Clinical Associate’s Medical Defence subscription.

Outcomes

Since additional capacity is provided and the funding is accountable public money we would require the following measured outcomes:

- A commitment to develop one or more specific new services in line with Enfield’s Primary Care Strategy Implementation Plan and/or QIPP activity.
- A commitment to improve access to primary care services.
- A commitment to develop/expand undergraduate teaching activity within the practice.

Application Details

Practices who wish to apply should:

1. Contact Dr Angela Lennox to have an informal discussion about their application;
2. Send a letter to peter.lathlean@nclondon.nhs.uk outlining their strengths as a host practice and the benefits (outcomes) patients will receive as part of the practice hosting the Clinical Associate;
Following receipt of expressions of interest letters, a panel will be established to decide upon which practice in each Network will host the Clinical Associate. A decision will be communicated to practices regardless of whether they are successful in their bid or not.

4. COST OF CLINICAL ASSOCIATES

The Clinical Associates will be funded at Clinical Academic Grade 9 (Principal Clinical Teaching Fellow). There are three points in the scale, which are as follows:

- £61,650
- £66,743
- £70,263

All are plus London weighting of £2,806 and on-costs of 26% for NI and superannuation. It is suggested that the first point would be for GPs within one year of qualification, second point 1-2 years and top point for 3 or more years.

At mid point and with on costs and London weighting added to each of the four Clinical Associate salaries, assuming all are appointed on the middle point of the salary scale, the total maximum staffing cost of the contract with UCL is £766,054 over two years.

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<tr>
<th>Desc</th>
<th>To Be (£)</th>
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<tbody>
<tr>
<td>Salary</td>
<td>£66,743</td>
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<tr>
<td>London weighting</td>
<td>£2,806</td>
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<tr>
<td>Oncosts (UCL 26%)</td>
<td>£18,083</td>
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<tr>
<td>Supervision</td>
<td>£8,125</td>
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<td>Total 1 wte</td>
<td>£95,757</td>
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<tr>
<td>Total (two years)</td>
<td>£766,054</td>
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5. BENEFITS

The appointment of the four Clinical Associate posts will increase capacity within each of the four localities in Enfield. Whilst the posts will have an impact on capacity, the benefits of the role are not only found through additional manpower. The primary focus for the roles will be on sharing best practice through service development. The Clinical Associates will work with practices in their locality, focusing on specific disease areas and improving protocols and processes for those disease areas. The Clinical Associates will have an academic background and their links with University College London Medical School will aid their work in Enfield, ensuring there are links to research, innovation and best practice.

From work with the steering group, local GPs/practices have commented that Enfield finds it difficult to recruit and retain staff. Enfield is an outer London borough, but in parts of the borough the deprivation and population resemble much of the challenges faced by inner London boroughs. Through collaboration with UCL Medical School we hope to make Enfield an interesting place to work, through the Clinical Associates and placements created in the borough, we aim to make the borough a place where links with UCL are capitalised upon to make the borough a training borough, where undergraduate GPs want to continue to work post graduating.

RECOMMENDED ACTION:
The Committee are asked to:

- **NOTE** and **COMMENT** on the contents of the report;
- **APPROVE** the cost of the contract with University College London Medical School.

Appendix A

**Academic Clinical Associates in General Practice**

**Four full-time posts**

**DRAFT ADVERT**

1.1 **Salary: £66,743**

1.2 **INCLUDING LONDON WEIGHTING**

1.3 **POSTS ARE AVAILABLE FOR TWO YEARS**

The Research Department of Primary Care & Population Health at University College London, in partnership with Enfield Primary Care Trust (soon to be Enfield Clinical Commissioning Group) is seeking to appoint recently qualified general practitioners to four new, full time clinical academic training posts. These Academic Clinical Associate (ACA) posts will provide opportunities to develop teaching and research skills in one of the UK’s foremost university departments of primary care, whilst undertaking clinical and service development activity in one or more general practices within the Enfield area.

Enfield is in the process of developing four GP Networks. The Networks will be led locally by the Enfield Clinical Commissioning Group, with specific Clinical Lead GP posts allocated to each Network. One ACA will work with each Network of practices dividing their time between local clinical practice and carrying out teaching, service development and research activities in partnership with University College Medical School.

Each post provides:

- 4 Clinical sessions in an Enfield general practice
- 5 sessions of academic time (teaching/research/service development)
- 1 Professional development session
- Individually supervised research and teaching activities within the academic department
- Formal courses related to educational theory & practice and research methods
- Mentorship and support for integrating academic and clinical practice

These posts will be available from 8 January 2013. Applicants would need to be available to start by 4 March 2013 at the latest.
Applicants should be qualified GPs eligible for UK NHS practice and able to demonstrate a positive interest in undertaking academic training in addition to maintaining a regular clinical UCL Research Department of Primary Care and Population Health (PCPH) based at the Royal Free Campus in Hampstead.

Full job description and application forms can be obtained from http://www.ucl.ac.uk/pcps/information/vacancies/index.htm or from Mrs Corinne Ward (c.ward@ucl.ac.uk)

For an informal discussion about the posts please contact Dr Joe Rosenthal (j.rosenthal@ucl.ac.uk) or 020 7472 6116.

The closing date for applications is XXXXXXXXXX

Interviews will take place on XXXXXXXXXXXXX
Appendix B

INSITUTE OF EPIDEMIOLOGY AND HEALTH CARE
Research Department of Primary care and Population Health

DRAFT JOB DESCRIPTION

FULL TIME ACADEMIC CLINICAL ASSOCIATE IN GENERAL PRACTICE
(University College London/Enfield Primary Care Trust)
4 POSTS AVAILABLE

SALARY: £66,743 Including London Weighting. Post available for two years

ROLE DESCRIPTION

GENERAL INFORMATION

Job Title: Academic Clinical Associate in General Practice
(4 posts available)

Hours: 10 sessions per week i.e.:
• 4 Clinical
• 5 Teaching/research/service development
• 1 Professional development

Posts: 4 (1 per Clinical Network)

Main Base: GP practice in Enfield / UCL Medical School, Royal Free Campus

Tenure: 2-year fixed term period

ROLE SUMMARY

The Research Department of Primary Care & Population Health at University College London, in partnership with Enfield Primary Care Trust (soon to be Enfield Clinical Commissioning Group) is seeking to appoint recently qualified general practitioners to four new, full time clinical academic training posts. These Academic Clinical Associates (ACA) posts will provide opportunities to develop teaching and research skills in one of the UK’s foremost university departments of primary care, whilst undertaking clinical and service development activity in one or more general practices within the Enfield area.
These full time posts will comprise:

- 5 sessions of academic time (teaching/research/service development)
- 4 Clinical sessions in an Enfield general practice
- 1 Professional development session
- Individually supervised research and teaching activities within the academic department
- Formal courses related to educational theory & practice and research methods
- Mentorship and support for integrating academic and clinical practice

Enfield is in the process of developing four GP Networks. The Networks will be led locally by the Enfield Clinical Commissioning Group, with specific Clinical Lead GP posts allocated to each Network. The ACAs will work with each Network of practices; some sessions will be based in practice and others carrying out service development and research activities within the Network. For the remainder of sessions the successful post holder will work within University College London Medical School carrying out academic responsibilities.

**MAIN DUTIES AND RESPONSIBILITIES**

The academic training programme within the Department of Primary Care & Population Health (PCPH) provides opportunities for general practitioners interested in both teaching and research. ACAs should expect to gain training and experience in both areas, though may major in one or the other depending on individual circumstances. The interests of the ACAs, the local needs of Enfield general practices, and the ability of the academic department to supervise their work will be considerations in the choice of specific subject area. Associates primarily interested in education, in addition to gaining teaching practice, should expect to undertake a project on a topic related to educational research.

**TEACHING**

With the help of an extensive network of teaching practices our Primary Care Education Group within PCPH is responsible for delivering approximately 15% of the medical undergraduate programme at UCL and provides teaching in all six years of the undergraduate curriculum. The subjects taught by GPs include: core general practice, clinical skills, communication skills, general medicine, elderly medicine, dermatology, child health, women’s health and mental health in the community. With over 400 students per year this constitutes one of the largest programmes of community based undergraduate teaching in the UK. The department also offers an intercalated BSc degree in Primary Care for up to 12 students per year.

**Specific duties related to teaching**

- Undertake a programme of training to develop expertise in clinical and general practice education
- With supervision from senior clinical academic staff, take responsibility for defined programmes of undergraduate teaching, primarily in the general practice setting
- Develop necessary teaching related materials
- Attend and contribute to meetings and seminars
• Work collaboratively with academic and administrative members of the teaching team

• Provide reports on teaching related activities as required.

RESEARCH

The multidisciplinary character of the UCL Institute of Epidemiology and Health Care (which includes the Research Department of Primary Care & Population Health) is a major strength for research. Staff appointments represent general practice, health services research, cardiovascular epidemiology, infectious disease epidemiology and prevention, sexual health and HIV epidemiology and public health, medical sociology, health psychology, primary care nursing, education, and statistics. The work groups within PCPH specifically are as follows listed below and described in more detail at http://www.ucl.ac.uk/pcph/

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• The Centre for Aging Population Studies
• The Primary Care Mental Health Research Group
• The E-Health Group The Open Learning Unit
• The Primary Care Education Group

Specific duties related to research

• Undertake training in research methods appropriate to an area of interest to the ACA, the academic department and Enfield PCT/CCG

• With mentoring and supervision, take responsibility for a defined research project (clinical, educational or service development)

• With mentoring and supervision, collect and analyse research data and write a report of and publish on the research results.

• Work collaboratively with academic and administrative members of the research team

• Attend and contribute to relevant research seminars.

• Participate in the general academic life of the department
CLINICAL DELIVERY

The ACAs will carry out GP consultations and contribute to GP practice activities. They will carry out four sessions in clinical practice each week, there may be opportunities to gain experience in more than one Enfield practice during their 2-year contract.

Specific duties related to Clinical Practice

- To work closely with the GP primary health care team to deliver clinical care
- Provide clinical care to patients this will include consultation sessions, clinical administration, home visits, surgery meetings and on-call (excluding out of hours).
- Working with the practice clinical leads and management team support the achievement of, QOF and Enhanced services.
- Provide a focus on quality, safety and improving the patient experience.
- Ensure that clinical supervision and reflective practice is undertaken.
- Ensure an annual appraisal is completed.
- Act as a clinical champion and support the GP practice in delivering education for undergraduate students.

LOCALITY NETWORK DEVELOPMENT

Based on the priorities for the locality, the ACAs will take on pathway/ service development work within their Network. An example of this may be the development of a Local Enhanced Service for COPD or practice development work in regards to COPD prevalence, case finding or chronic disease management. This is to be determined by Networks and will contribute to the delivery of the Network Implementation Plan. It is anticipated that ACAs will work on different priorities with the learning replicated across neighbouring locality Networks.

Specific duties related to Network Development

- Assist the Clinical Network Lead and Network Coordinator on the production and delivery of the Primary Care Network Implementation Plan.
- Support the Clinical Lead in engaging GPs and other stakeholders in the planning and development of new local services.
- Facilitate group workshops in developing plans for local implementation e.g. Protected Learning (PLT).
Key Relationships

The ACAs will work with a Network of GPs, receiving supervision and leadership from the Network Clinical Lead.

The ACAs will be required to develop good relations with the following key stakeholders:

- GP Practices within the Network
- Enfield CCG
- Patients and the public
- Allied health professionals in the Network
- Community and acute providers
- NHS North Central London
- Other Enfield networks
- London Borough of Enfield officers
- NHS London and DOH
- Local Professional Committees and professional associations
- Local primary care research networks
- The local Academic Health Service Networks (i.e. UCL Partners)
- Third sector and private providers
- Other stakeholders as required
**PERSON SPECIFICATION**

**Job Title:** Academic Clinical Associate

This is a specification of the qualifications, knowledge, experience, skills and abilities, that are required to carry out effectively the responsibilities of the post (as outlined in the role description) and forms the basis for selecting a candidate.

<table>
<thead>
<tr>
<th>REQUIREMENTS</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
<th>ASSESSMENT</th>
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</table>
| EDUCATION AND QUALIFICATIONS | • Full GMC registration;  
• Membership of Royal College of General Practitioners;  
• On an NHS GP Performer’s list | • Completed or interested in working towards a higher academic degree; | A |
| KNOWLEDGE | • An awareness of key research issues in primary care;  
• Awareness of on-going changes and developments in NHS organisation. | | IP |
| EXPERIENCE | • Recent experience of working in NHS general practice | • Demonstrated involvement in research and/or teaching in an academic setting | AI |
| SKILLS, ABILITIES and PERSONAL QUALITIES | • Ability to demonstrate a positive interest in developing postgraduate academic skills;  
• Willingness to teach undergraduate medical students in a clinical or non-clinical setting;  
• High ethical and professional standards;  
• Excellent verbal and written communication skills;  
• Ability to take on tasks and responsibilities in a multi-professional team and to be able to work effectively and sensitively within it;  
• Ability to organise and prioritise workload, to delegate responsibility as appropriate; | | AIP |
Key:  A = Application Form / I = Interview / P = Presentation

To add

- *Up to date salary scale*
- *UCL terms and conditions*
- *Institutional profiles*
- *How to apply*
- *Draft advert*
The Board is asked to consider a proposal to fund a number of consultant sessions to audit 100 GP referrals each from a number of specialties namely cardiology, ENT, urology and respiratory.

The aim is to understand if the referrals could have been managed in a different way i.e. to establish if the decision could have been different to that actually made e.g. to refer onto acute providers and if they could have been managed differently what support could have been provided to the GP and the patient.

The specialties listed above have been chosen primarily as each one is subject to a QIPP scheme within Enfield to review the setting up of a community or primary care based service to act as a better way to manage a significant cohort of patients without the need to go into a local hospital.

This audit will inform commissioners over what type of clinical services Enfield patients and GPs could benefit from if consultant triage of referrals was implemented in these specialties. This may include offering advice and guidance to GPs on more appropriate treatment plans for patients and offering training sessions on particular clinical specialty topics. This in turn will improve the patient experience through a more appropriate and timely management of their condition and ultimately improve clinical outcomes of these patients.

This report further recommends that consultants are sourced from outside of the two main local acute providers so as to provide an independent review of triaging decisions and offering external expertise on what could be put in place to support patients and GPs better. In particular, commissioners will seek consultants who have experience of undertaking this kind of work and expertise in supporting GPs in the management of patients without the need to refer to acute trusts where clinically appropriate.

If this audit is shown to be effective in that a significant proportion of referrals in these specialties with the right support could be managed outside of hospital then a further proposal will be brought forward to the Board to consider supporting the funding of independent triage and GP support for referrals in one or more of these specialties of a more permanent basis.
RECOMMENDED ACTION:

The sub-committee are asked to:

DISCUSS and AGREE to the proposal for the funding of consultant sessions to audit 100 referrals each from cardiology, ENT, urology and respiratory and for a report to come back to a future meeting of the Board with the outcome of this work.

1. BACKGROUND

Enfield has made significant inroads into the number and type of GP referrals sent into our local acute providers. All non urgent GP referrals are expected to be sent through the Referral Management Service (RMS) for triage by a local GP before a decision is taken on whether they are appropriate for a referral into an acute trust. The RMS has successfully managed to get 85% of non urgent referrals now going through it for triage.

In addition, a number of community based services have now been set up in Enfield to act as an alternative care setting to acute hospitals and support to local GPs which include ophthalmology and gynaecology.

Together these initiatives are effectively supporting the aims of the Primary Care Strategy, namely, improving access for patients, improving patient experience and improving patient outcomes.

However, commissioners are looking at how we can make further improvements for patients and so are investigating a number of additional areas where community based services could be set up and these are: ENT, urology, respiratory and cardiology. These are all areas where we feel the development of alternative care settings will act as a better way to manage a significant cohort of patients without the need to go into a local hospital. In addition, these services will have a significant role in supporting local GPs in the management of patients and offering them advice, training and guidance in specific clinical speciality areas.

To help develop these proposals further and in particular to understand the volumes of patients who could benefit from this kind of service and support for GPs there is a need to undertake a retrospective audit of GP referrals within these specialties and this paper proposes how this could be undertaken.

2. PROPOSAL

It is proposed that a clinical audit is conducted of 100 GP referrals that have come through RMS in Enfield by an independent consultant within each of the following specialties: ENT, urology, respiratory and cardiology.

The consultants will be sourced from outside of the two main local acute providers as to provide an independent review of triaging decisions and offering external expertise on what could be put in place to support patients and GPs better. In particular, commissioners will seek consultants who have experience of undertaking this kind of work and expertise in supporting GPs in the management of patients without the need to refer to acute trusts where clinically appropriate.

This audit will inform commissioners over what type of clinical services Enfield patients and GPs could benefit from if consultant triage of referrals was implemented in these specialties. This may include offering advice and guidance to GPs on more appropriate
treatment plans for patients and offering training sessions on particular clinical specialty topics. This in turn will improve the patient experience through a more appropriate and timely management of their condition and ultimately improve clinical outcomes of these patients.

If this audit is shown to be effective in that a significant proportion of referrals in these specialties with the right support could be managed outside of hospital then a further proposal will be brought forward to the Board to consider supporting the funding of independent triage and GP support for referrals in one or more of these specialties of a more permanent basis.

It is anticipated that it will take 8-12 hours for each consultant to review the referrals forms for 100 patients from each specialty and to set out what referral decision they feel would be most appropriate taking into account if there were in place consultant support to provide GPs with advice and guidance on the management of the patients and/or the development of community based services. This equates to the equivalent of 2-3 clinical sessions (4 hours is equal to 1 session) and as such we have estimated that each session will cost around £400 (tbc) and so in total we are proposing an investment of £4800 (4 specialties x 3 sessions at £400 per session) to undertake the audit.

A small working group will be setup to support the audits and in particular review the outcomes of this work and to set out recommendations of what services could be put in place within these specialty areas to improve access, patient outcomes and experience. The Head of QIPP and Service Redesign and the Head of Clinical Commissioning will take this work forward.

**RECOMMENDED ACTION:**

The group are asked to:

**DISCUSS and AGREE** to the proposal for the funding of consultant sessions to audit 100 referrals each from cardiology, ENT, urology and respiratory and for a report to come back to a future meeting of the Board with the outcome of this work.
<table>
<thead>
<tr>
<th>Scheme</th>
<th>Overview</th>
<th>Primary Care Development</th>
<th>Public Health Priorities (see footer)</th>
<th>2012-2013</th>
<th>2013-2014</th>
<th>2014-2015</th>
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<tbody>
<tr>
<td>GP Work Force</td>
<td>To recruit four Clinical Associate GPs to work in each of the four Network areas identified by the borough. The Clinical Associates will be graduate GPs who will split their week between clinical sessions in an Enfield practice, contributing to service development through their local Networks and teaching and professional development</td>
<td>Patient Access • 17,472 additional appointment capacity per annum</td>
<td>Narrowing the gap Healthy lifestyles</td>
<td>£66,757</td>
<td>£383,027</td>
<td>£316,270</td>
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<tr>
<td>Chronic Obstructive Pulmonary Disorder (COPD)</td>
<td>Create a COPD Primary Care pathway.</td>
<td>Patient Access • More services available in GP surgeries</td>
<td>Narrowing the Gap £85,000 (starting Jan)</td>
<td>£264,000</td>
<td>£199,000</td>
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</tbody>
</table>

1. **Healthy Start** – child poverty, infant mortality, childhood obesity, immunisation, under 18 conceptions and maternity services  
2. **Narrowing the Gap** – health inequalities, life expectancy, cardiovascular, cancer rates, respiratory disease, diabetes, long term conditions.  
3. **Life styles** – impact of adult obesity, P.E. sexual health, smoking substance misuse  
4. **Healthy Places** – impacts residents health and wellbeing (deprivation, inequalities, migration, re generation, housing and homelessness, crime etc.
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<tr>
<td>Deep Vein Thrombosis (DVT)</td>
<td>create better patient access for those with suspected DVT and to create a pathway for patients in the community to avoid an A&amp;E tariff (Category 2 investigation with category 1 treatment for attendance £134.40) for those whose results are negative.</td>
<td>Patient Access • Improve patient access to locally based services 7 practices chosen to cover the borough Patient Experience • Improve communication and smooth the patient journey between primary and secondary care • Improve the education of patients around self-management of their conditions. Patient Outcomes • Reduce waiting times for patients needing DVT assessment/treatment</td>
<td>Narrowing the Gap</td>
<td>£11,810</td>
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1. **Healthy Start** – child poverty, infant mortality, childhood obesity, immunisation, under 18 conceptions and maternity services
2. **Narrowing the Gap** – health inequalities, life expectancy, cardiovascular, cancer rates, respiratory disease, diabetes, long term conditions.
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| Anti-Coag| to review and agree in principle the funding for the training, clinical decision support software (CDSS) and clinical governance section for this service. | Patient Access  
• Patient choice  
• Shorter distances to travel  
Patient Experience  
• Patient satisfaction surveys carried out in Haringey who employ a similar model indicates that patients would much rather have their treatment done at a local primary care based clinic rather than be sat in a hospital waiting room for a long period of time.  
Patient Outcomes  
• potentially much greater management of their anticoagulation patients and still have the support of a consultant should they require it. | Narrowing the Gap | £30,000 | £34,450 | £32,445 |

1 **Healthy Start** – child poverty, infant mortality, childhood obesity, immunisation, under 18 conceptions and maternity services  
2 **Narrowing the Gap** – health inequalities, life expectancy, cardiovascular, cancer rates, respiratory disease, diabetes, long term conditions.  
3 **Life styles** – impact of adult obesity, P.E. sexual health, smoking substance misuse  
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| Information Technology        | To migrate all GP Practices to EMIS Web and Vision 360 to enable data sharing. In addition an SMS texting solution [iPato] and a document management solution [DocMan] will also be deployed where needed to further strengthen benefits of collaboration and patient communication. Patient arrival screens will also be deployed at Practices that do not already have them. | Patient Access Increase in appointments through the effective management of DNAs  
Patient Experience Improved experience through collaboration and sharing of patient information.  
Patient Outcomes Data sharing with community, acute and other specialist providers to treat and communicate effectively with patients will reduce delays in treatment and provide early diagnosis | Narrowing the Gap | £500,000   | £500,000   |           |
| Premises (CQC, Improvement grants) | Improve the facilities of GP surgeries.                                                                                                                                                                                                                                                                                                                       | Patient Access Help practices develop storage rooms to treatment rooms  
Patient Experience More fit for purpose premises  
Patients Outcomes Patients get seen in appropriate settings |                                                        | £126,000   | £200,000   | £200,000   |

1 Healthy Start – child poverty, infant mortality, childhood obesity, immunisation, under 18 conceptions and maternity services  
3 Life styles – impact of adult obesity, P.E. sexual health, smoking substance misuse  
4 Healthy Places – impacts residents health and wellbeing (deprivation, inequalities, migration, re generation, housing and homelessness, crime etc
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<th>Public Health Priorities (see footer)</th>
<th>2012-2013</th>
<th>2013-2014</th>
<th>2014-2015</th>
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</table>
| Minor Ailment Scheme (MAS)     | • To improve access and choice for people with minor ailments by promoting self care through pharmacy services, including provision of advice and where appropriate medicines without the need to visit the GP practice.  
• To improve primary care capacity by reducing medical practice workload related to minor ailments. | Patient Access  
• Reduction in GP workload for treating patients with MA (Nationally this equates to 18% GP workload)  
Patient Experience  
• Removes cost barrier to patients who access other providers as a result of having to purchase medication  
Patient Outcomes  
• Making better use of the skills and expertise of community pharmacists and supporting their role as an important 'hub' in the primary care service model  
• Empowering self care agendas | Narrowing the Gap | £60,000 | £170,000 | £170,000 |

1. **Healthy Start** – child poverty, infant mortality, childhood obesity, immunisation, under 18 conceptions and maternity services
2. **Narrowing the Gap** – health inequalities, life expectancy, cardiovascular, cancer rates, respiratory disease, diabetes, long term conditions.
3. **Life styles** – impact of adult obesity, P.E. sexual health, smoking substance misuse
4. **Healthy Places** – impacts residents health and wellbeing (deprivation, inequalities, migration, re generation, housing and homelessness, crime etc
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</table>
| **Consultant Lead Triage** | • To fund a number of consultant sessions to audit 100 GP referrals each from a number of specialties namely cardiology, ENT, urology and respiratory.  
• To understand if the referrals could have been managed in a different way i.e. to establish if the decision could have been different to that actually made e.g. to refer onto acute providers and if they could have been managed differently what support could have been provided to the GP and the patient. | **Patient Access**  
N/A  
**Patient Experience**  
• offering advice and guidance to GPs on more appropriate treatment plans for patients more appropriate and timely management of their condition  
**Patient Outcomes**  
• better health outcome | Narrowing the Gap | £4,800 | | |
| **Primary Care Foundation** | Improve the way practices manage access to their services and respond to urgent requests for care. | **Patient Access**  
Restructuring services internally to create extra access/capacity  
**Patient Experience**  
Patients experience a better quality of service | | £50,000 | | |

1. **Healthy Start** – child poverty, infant mortality, childhood obesity, immunisation, under 18 conceptions and maternity services  
2. **Narrowing the Gap** – health inequalities, life expectancy, cardiovascular, cancer rates, respiratory disease, diabetes, long term conditions.  
3. **Life styles** – impact of adult obesity, P.E. sexual health, smoking substance misuse  
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<tr>
<td><strong>Health Checks</strong></td>
<td>The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease.</td>
<td><strong>Patient Access</strong> Patients attend local GP services <strong>Patient Outcomes</strong> The checks aim to prevent heart disease, stroke, diabetes and kidney diseases by checking patients of certain ages. The checks will identify patient’s risk factors and deliver advice either to help prevent the onset of the above or help patients manage early signs/long-term care for better health outcomes.</td>
<td>Narrowing the Gap Life styles</td>
<td>£154,000</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td><strong>Enhanced Access</strong></td>
<td>Implement a 6 month pilot to increase access for patients by creating additional appointments</td>
<td><strong>Patient Access</strong> 76,896 additional appointments <strong>Patient Experience</strong> Enable patients to access GP appointment quicker</td>
<td>Narrowing the Gap Life styles</td>
<td>£323,799</td>
<td>£323,799</td>
<td>__________</td>
</tr>
</tbody>
</table>

1. **Healthy Start** – child poverty, infant mortality, childhood obesity, immunisation, under 18 conceptions and maternity services
2. **Narrowing the Gap** – health inequalities, life expectancy, cardiovascular, cancer rates, respiratory disease, diabetes, long term conditions.
3. **Life styles** – impact of adult obesity, P.E. sexual health, smoking substance misuse
4. **Healthy Places** – impacts residents health and wellbeing (deprivation, inequalities, migration, re generation, housing and homelessness, crime etc
This paper proposes that Enfield Clinical Commissioning Group implement a COPD Local Enhanced Service (LES) to improve the primary care management of COPD. The proposed service focuses on the following areas:

- Case finding to identify undiagnosed patients (increased spirometry);
- Changes to coding so that patients can be identified to be sent to pulmonary rehabilitation (subject to separate proposals being developed);
- COPD training sessions for local GPs led by secondary care consultants;
- Self management work (recorded MRC breathlessness scale, starter packs, self management advice given and referral to Breathe easy and smoking cessation);
- Twice year review of patients with severe COPD;
- Post discharge review of all admitted COPD patients.

As mentioned above, the proposal is that this service can only be delivered by GP practices and so will be delivered through a Local Enhanced Service (LES). This proposal has been approved by the Enfield Primary Care Subcommittee of the Health and Well Being Board and the NCL Programme Board for Primary Care Strategy The contents of the LES are adopted from the NHS Islington LES for COPD, with some minor amendments where for Enfield more of a focus on smoking cessation was identified as important for the borough.

This report describes the LES in detail and requests that the Committee approve £259k of spend from the Enfield Primary Care Strategy budget for a 12 month period likely to span two financial years. This paper seeks approval for the budgeted spend, further work will be undertaken for approval of the LES.

**RECOMMENDED ACTION:**

The Committee are asked to:

**APPROVE** the proposal that funding from the Primary Care Strategy budget for Enfield be invested in creating a COPD Local Enhanced Service (LES).
Objective(s) / Plans supported by this paper:
Principle Objective 2: To deliver the NHS North Central London QIPP Plan.

Patient & Public Involvement (PPI): Patient and public involvement has been sought through existing channels and meetings with patients and representative groups to inform the work that is presented to the Committee.

Equality Impact Assessment: Not applicable.

Risks: There are no new risks to be recorded.

Resource Implications: Funding is available via the Primary Care Strategy funds already agreed with NCL for Enfield on non-recurrent basis.

Audit Trail: There is no audit trail for this report.

Next Steps: Development of Local Enhanced Service Specification
1. INTRODUCTION

In comparing Enfield's range of primary care enhanced services to that of other boroughs in North Central London, Enfield has the least Local Enhanced Services. Islington and Camden have the widest range of enhanced services. Clinical leaders in Enfield have reviewed the enhanced services offered in other boroughs against the health needs of patients in the borough. From the review, it became evident that the COPD Local Enhanced Service offered to patients in NHS Islington would be hugely beneficial to patients if offered in NHS Enfield. Therefore, an Enfield version of the LES was presented to the Enfield Primary Care Subcommittee of the Health and Well Being Board in September 2012. The group is made up of a wide range of stakeholders including, clinicians, patient representatives and colleagues in the local authority. The group approved the LES and made a recommendation that the NHS North Central London Primary Care Strategy Programme Board approve the spend of £259k against the NHS Enfield Primary Care Strategy budget so that the LES can be offered to patients in Enfield. The Programme Board approved the initiation of the LES in October 2012. The FR&Q Committee are now asked to ratify the release of funding to develop a LES for COPD in Enfield based on the contents of this report.

According to the London Health Programmes profile for Chronic Obstructive Pulmonary Disease (COPD) in Enfield for 2011, there were a recorded 2,854 people living with COPD, compared to an expected 10,225 un-recorded/ diagnosed. There were also 251 deaths associated to COPD and 378 emergency admissions related to COPD for patients registered as having COPD. Overall, costs for Obstructive Airways Disease (which was a previous term for COPD) were calculated to have been in the region of £1.2m.

2. LINKS TO WIDER SERVICE REDESIGN WORK FOR COPD

A business case for a community respiratory service to manage patients with COPD is in development as part of NHS Enfield’s QIPP strategy. The community service will deliver an integrated service closer to the patient, improving patient outcomes, reducing hospital admissions and length of stay. The service will deliver care for patients with COPD and other respiratory conditions that can be managed in the community and will comprise community clinics, domiciliary visits, pulmonary rehabilitation and oxygen services. The service will be an integrated service that manages a pathway of care across GP, community and acute care.

The community service will manage those patients whose diagnosis of COPD is confirmed with spirometry. The service will only accept referrals from GPs with a confirmed diagnosis. The service will manage patients during an exacerbation, preventing admission to an acute trust and support the early discharge of those who are admitted. On discharge from the community service, the service will hand the patient over to the GP practice for ongoing management of their COPD.

The community service does not include capacity to identify patients nor to offer primary care education but is dependent on primary care to undertake these responsibilities in order to reduce future admissions and to manage those patients who are discharged from the community service. The service will be reliant upon the LES to ensure GP practices are able to diagnose and manage patients with COPD.
The pulmonary rehab programme consists of a programme of twelve classes which are available for those patients who would benefit from pulmonary rehab with a confirmed COPD diagnosis. Classes will be available twice a week throughout the year.

3. PROPOSED COPD LOCAL ENHANCED SERVICE

The NHS North Central London Primary Care Strategy describes the vision for Primary Care Networks. Networks of practices in a locality working together to deliver services to their own and other practices patients. In the case of COPD, an example could be that one of the practices in a Network delivers Spirometry to COPD patients from the whole Network. In this example, the practice who carries out the Spirometry may seek to gain remuneration from the other practices in the Network for their staff time or per Spirometry carried out. They may also wish to seek reimbursement through their practice nurse or a salaried GP attending each of the practices in the Network to carry out a COPD clinic to deliver the LES. This type of arrangement will be at the discretion of practices, however the intention of this LES is that the markers within it are not focused on individual practices, they are focused on Network wide achievement of the markers.

In terms of payment. Payments for the LES will still be made to individual practices and sign up will also remain with individual practices. Practices will sign up to the LES and hold the same contractual standing as any other LES, in so far as the contract will be with the commissioner and the practice as provider. The difference between this LES is that practice achievement of the markers within the LES will be awarded based on the achievement of the Network. Where the marker requires 80% coverage, this will be taken from the Network average, as opposed to the practices actual percentage achievement. Therefore, even where a practice individually achieves 80%, if the Network average is below this, the practice will not recoup all of the payment for that component of the scheme.

To participate in this LES, the Network must:

- Provide care that meets the requirements of the 6 components of this LES.
- Code activity using READ codes to enable ease of data extraction for reimbursement.
- Return all reporting data as required by the CCG and actively participate in evaluation exercises conducted by the CCG.

**Payment**

- One third of the maximum payment for the LES will be paid up front on based on a practice’s list size.
- Final payment will be made based on data provided to the CCG relating to activity based on the practice’s list size.

Payment for each element of the LES is summarised in the table below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Monitoring requirement</th>
<th>Payment</th>
<th>Network or practice achieved</th>
<th>Source of data</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD 1: COPD leadership, learning and</td>
<td>Completion of a practice-based COPD learning session and report</td>
<td>£600 lump sum per practice</td>
<td>Practice</td>
<td>Practice sign-up information sent to CCG</td>
</tr>
<tr>
<td>development sent to PCT</td>
<td>COPD 2: Case finding</td>
<td>COPD 3: Supporting self-management, smoking cessation and Pulmonary Rehabilitation</td>
<td>COPD 4: Additional management of patients with very severe COPD</td>
<td>COPD 5: Managing care post unplanned hospital admission or emergency department</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>The number of case finding spirometries performed (on eligible patients)</td>
<td>£20 per case finding spirometry up to a maximum of 75 per average list size</td>
<td>a) 70% of patients on COPD register given advice on self-management (including self-management booklet)</td>
<td>Number of patients with very severe COPD who have had 2 reviews in the year and for which all essential clinical parameters have been completed</td>
<td>Number and percentage of patients reviewed post unplanned admission or emergency department</td>
</tr>
<tr>
<td>Practice (although could be provided by Network)</td>
<td>End of LES audit</td>
<td>b) 80% of patients with MRC dyspnoea score grades 3,4, 5 ever referred to pulmonary rehabilitation (once this is up and running)</td>
<td>£50 per patient with severe COPD with a minimum coverage of 70%</td>
<td>£50 per post-admission/attendance review with a minimum of 70% of post admission/attendance reviews conducted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) 90% of patients on the COPD register referred to the smoking cessation service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>d) Number of appropriate COPD patients given a starter pack</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>£1200 per average sized-practice² for a and b.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practices will be expected to deliver (c) but they will not be measured for achievement/payment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 The amount per case finding spirometry is static (i.e. £20) but the maximum will vary by list size.
Exception Reporting

This LES will allow exception reporting for the following:

- Patients who have been recorded as refusing or unable to take part in a review, who have been invited on at least three occasions during the preceding twelve months.
- Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. terminal illness.

COPD 1: COPD LEADERSHIP AND LEARNING IN THE PRACTICE

Aim

- To support and improve the clinical leadership of COPD in practices and to support practice staff to maintain up-to-date knowledge of COPD and its management.

Process

Practices must:

a) Identify a named COPD clinical lead in the practice.

b) Devote a practice education session of at least 2 hours duration to COPD education and learning. This session should be attended by all practice staff involved in the care and management of COPD patients.

The resources/sessions listed under (A) below are sufficient on their own to make up this 2 hour education session. If practices choose to use the resources/sessions listed in (B), they will need to combine at least two of these, in order to make up the two hour education session. The resources listed in (B) are all valuable learning tools, but on their own are not sufficient.

Section A

a. A facilitated session by a respiratory consultant. This training session could be based on the IMPRESS COPD Learning Package (DVD & CD) “Effective Care - Effective Communication: Living and Dying with COPD” or other appropriate learning resources e.g. the Bristol COPD Knowledge Questionnaire (see Appendix 10 for more information) following discussion & agreement with Dr Stern

Section B

b. “In-practice” assessment of spirometry competence (technique and interpretation) via direct observation and feedback by Respiratory Consultant – except where there is an agreement that this will be done pan Network. In which case, the assessment will be with the clinician carrying out Spirometry.

c. Completing a BMJ Learning module on COPD. 
(http://n3.learning.bmj.com/learning/main.html)

d. Completing the Bristol COPD Questionnaire
e. Any other education/training resources on COPD that the practice considers appropriate to their individual learning and CPD needs, in consultation with the PCT.

c) Have a spirometer and pulse oximeter – if carried out by Network then an agreement will be sought as evidence that this is in place and expected by the Network.

d) Ensure all staff performing spirometry has attended an approved/accredited competency based training course in spirometry in the past two years or an update if they have been trained previously.

Reporting & payment

Practices will be paid a lump sum of £600 for:

- Attendance at LES launch
- Returning a statement that the practice has completed the COPD education and learning session and the names of the practice staff who attended/completed it
- Providing the name of the clinical lead and the date of last training/update for clinicians who do spirometry at the practice or Network

COPD 2: CASE FINDING

Aim

- To identify patients with undiagnosed COPD

Process

Patients eligible for case finding spirometry as part of this LES include those over 35, who are smokers or ex-smokers with any of the following symptoms: exertional breathlessness, chronic cough, regular sputum production, frequent winter ‘bronchitis’ or wheeze, who have no clinical features of asthma (NICE guidance). If patients meet the eligibility criteria for case finding spirometry, but have undergone spirometry in the previous two years, clinical judgement should be used to determine whether to offer repeat spirometry, based on the patient’s symptoms.

Practices are free to choose how they identify their eligible patients, for example opportunistically (when they attend for an appointment) or by trying to identify them from patient records and inviting them in specifically for spirometry, or by a combination of methods. Three approaches are described below as examples:

a) An opportunistic approach: Practices could assess patients for their eligibility for spirometry (check for symptoms if current or ex-smoker and over 35) when they attend for another appointment such as an annual review for mental health, cardiovascular disease, diabetes or asthma, an Upper Respiratory Tract Infection (URTI), an NHS Health Check, and at any smoking-related appointment (e.g. smoking cessation, smoking status check).

b) Using a batch process or practice-specific ‘follow up’ system: Practices could put a ‘flag’ or ‘follow up’ note on all patients aged over 35 who are smokers or ex-smokers, who have not received spirometry in the past two years (Please see Appendix 2 for list of relevant codes to use in your practice search). When these
patients attend the practice they can be asked if they have symptoms and, if they fit the NICE criteria, be offered spirometry.

c) Searching for eligible patients using respiratory codes: If a practice codes respiratory symptoms\(^3\), they can search their records for all patients who are over 35 and are smokers/ex smokers with coded symptoms consistent with NICE criteria for COPD and invite them into the practice for spirometry. As in (b) above, patients who have previously undergone spirometry at any point in the past should be excluded.

Irrespective of the approach used to case finding patients with undiagnosed COPD, practices may want to consider prioritising eligible patients (i.e. 35+, smoker/ex-smoker with symptoms) in the following groups:-

- Patients with a mental health diagnosis (owing to evidence of under-diagnosis of physical health problems in this patient group and higher than average smoking prevalence).
- Patients with cardiovascular disease (local data indicate that in 40% of all deaths where COPD was a contributing factor and not the original underlying cause, CVD was the main underlying cause).

**Reporting & payment**

Data on the total number of case finding spirometries conducted (READ CODE 68M) will be extracted remotely by the PCT. Practices will be paid at the end of the LES.

Practices will be paid £20 per case finding spirometry conducted up to a maximum of 75 per average list size.

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**COPD 3: SUPPORTING SELF-MANAGEMENT AND PULMONARY REHABILITATION**

**Aim**

- To improve patient self management and increase referrals to smoking cessation, pulmonary rehabilitation for eligible patients

**Process**

This part of the LES includes four elements:

a. **Patient self-management - goal setting**

Practitioners are expected to use the ‘COPD Self-management Plan’ booklet\(^4\) to facilitate self-management discussions with COPD patients. Self-management is a new approach for many patients and they will require practitioners to spend some time supporting them in order to benefit. In some instances this support may involve helping patients fill in certain sections of the self-management plan booklet. Patients should be encouraged to bring their booklet to all appointments for updating. Practitioners should identify goals with the patient and make a plan for their completion (READ CODES 66YI and 67L).

b. **Pulmonary Rehabilitation**

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\(^3\) It is recognised that many practices do not code respiratory symptoms which is why this is presented as an option.
Pulmonary Rehabilitation should be offered to all patients who are functionally disabled by breathlessness (MRC dyspnoea score grades 3, 4 and 5). Note that Pulmonary Rehabilitation is not available at present in Enfield, but once this is available then this part of the LES will be implemented.

c. Patient self management - starter packs
Patients on the COPD register should be recorded as either at risk or not at risk of an exacerbation based on exacerbation history and severity of disease. Those at risk should be given a starter pack (a course of corticosteroids and antibiotics) (READ CODE 8CR1)\(^5\).

d. Signposting COPD patients to relevant resources and training
Practices should ensure that they discuss relevant resources and training with their COPD patients, such as the Expert Patient Programme course, and refer/signpost the patient as appropriate. Practices should consider making the short video on Raising Awareness of Pulmonary Rehabilitation available on the practice screens where applicable.

e. Referral to Smoking Cessation Service
Practices should ensure that patients are referred to the smoking cessation service. All patients with COPD should have their smoking history recorded and all smokers should be encouraged to stop smoking either with primary support from the practice or via a referral to the stop-smoking service.

Reporting & payment

Remote data extractions will be carried out on the following elements for payment purposes:

a) Percentage of patients on the COPD register given advice on self-management (including self management booklet, READ code 66YI) – full payment for 70% for all patients with COPD.

b) Percentage of patients with MRC dyspnoea score grades 3, 4 and 5, referred to (or declined) pulmonary rehabilitation – full payment for 80% for all patients with COPD MRC grades 3, 4 & 5 ever referred to pulmonary rehabilitation.

c) The number of appropriate patients given a starter pack – no payment for this.

d) Percentage of patients referred to smoking cessation

Payment of £1,200 per practice for average list size will be paid upon completion of the audit.

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**COPD 4: ADDITIONAL MANAGEMENT OF PATIENTS WITH VERY SEVERE COPD**

Aim

- To improve management of people with very severe COPD (FEV\(_1\) <30% predicted).

Process

Practices should ensure that patients with very severe COPD (FEV\(_1\) <30% predicted) are reviewed every six months\(^6\) and receive as a minimum the following assessments:

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\(^5\) See NICE guidance

\(^6\) NICE guidance – need to reference in full please.
• Spirometry
• Review of medications
• Oxygen saturation (SaO2) - patients with SaO2<92%, when stable, should be referred to secondary care for arterial blood gases and assessment for Long Term Oxygen Treatment.

In addition, practices may wish to consider undertaking the following assessments, if appropriate:

• If on Long Term Oxygen treatment, record last assessment.
• If on Non Invasive Ventilation record last assessment.
• Health education on diet (measure BMI if appropriate)
• Smoking cessation intervention for patients who are still smoking.
• Need for social services and occupational therapy input and referral to SHINE.
• Need for referral to community respiratory team.
• Advanced Care Planning discussion, if patient’s wishes are not known, including CPR, Non Invasive Ventilation and place of care (using available literature, see Appendix 6) and include on the supportive/palliative care (GSF) register if appropriate.
• Screening for anxiety and/ or depression.
• Documentation of co-morbidities e.g. heart failure
• Whether the patient is at risk of osteoporosis.  

The COPD EMIS template will be updated to incorporate fields/tick boxes for “heart failure?” and “at risk of osteoporosis?”, and this updated template will be loaded onto practice systems remotely. Practices’ permission will be sought in advance. A similar process will take place for Vision-360 practice systems. As iSoft will no longer be supported no templates will be developed for this system.

**Reporting & payment**

A payment of £50 will be made for each severe patient who has received such care. To receive this payment, practices will be expected to achieve this for at least 70% of patients in the Network with severe COPD, as measured by having completed the spirometry, medication review and SaO2. An average sized practice can expect to have less than ten very severe patients.

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**COPD 5: MANAGING CARE POST HOSPITAL ADMISSION AND POST EMERGENCY DEPARTMENT ATTENDANCE**

**Aim**

• To improve the review and management of people post unplanned hospital admission or emergency department (ED) attendance (and to prevent readmission/re-attendance where possible)

**Process**

Practices should ensure that patients are contacted within 14 days of receipt of a discharge summary following a non-elective admission with COPD (including an acute exacerbation,
pneumonia, other) or following an emergency department (ED) attendance or a review. If any of these hospital admissions or attendances is incorrectly coded as COPD, please record and report coding error to the hospital and copy to the Enfield CCG acute commissioning lead.

The review should be in person (if required) or by telephone and include (where necessary):

- Confirmation of the COPD diagnosis if not previously made with spirometry.
- Confirmations that follow up arrangements for smoking cessation interventions are in place for current smokers.
- Assessment of inhaler technique
- Oximetry
- Symptom control (day and night)
- New/worse ankle oedema
- Medication review to a) clarify any changes made to maintenance medications on discharge and to make sure these are continued or discontinued appropriately and b) to assess patient’s need for blister packs, and where indicated, to make the necessary arrangements.
- Offer of pulmonary rehabilitation, if patient has not been referred within the past year or not already arranged by the hospital.
- Screening for anxiety and/or depression.
- Assessment of social care, enablement? Or SHINE requirements and referral where necessary, if not arranged on discharge.
- Advanced Care Planning discussion, if patient’s wishes are not known, including CPR, Non Invasive Ventilation and place of care

Reporting & payment

At the end of LES audit, practices should submit data on the number and percentage of post hospital admission/attendance (ED and non-elective inpatient) reviews conducted. Practices should also report the number of unplanned hospital admissions and ED attendances incorrectly coded as COPD. A data return template will be provided for this purpose.

A payment of £50 will be made for each post-admission or ED attendance review. To receive this payment, Networks will be expected to have done a review following at least 70% of unplanned admissions/attendances.

**COPD6: Audit of medication use in COPD**

**Aim**

To ensure practices are aware of responsible and appropriate use of medicines in COPD

**Process**

Practices should assess two areas of medication usage in their COPD population which would benefit from audit

The specific audits below have been chosen to avoid duplication of other medicines management work (for instance freed up resources scheme in South Islington, Quality and Outcomes Framework MEDICINES audits agreed with prescribing advisors).
Standards for the audit should be discussed with the practice team. The audit cycle should be completed within the timeframe of the LES and a copy of the audit returned to NHS Enfield.

Practices should audit the following two groups of patients to analyse prescribing in the past year:

- Review of all patients on a combined inhaler usage including recording of COPD severity, record of pulmonary rehabilitation offer, record of stopping smoking intervention (if current smoker) and medication review.
- Audit of varenicline prescribing for patients with COPD who are current smokers, assessment of number of support sessions offered and proportion of patients prescribed NRT concomitantly, outcome of intervention.

**Reporting and payment**

Practices will be paid a lump sum of £500 for performing the audits per average sized practice. Practices will be provided with an audit template for this purpose.

**4. FINANCE**

The scheme overall is expected to cost the borough in the region of £259k over a 12 month period, dependent on practice take up and on individual practice achievement. This equates to an average per practice of approximately £4,800 per annum.

As noted by the Primary Care Subcommittee of the Health and Well Being Board, the group would like to ensure that the investment put in to practices is additional. Practices will therefore be asked, as part of a spot check audit, to provide evidence that the £4,800 investment was in addition to existing capacity.

**Table 1. Investment per domain**

<table>
<thead>
<tr>
<th>Marker</th>
<th>COPD 1</th>
<th>COPD 2</th>
<th>COPD 3</th>
<th>COPD 4</th>
<th>COPD 5</th>
<th>COPD 6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice</td>
<td>600</td>
<td>1500</td>
<td>1200</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>4800</td>
</tr>
<tr>
<td>Borough</td>
<td>32400</td>
<td>81000</td>
<td>64800</td>
<td>27000</td>
<td>27000</td>
<td>27000</td>
<td>259200</td>
</tr>
</tbody>
</table>

**4. NEXT STEPS**

Following a decision by the Committee on whether to sanction the investment into the LES for COPD, the LES will be presented to the Clinical Commissioning Group (CCG). Should the CCG decide to approve the LES, the CCG will make a recommendation to the NHS Commissioning Board that the LES be implemented and funding be provided via the NHS North Central London Strategy.

**RECOMMENDED ACTION:**

The Committee are asked to:

APPROVE the proposal that funding from the Primary Care Strategy budget for Enfield be
invested in creating a COPD Local Enhanced Service (LES)
Proposal for an Advanced Access Local Enhanced Service pilot

LEAD DIRECTOR: Liz Wise
Chief Officer (Designate)
Enfield Clinical Commissioning Group

AUTHOR(S): Sean Barnett
Programme Manager – Primary Care Development

Daniel Morgan
Project Manager – Primary Care Development

CONTACT DETAILS: Daniel Morgan
Daniel.morgan@nclondon.nhs.uk

SUMMARY:
Stakeholder feedback gathered as part of the development of the Enfield Primary Care Strategy Implementation Plan has highlighted the need to improve access to primary care in Enfield. Improving access can be achieved through a range of different routes, Enfield Clinical Commissioning Group (CCG) wishes to implement a Local Enhanced Service (LES), investing in additional practice level capacity to offer additional appointments to local people. This paper outlines the proposed Local Enhanced Service, which will cost the borough £647K over 6 months from funds allocated to delivery of the Primary Care Strategy and sustained longer term on a ‘spend to save’ basis through the reduction of A&E attendances that could have appropriately been managed in primary care.

The proposed Local Enhanced Service (LES) will generate 76,896 additional appointments in the 6 month period. This equates to £8.40 per appointment, which if compared to the lowest priced A&E attendance cost would mean that for every 6 extra GP appointments delivered, if only 1 A&E attendance was reduced the scheme would break even.

In addition to the LES, Enfield has already started work in partnership with local practices and the Primary Care Foundation to look at practice systems for managing patient demand. The borough also has plans to introduce the minor ailments scheme, which again will help to improve access, reducing the reliance of GP practices for administering prescriptions for some minor ailments. Whilst these initiatives will improve access, it is felt that employing additional GP capacity will further improve access and reduce the level of A&E attendances for primary care complaints, therefore moving the capacity to primary care instead of A&E.

RECOMMENDED ACTION:
The Committee are asked to:

- APPROVE the proposal to launch a 6 month pilot using funding from the primary care strategy
Objective(s) / Plans supported by this paper:
Principle Objective 2: To deliver the NHS North Central London QIPP Plan.

Patient & Public Involvement (PPI): Patient and public involvement has been sought through existing channels and meetings with patients and representative groups to inform the work that is presented to the Committee.

Equality Impact Assessment: Not applicable.

Risks: There are no new risks to be recorded.

Resource Implications: Resources are from the top-sliced Primary Care Strategy funds already agreed.

Audit Trail: There is no audit trail for this report.

Next Steps: Development of a Local Enhanced Service Specification
1. INTRODUCTION

At the September 2012 meeting of the Enfield's Health & Well Being Board Subcommittee, the group tasked with implementing the Primary Care Strategy in Enfield, a paper was tabled which outlined the results of the short term pilot of Doctor First, which was a Local Enhanced Service rolled out in March 2012, the paper outlined proposals for a new Access Local Enhanced Service for Enfield, proposing an investment of £647K to improving patient Access, highlighting the need for improved Access based on satisfaction rates and patient/stakeholder feedback.

The subcommittee gave feedback on the paper that was tabled, focusing on the weighting on particular markers within the scheme and the need for any new investment to provide additional capacity to what is offered at present. Therefore, practices adopting the Local Enhanced Service would need to show how the additional investment is being used over and above that of current investment. This paper provides the group with an updated proposal following further feedback gathered at the October meeting of the subcommittee and the NHS North Central London Primary Care Strategy Programme Board.

2. UPDATED PROPOSAL FOR ACCESS LES

Whilst there were some successes of the Doctor First pilot in March 2012, in particular where those practices who offered the greatest number of extra appointments saw small increases, or reductions, in A&E attendances, feedback from practices has been that the extra capacity was a positive change, but the timescale for implementation meant that they were unable to raise enough public awareness to make it a complete success. The LES outlined below seeks to build on the previous pilot.

a. Structure of the longer term pilot

It is proposed that the pilot period is 6 months. The proposed structure of payment for the LES is as follows:

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>Percentage weighting</th>
<th>Total cost of component</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Access action plan, where practices will explain how they intend to advertise their appointment system and increase in appts</td>
<td>3%</td>
<td>£21,200 (£392 per practice)</td>
</tr>
<tr>
<td>2.</td>
<td>Attendance at telephone triage training for all practice clinicians carrying out this activity</td>
<td>3%</td>
<td>£21,200 (£392 per practice)</td>
</tr>
<tr>
<td>3.</td>
<td>Increased appointments offered to patients in line with ratio per practice list size</td>
<td>60%</td>
<td>£384,000</td>
</tr>
<tr>
<td>4.</td>
<td>Practices/Networks to provide a bypass number to local A&amp;E departments and 111 service who need to refer patients back to the practice</td>
<td>3%</td>
<td>£21,200 (£392 per practice)</td>
</tr>
<tr>
<td>5.</td>
<td>The Networks GP</td>
<td>31%</td>
<td>£200,000</td>
</tr>
</tbody>
</table>
### Satisfaction Survey results

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>to be at or higher than</td>
<td>the London average in specified questions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

#### (1) Access action plan

Practices to complete and submit an access action plan outlining the proposed changes they intend to make to their appointment system. The action plan will need to describe how the practice intends to publicise the increase in telephone triage appointments. Practices will be expected to advertise the changes to their appointment system, clearly describing the additional practice capacity being employed to improve patient access and to offer telephone triage for urgent on the day appointment requests. Practices will be required to explain how they intend to do this as part of the Access action plan. This component is worth £392 per practice.

#### (2) Telephone triage training

NHS North Central London will provide two half day sessions of telephone triage training for GPs. Each practice taking part in the LES will need to be represented by the GP or GPs who will carry out triage for the practice. Where triage will be across a Network of practices, those GPs who will be carrying out the triage will be expected to attend the training and this arrangement specified in each practices’ access action plan (see above). This component is worth £392 to participating practices.

#### (3) Increase in telephone/ face to face appointments

Every patient who requires an urgent on the day appointment with the practice should be able to receive an appointment, whether as part of a telephone consultation or a face-to-face contact with a GP. To ensure this is the case, practices will be asked to provide a baseline number of appointments delivered in the same six month period in the previous year. Practices will then be asked to deliver an increase in appointments in line with their practice list size.

<table>
<thead>
<tr>
<th>Practice list</th>
<th>Number of additional sessions per week*</th>
<th>Number of additional appointments in 6 month period**</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 2,000</td>
<td>1</td>
<td>432</td>
</tr>
<tr>
<td>2,001 – 4,000</td>
<td>2</td>
<td>864</td>
</tr>
<tr>
<td>4,001 – 6,000</td>
<td>3</td>
<td>1,296</td>
</tr>
<tr>
<td>6,001 – 8,000</td>
<td>4</td>
<td>1,728</td>
</tr>
<tr>
<td>8,001 – 10,000</td>
<td>5</td>
<td>2,160</td>
</tr>
<tr>
<td>10,000 and above</td>
<td>6</td>
<td>2,592</td>
</tr>
</tbody>
</table>

*1 session = 3 hours
**10 minutes per appointment

#### (4) A&E/111 redirection

Practices will be expected to offer appointments to patients redirected back to primary care from A&E. This element of the scheme can be offered as a Network or individually by practices. Practices must offer a bypass phone line so that A&E departments can contact the practice. At least 10% of these additional appointment slots should be reserved and allocated only for redirected patients (eg A&E or 111 redirection).
(5) GP Patient Satisfaction Survey

Practices will be remunerated for this section of the LES dependent on the success of the Network, with a sliding scale for payment, therein encouraging practices to work together to improve their appointment systems. Each Network will need to achieve a satisfaction score at or above the London average for questions related to:

- How easy it is to get through to the practice on the phone (Enfield 62%, London 64% and England 67%);
- Ability to see a GP fairly quickly (Enfield 75%, London 76% and England 80%);
- Satisfaction with opening hours (Enfield 76%, London 76% and England 78%);


Payment for this element of the LES will be dependent on the success of each Network. However, as practices will have had to bear the cost of employing additional staff, a sliding scale will be used for payment so that failure by one practice does not mean complete failure for the whole Network.

<table>
<thead>
<tr>
<th>Percentage of practices in Network achieving target</th>
<th>Payment of component of LES for those practices who met target</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>80 – 99%</td>
<td>75%</td>
</tr>
<tr>
<td>65 – 79%</td>
<td>65%</td>
</tr>
<tr>
<td>50 – 64%</td>
<td>50%</td>
</tr>
<tr>
<td>25 – 49%</td>
<td>30%</td>
</tr>
<tr>
<td>1 – 24%</td>
<td>15%</td>
</tr>
</tbody>
</table>

As an example. If 50% of practices achieved the target, that 50% would only receive 50% of the total payment they would have received for achieving this element of the scheme.

b. Expected benefits

The LES is expected to generate additional practice level capacity, increasing the availability of appointments to patients, improving practice morale, enabling more care to be delivered in primary care, increasing patient satisfaction with access and improving the patient’s experience, as well as reducing the number of patients attending A&E unnecessarily for primary care complaints, therein reducing the overall cost to the NHS and increasing the amount of capacity A&E departments have to respond to medical emergencies.

3. FINANCE AND ACTIVITY

The proposed amount of funding for the scheme is £647,600 over 6 months. The scheme will be broken down into 5 components, the bulk of the funding being allocated towards additional appointments, with the rest to funding allocated to process and outcome targets.

As noted by the Primary Care Subcommittee of the Health & Well Being Board, the group would like to ensure that the investment put in to practices is additional. Practices will therefore be asked, as part of a spot check audit, to provide evidence that the investment was in addition to existing capacity.
Table 1 below shows the cost of the scheme in comparison to the total number of additional appointments to be delivered. As is shown below, the cost per additional GP appointment (dividing the costs of all components of the scheme by the total number of appointments to be delivered) is £8.40. Comparing the GP appointment cost to the cost of the lowest priced A&E attendance (£54), table 2 shows that an average of 6 GP appointments can be delivered from the LES for the price of one A&E attendance.

Table 1. Cost per GP appt of the scheme

<table>
<thead>
<tr>
<th>Description</th>
<th>£</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of the scheme</td>
<td>£647,600</td>
<td></td>
</tr>
<tr>
<td>Number of GP appts</td>
<td>76,896</td>
<td></td>
</tr>
<tr>
<td>Cost per appt</td>
<td>£8.40</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Cost comparison GP appts funded by the scheme compared to the lowest cost A&E attendance

<table>
<thead>
<tr>
<th>Description</th>
<th>£</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of lowest cost A&amp;E att w/o MFF</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>No of GP appts for cost of 1 A&amp;E att</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Based on the assumption that through the LES at least 1 in 6 additional GP appointments that were not delivered would have converted into 1 A&E attendance, the scheme will break even ensuring reducing a total of 11,993 A&E attendances in the 6 months of the pilot. Chart 1 shows a break down of the decrease per month, assuming that the reduction is loaded towards the end of the pilot where increased awareness of additional GP capacity is in place.

Chart 1. Break even forecast

Table 3. Number of A&E attendances to be reduced to create scheme breakeven over 6 months

<table>
<thead>
<tr>
<th>Description</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of GP appts from LES (increase)</td>
<td>76,896</td>
</tr>
<tr>
<td>Breakeven no of A&amp;E atts (reduction)</td>
<td>11,993</td>
</tr>
</tbody>
</table>
4. NEXT STEPS

Should the group approve the scheme, the LES specification will need to be approved by the Clinical Commissioning Group and the Central Management Team before it can be implemented. The specification will need input from the Local Medical Committee also before it is finalised.

RECOMMENDED ACTION:

The Committee are asked to:

- APPROVE the proposal to launch a 6 month pilot using funding from the primary care strategy

DATE: 25th October 2012

TITLE: Proposal for primary care based DVT service

LEAD DIRECTOR/MANAGER: Dr Mo Abedi
PEC Chair

AUTHOR(S): Sarah Garner
QIPP and Service Redesign Project Manager

SUMMARY:
This paper has been written to seek funding for a primary care hub-based DVT testing model for Enfield which was approved to be developed by the Enfield Financial Recovery and QIPP Committee at its September 2012 meeting and the Health and Well Being Subcommittee overseeing developments in Primary Care.

National prevalence of DVT suggests an incidence of 1:1000 per annum (estimated prevalence rate in Enfield pop. 300 cases per year). This is a crude rate and makes no allowance for DVTs occurring whilst in hospital. The actual number of patients receiving a confirmed diagnosis in Enfield was 37 in 2011/12 (significantly lower than the rate expected).

There were 502 patients presenting with a suspected DVT in 2011/12 at Barnet and Chase Farm Hospital and North Middlesex University Hospital. This is higher than the estimated prevalence rate and 227 of these have been referred to A&E via their GP, generating 700 follow up attendances, approximate cost for the service is £122,035 per annum. This is costed at £134.40 for an A&E Category 2 investigation with category 1 treatment (including MFF) and on average three follow ups charged at the same tariff.

Whilst accurate figures for DVTs presenting in primary care are difficult to find, studies of referral of swollen leg/suspect DVT have shown conversion rates from suspicion to proven of between 33% and 50%, (National Institute for Clinical Excellence).

Traditionally, patients with suspected DVT have been diagnosed and managed in secondary care. Following the introduction of near patient testing kits and assessment tools for DVT diagnosis can now be managed in primary care and as a result lead to a more safe and effective way of excluding this condition in the community in patients with a low probability of the condition.

The proposed pathway and savings rely on GPs undertaking the Wells Score Test before appropriately referring on to a GP hub for a D Dimer test. If this is found to be positive the patient will be referred to secondary care for a Doppler ultrasound and further treatment.
The aim of this service is to enter into a Local Enhanced Service (LES) with approximately seven GP practices based between the four clusters (for equal distance travel for patients) to:

- Provide suitable treatment
- Improve patient access to locally based services
- Reduce in waiting times for assessment
- Improve communication and smooth the patient journey between primary and secondary care
- Provide better value for money due to a more cost effective use of resources
- Reduce in the number of times patients have to attend secondary care and the subsequent reductions in follow up appointments
- Improve patient satisfaction through delivering a quick, accessible and quality service
- Improve the education of patients around self-management of their conditions
- Improve the quality of GP referrals and the management of DVT

\textbf{NB:} 7 practices have been chosen by location, for patient travel ease and also in order to meet the criteria practices will need suitably qualified staff to be on duty during GP opening hours, which not all practices can adhere to.

This Group is asked to approve the funding for the new service which amounts to £11,810 which consists of the D Dimer equipment (£5000) and a payment of £30 for each patient that is given a D Dimer Test (£6810).

\textbf{RECOMMENDED ACTION:}

The Committee are asked to:

\textbf{COMMENT} and \textbf{APPROVE} on the proposals outlined in this report and in particular the funding of £11,810 to set up this proposed service.

\textbf{Objective(s) / Plans supported by this paper:}
Principle Objective 2: To deliver the NHS North Central London QIPP Plan.

\textbf{Patient & Public Involvement (PPI):} Patient and public involvement has been sought through existing channels and meetings with patients and representative groups to inform the work that is presented to the Committee.

\textbf{Equality Impact Assessment:} Not applicable.

\textbf{Risks:} There are no new risks to be recorded.
Resource Implications: There are no direct resource implications from this report.

Audit Trail: There is no audit trail for this report.
1. INTRODUCTION

In line with Care Closer to Home being a choice for patients and the Department of Health White Paper January 2006 Our Health, Our Care, Our Say: a new direction for community services plans to give patients access to services within the community they may have found difficult to access previously such as community based DVT testing.

The service objective is to create better patient access for those with suspected DVT and to create a pathway for patients in the community to avoid an A&E tariff (Category 2 investigation with category 1 treatment for attendance £134.40) for those whose results are negative.

The pathway

- Patients will present at their GP practice.
- GP will inform patient of suspected diagnosis and undertake a Wells Scoring Test.
- If the Wells Scoring Test indicates a high probability the GP will make an appointment for the patient to attend a cluster GP practice for a D Dimer Test.
- If the patient is attending an appointment with a cluster GP practice the D Dimer Test will be made available to them.
- If positive the GP will send the patient to the nearest A&E for treatment, Doppler ultrasound and anticoagulation treatment.
- If negative the GP will conduct further examination and assessment or repatriate the patient back to their own practice for further examination.
- Most patients will receive diagnosis on day of appointment and leave with robust management plans.
- The service provider will offer rapid feedback to the referring clinician.
- Patients will always be seen by a DVT trained clinician.

Objectives

- Offer a DVT diagnostic and assessment service.
- Reduce waiting times for patients needing DVT assessment/treatment.
- Reduce the numbers of A&E attendances for suspected DVT and follow up attendances where necessary
- Adherence to national and local guidelines and evidence based practice avoiding inappropriate investigations.

The requirements would be:

- They must be Enfield based GPs
- They must be able to see patients from other referring practices during normal surgery hours
- They must enable staff members to undertake the training for the D Dimer
- They must have someone on duty at all times to provide this service to patients during normal surgery hours
- They must be able to provide monthly reports to the commissioning manager to form an audit trail

The table on the next page sets out the costs and savings associated with this proposed service.

### Costings

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Attendance (including MFF)</td>
<td>£134.40</td>
</tr>
<tr>
<td>Follow up</td>
<td>£134.40</td>
</tr>
</tbody>
</table>

### Anticipated patient numbers for service

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of suspected DVT patients</td>
<td>227</td>
</tr>
<tr>
<td>Approx number of patients to be referred to the cluster GP practices</td>
<td>159 (70%)</td>
</tr>
<tr>
<td>Anticipated number of patients for no further action (from 159)</td>
<td>95 (60%)</td>
</tr>
<tr>
<td>Anticipated total number of Patients referred to A&amp;E for treatment (on average 3 x appts) (from 159)</td>
<td>64</td>
</tr>
<tr>
<td>Anticipated patients that will not attend the cluster (referred straight to A&amp;E from the GPs)</td>
<td>68</td>
</tr>
</tbody>
</table>

Savings as a result of A&E attendances avoided through no further action (95 patients)

**£51,072.00**

Total savings of primary care based DVT testing hubs

**£51,072.00**

The table above is based on the following:

- 227 GP referred appointments to Barnet and Chase Farm Hospitals and North Middlesex University Hospital
- Data evaluation has shown that 70% of DVT activity can be referred through the new DVT pathway (159 patients) from this
- Data evaluation has shown that 60% will not need any further action (95 patients) this will alleviate the need for an A&E attendance charged at £134.40 and three follow ups (average number of follows up compiled from data)
- Approximately 64 will go on to A&E for further tests and appropriate referral routes
- It is anticipated that the remaining 68 patients will be referred straight to A&E from the GPs for clinical safety issues and patient choice
The savings made on this project will be from the 95 patients that need no further action (£51,072.00 cost minus the £4,000 for the equipment to set up the Community Based GP testing hub)

Costs for Local Enhanced Service

- Practices will be paid one fee per patient from the following schedule, according to outcome.
- When outcomes 2 & 3 co-exist only one claim for payment is made.
- No payment will be made for patients that score 1 or less on the Wells Score

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>Outcome 2</th>
<th>Outcome 3</th>
<th>Outcome 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probability assessment resulting in “Low risk” score (no major risk factors present/none of the significant clinical signs) and negative D Dimer (no scan needed)</td>
<td>Probability assessment resulting in “Low risk” score but positive D Dimer (patient referred for scan using referral pro-forma)</td>
<td>Patient referred for scan following risk assessment and D Dimer testing, but practice requested to administer LMWH on day</td>
<td>Patient at high risk of DVT (D Dimer not indicated) but scan not available on day practice will be requested to administer LMWH until USS.</td>
</tr>
<tr>
<td>£30.00 per patient</td>
<td>£30.00 per patient</td>
<td>£30.00 per patient</td>
<td>£30.00 per patient</td>
</tr>
</tbody>
</table>

The cost of providing this service is estimated to be around £11,810 per annum which is broken down as follows:

- £30 per patient multiplied by 227 patients = £6,810
- Cost of DVT D Dimer - £5,000

The scoping document originally took into account that 60% of patients would be treated via the Primary Care DVT Service but the amount specified indicates that 100% are eligible for payment via the LES (227 patients) but this is worse case scenario.

The funding is requested for a period of one year, during this time the service will be evaluated and modelled accordingly to meet the needs of the residents of Enfield and during this time a decision will be made to either maintain the service or return the service to its original format.
RECOMMENDED ACTION:

The Committee are asked to:

COMMENT and APPROVE on the proposals outlined in this report and in particular the funding of £11,810 to set up this proposed service.

DATE: 25th October 2012

TITLE: Enfield Primary Care Anticoagulation Clinics

LEAD DIRECTOR/MANAGER: Dr Mo Abedi – Clinical Lead, Richard Watson – Head of QIPP & Service Re-design

AUTHOR(S): Imran Madarbux
imran.madarbux@nclondon.nhs.uk

SUMMARY:
The aim of this project is to develop a suitable community anticoagulation service for Enfield patients in primary care.

Traditionally, stable anticoagulation patients have been treated in hospital based settings, which may not be in an ideal location for patients to travel to and also blocks up the waiting list times for more complex care patients.

This paper sets out the main options and reasons for delivering a community anticoagulation service in Enfield. The options considered are:

a) do nothing – keep the existing service in Enfield,
b) expand the current Enfield service,
c) go out to a pan Enfield service which can be done either as an enhanced service, contract variation or full procurement.

The committee is asked to assume option c as the selected option (pending further clarification on activity modelling).

The proposal within this document is to review and agree in principle the funding for the training, clinical decision support software (CDSS) and clinical governance section for this service. A summary of a quote given by the Whittington Hospital, who will be providing this reviewing service, is given below:-

Assumptions:-
5 practices with average 100pts = 500 pts. 10% growth rate
10 clinicians requiring training = 2/practice
Clinical governance @ £20k/year

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>No patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HeartBeatSPS @ £9/pt/year</td>
<td>£4,500</td>
<td>£4,950</td>
<td>£5,445</td>
<td>£5,990</td>
</tr>
<tr>
<td>Initial Training</td>
<td>£15,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Re-accreditation each 2 years</td>
<td>0</td>
<td>0</td>
<td>£7,000</td>
<td>0</td>
</tr>
<tr>
<td>Clinical governance</td>
<td>£20,000</td>
<td>£20,000</td>
<td>£20,000</td>
<td>£20,000</td>
</tr>
<tr>
<td>Total</td>
<td>£39,500</td>
<td>£24,950</td>
<td>£32,445</td>
<td>£25,990</td>
</tr>
</tbody>
</table>

The quote has been given on the basis of the service running from five sites across Enfield which has been judged to be the optimum number for the proposed service. However, as the service is set up it may be the case that further sites are added. This paper is proposing that the costs over the first three
years are met by the Primary Care Strategy and on-going funding is provided through the savings incurred through this activity not going into an acute setting. A more detailed price will be worked up during October to come back to the Group for final approval if agreement is given in principle to this proposal.

To date, the scoping paper has been approved for option three by the Enfield Financial Recovery and QIPP Committee on the 29 August 2012, pending further analysis on the volume of stable patients being transferred from the acute hospital to primary care based clinics.

The primary care anticoagulation clinics will look to improve on the following key areas:-

1. **Access** - by giving patients the choice for a one stop clinic based in a number of GP practices which is potentially situated at a much shorter distance than the acute hospital which is in line with the national Care Closer to Home Strategy.

2. **Patient experience** – as a result of the improved access, this will then positively impact on patient experience. Patient satisfaction surveys carried out in Haringey who employ a similar model indicates that patients would much rather have their treatment done at a local primary care based clinic rather than be sat in a hospital waiting room for a long period of time.

3. **Outcomes** – an advantage for GPs is that they will have potentially much greater management of their anticoagulation patients and still have the support of a consultant should they require it.

**RECOMMENDED ACTION:**

The Committee are asked to:

**COMMENT and APPROVE IN PRINCIPLE** on the training and equipment costs outlined in this report

**Objective(s) / Plans supported by this paper:**

Principle Objective 2: To deliver the NHS North Central London QIPP Plan.

**Patient & Public Involvement (PPI):** Patient and public involvement has been sought through existing channels and meetings with patients and representative groups to inform the work that is presented to the Committee.

**Equality Impact Assessment:** Not applicable.

**Risks:** There are no new risks to be recorded.

**Resource Implications:** There are no direct resource implications from this report.

**Audit Trail:** There is no audit trail for this report.
Project Scope Document

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Primary Care Anticoagulation Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager</td>
<td>Imran Madarbux</td>
</tr>
<tr>
<td>GP Lead</td>
<td>Dr Mo Abedi</td>
</tr>
</tbody>
</table>

Details of Project

1. Project Aim and Purpose

The aim of this project is to develop a suitable community anticoagulation service for Enfield patients in primary care.

Traditionally, stable anticoagulation patients have been treated in hospital based settings, which may not be in an ideal location for patients to travel to and also blocks up the waiting list times for more complex care patients.

Enfield SUS data shows the breakdown of anticoagulation patients treated at our two main acute providers over the last financial year (2011/12):

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>FIRST ACTIVITY</th>
<th>FOLLOW-UP ACTIVITY</th>
<th>Total ACTIVITY</th>
<th>Total NPBR_COST-2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCF</td>
<td>463</td>
<td>27523</td>
<td>27986</td>
<td>£689,434</td>
</tr>
<tr>
<td>NMUH</td>
<td>259</td>
<td>7377</td>
<td>7636</td>
<td>£193,010</td>
</tr>
<tr>
<td>Total 2011/12</td>
<td>722</td>
<td>34900</td>
<td>35622</td>
<td>£882,444.00</td>
</tr>
</tbody>
</table>

Whilst there has been a decrease in first and follow up activity at both acute trusts over the last two years there is a significant first to follow up ratio at both trusts. BCF, for example, has 59 f-ups for every first. After an initial meeting with the lead anticoagulation nurse at BCF, one possible explanation given was that when compared to NMUH patients, they were first seen by a Haematologist before being transferred to the anticoagulation clinic. This is not conclusive or evidenced based and further investigation work is being conducted to analyse current stable patients to understand the reasons behind this.

A separate analysis conducted by NMUH hospital shows that 10.5% of anticoagulation activity at NMUH over an 11 month period required transportation as well. We are currently unable to break this down into specific anticoagulation patients or costs.

The new service would work across both primary and secondary care, where the initiation of the therapy is performed at secondary care and then, once stable patients will then be transferred over to an appropriate community setting managed by primary care.

The main aims of the service are as follows:

- To provide a service that is near to patients and is easily accessible.
To provide increased capacity in the community to meet the appropriate demand for anticoagulation monitoring.
To shift the majority of routine stable patients away from secondary care into the community to ensure that the hospital can focus on new and high risk patients.
To ensure that the same level of care and quality of service is provided to patients in both primary and secondary care.
To ensure that the maintenance of stable patients is properly and appropriately controlled.
All patients are regularly reviewed for continuation of therapy and discontinued where appropriate.
To support patients in understanding and managing their anticoagulation treatment.

2. Project Objectives

As part of the Department of Health White Paper January 2006 Our Health, Our Care, Our Say: a new direction for community services plans to give patients better choice and access to services within the community that previously they may have found difficult to access.

Pending approval, this project will also form part of the QIPP financial recovery programme for 2012/13.

Key service objectives include:

- Ensure that adequate premises are provided and set-up in appropriate locations for ease of accessibility to all Enfield residents.
- Provision and quality monitoring of near patient testing (NPT) equipment per provider.
- Provision and installation of appropriate computer decision support software (CDSS) per provider.
- Appropriate specialist training by an accredited trainer to manage anticoagulation patients in the community. This should include training of NPT and CDSS.
- An approved care pathway for transfer of patients between secondary and primary care. This will include eligibility criteria, home visits and termination of anticoagulation therapy.
- Approved clinical governance and monitoring standards in place.

3. Out of Scope

The following exclusions will apply:
- Patients less than 16 years of age (refer to secondary care)
- High risk anticoagulation patients (to be managed in secondary care)
- Initiation of new anticoagulation patients (to be managed in secondary care)
- Patients who are not registered with a NHS Enfield practice

A detailed clinical exclusions list would be developed as part of the service specification.

4. Benefits Identification

Benefits of service to primary and secondary care:
- Reduction in waiting times
- Release secondary care pressures for more complex cases
- Meet the choice agenda
- Improve patient experience
- Improved maintenance of patient records
- Reduction in transportation costs through home community home visits or self-care
- Provision of cost efficient, cost effective service
Benefits to potential providers:
- Improved communications with secondary care colleagues and increased level of knowledge for other health professional
- This service will have a strong educational and learning element, which will help to spread good medical practice and in turn see effective management of anticoagulation patients
- Cost effectiveness, clinical effectiveness and value for money
- Satisfaction of a ‘one stop’ approach

5. Research of Previous/Existing Projects

Current Enfield Community Anticoagulation Service:-
The current NHS Enfield model has been running for several years now and is based on the NHS Haringey model detailed below. It was agreed at the PEC meeting on the 6 June 2012 that the service should be formally contracted for 6 months which runs out on the 30 November 2012. The service is run by a company called Chemi-Call Ltd who operate from two sites located in Forest Road Health Centre and the Evergreen Health Centre. Currently the service only takes in stable patients from the NMUH who are registered with a GP at one of the two sites. All training, IT and clinical governance monitoring are provided by The Whittington Hospital.

<table>
<thead>
<tr>
<th>Service costs</th>
<th>– package price for 6 months = £15,600. (£300 per clinic x 2 sites)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pros</td>
<td>– service has been running for over 4 years and has a good relationship with NMUH. Price is fixed regardless of number of patients that come through the system.</td>
</tr>
<tr>
<td>Cons</td>
<td>– service limited to just patients of the two GP practices who provide the clinics with no patients from other GP practices in Enfield, BCF patients or housebound patients included. Price is fixed regardless of number of patients that come through the system.</td>
</tr>
</tbody>
</table>

Haringey Community Anticoagulation Service:-
NHS Haringey commissioned a community anticoagulation and stroke prevention service from 6 providers: 5 general practices and 1 community pharmacy. This service has been operational now for the last 5 years and also provides home visits. The community service currently has 550 patients and operates at a lower tariff compared to the NMUH and Whittington Hospitals where the majority of their stable patients are transferred from. The providers are trained and educated by the Whittington Hospital on management of stable patients and also use the Whittington Hospital in house CDSS, Heartbeat to calculate International Normalise Ratio (INR) readings. NHS Haringey were unable to provide any evidence to show that considerable savings have been made but say that quality of care and patient satisfaction of the service has been good.

<table>
<thead>
<tr>
<th>Service costs</th>
<th>– £21.78 for a follow up appointment and an extra £30 payment is made for transportation costs for housebound patients which is based on 10% of their total follow-ups. This also correlates with the data above from NMUH which has actual activity data over an 11 month period their require 10.5% transport.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pros</td>
<td>– model has been running for 5 years without any need for change.</td>
</tr>
<tr>
<td>Cons</td>
<td>– provider tariff is only a little cheaper when compared to acute hospital f-up tariff and when adding in the extra fee for transportation of housebound patients this can amount to minimal savings.</td>
</tr>
</tbody>
</table>

6. Equality & Diversity
The model that is being proposed is for a community anticoagulation service that will be provided by multiple providers equitably across the borough. This will allow patients to seek treatment closer to home and will avoid unnecessary waits and possibly longer travelling times to hospital based appointments.

The proposed service is also a ‘one stop’ service which will be able to provide INR readings within minutes and save the patient from possibly having to make a second visit to review results.

The borough is well served in terms of the underground, over ground and also bus routes. This model of service provision will allow patients to travel to the nearest provider offering the testing within their local community.

### 7. Options Appraisal (including financial analysis)

#### Notes- activity planning

1. For a patient to be stable and transferred to the community clinic the minimum requirement set by the acute hospitals is that a patient would need 3 previous consecutive normal range INR results.

2. Following a meeting with BCF representatives, a clinical audit of stable patients will be conducted to try and understand the high number of f-ups. This will also be planned for NMUH to get a comparison between the two.

3. Assumption that providers will bear the cost of CDSS, NPT, relevant training and on-going consumables cost which is estimated at £8000 in year one.

4. Estimated number of sites needed has been set at 5 but options will be costed to represent the Haringey model which currently has 6 sites.

5. Average tariffs for 2012/13 between NMUH and BCF have been used to calculate acute costs which include MFF.

6. A 15% reduced tariff calculated from point 5 above is used for the basis of calculating community costs.

7. All first and follow-up activity data is taken for 2011/12 SUS as shown in section 1 above.

#### OPTION 1 – DO NOTHING

**Objective**: allow current contract with Chemi-Call Ltd to expire.

**Positives**: none.

**Negatives**: loss of existing community service and patients then being transferred back to acute providers with additional waits and increased cost to PCT.

**Setup costs**: none.

**Planned savings**: none.

#### OPTION 2 – EXTEND AND POSSIBLY EXPAND CURRENT NHS CONTRACT WITH CHEMI-CALL LTD

**Objective**: extend current contract with Chemi-Call Ltd through contract variation. This could potentially be extended out to include patients from BCF and from other GP practices but does assume that the provider will accept a significant increase in activity at no additional cost

**Positives**: increased coverage from inclusion of BCF patients and other GP practices.

**Negatives**: failure to expand on current two sites would mean possibly longer travelling times for
some patients. Procurement would limit contract increase to 10%, anything over that would need to go to full procurement (see option 3). Not financially viable for current provider to sustain current activity on a long term basis.

**Setup costs:** - none for commissioner, but provider would need to purchase additional NPT machines, CDSS software and send additional staff on the approved training course at the Whittington Hospital.

**Planned savings:**

Comparative data taken from Whittington Clinical Governance reports for the first 6 months of 2012 which monitors both the current Enfield providers as well as Haringey’s 6 providers show the following:

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Visits</th>
<th>Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haringey</td>
<td>482</td>
<td>2508</td>
<td>6</td>
</tr>
<tr>
<td>Enfield</td>
<td>113</td>
<td>669</td>
<td>1</td>
</tr>
</tbody>
</table>

**Activity for 6 months by CCG (Jan-June 2012)**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>New</th>
<th>Visits</th>
<th>Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haringey</td>
<td>80</td>
<td>6</td>
<td>418</td>
<td>1</td>
</tr>
<tr>
<td>Enfield</td>
<td>113</td>
<td>16</td>
<td>669</td>
<td>1</td>
</tr>
<tr>
<td>Average</td>
<td>97</td>
<td>11</td>
<td>544</td>
<td>1</td>
</tr>
</tbody>
</table>

**Average activity by site over 6 months by CCG (Jan-June 2012)**

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>New</th>
<th>Visits</th>
<th>Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haringey</td>
<td>13</td>
<td>1</td>
<td>70</td>
<td>1</td>
</tr>
<tr>
<td>Enfield</td>
<td>19</td>
<td>3</td>
<td>112</td>
<td>1</td>
</tr>
<tr>
<td>Average</td>
<td>16</td>
<td>2</td>
<td>91</td>
<td>1</td>
</tr>
</tbody>
</table>

**Average activity by site per month by CCG and overall average (Jan-June 2012)**

Taking the average number of visits between the two boroughs and splitting by month we can estimate that 91 visits per month are treated in the community providers.

Based on 182 visits a month for the two sites provided by Chemi-call the costs would be estimated as:-

Provider = £2600 per month (based on current contract price, no variation in price with activity)

NMUH = £4278.82 per month (based on £23.51 per f-up calculated from SUS data)

**SAVINGS = £1678.82 PER MONTH, £20,145.84 over 12 months.**

**OPTION 3 – PROCUREMENT OF A COMPREHENSIVE ANTICOAGULATION COMMUNITY SERVICE FOR ENFIELD**

**Objective:-** to procure a new service which will encompass the whole of Enfield to a potential provider, preferably GP practices through an enhanced service.

**Positives:-** whole system approach with maximum coverage of two main acute providers in
Enfield.

**Negatives**: potentially high set-up costs for provider with CDSS, NPT, training and education. Unknown engagement from BCF, due to meet with representative there on 23 August.

**Setup costs**: None for commissioner, but provider would need to purchase NPT machines, CDSS software and send staff on the approved training course at the Whittington.

**Planned savings**: This has been broken down in 4 sub options based upon different ways in which the volume of activity to be transferred to a community setting could be calculated. None of these are completely scientific and without a clinical audit it is difficult to accurately calculate the actual volume of activity that could transfer.

**OPTION 3A**: Assume that 91 follow-up visits (calculated from option 2 above) are seen across a number of sites. Per site this would be broken down as:

<table>
<thead>
<tr>
<th>Activity per site per month</th>
<th>1 site</th>
<th>2 site</th>
<th>3 site</th>
<th>4 site</th>
<th>5 site</th>
<th>6 site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>91</td>
<td>182</td>
<td>273</td>
<td>364</td>
<td>455</td>
<td>546</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost per activity per site per month (based on 15% reduction of 12/13 follow up tariff)</th>
<th>1 site</th>
<th>2 site</th>
<th>3 site</th>
<th>4 site</th>
<th>5 site</th>
<th>6 site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>£1,820.05</td>
<td>£3,640.09</td>
<td>£5,460.14</td>
<td>£7,280.18</td>
<td>£9,100.23</td>
<td>£10,920.27</td>
</tr>
</tbody>
</table>

Therefore, savings projected for the year are as follows:

<table>
<thead>
<tr>
<th>Remaining 1st activity in acutes</th>
<th>1 site</th>
<th>2 site</th>
<th>3 site</th>
<th>4 site</th>
<th>5 site</th>
<th>6 site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of remaining 1st</td>
<td>£44,987.82</td>
<td>£44,987.82</td>
<td>£44,987.82</td>
<td>£44,987.82</td>
<td>£44,987.82</td>
<td>£44,987.82</td>
</tr>
<tr>
<td>Remaining f-up activity in acutes</td>
<td>33808</td>
<td>32716</td>
<td>31624</td>
<td>30532</td>
<td>29440</td>
<td>28348</td>
</tr>
<tr>
<td>Cost of remaining f-ups</td>
<td>£795,502.24</td>
<td>£769,807.48</td>
<td>£744,112.72</td>
<td>£718,417.94</td>
<td>£692,723.20</td>
<td>£667,028.44</td>
</tr>
<tr>
<td>Total community activity</td>
<td>1,092</td>
<td>2,184</td>
<td>3,267</td>
<td>4,391</td>
<td>5,535</td>
<td>6,652</td>
</tr>
<tr>
<td>Total cost of community activity</td>
<td>£21,840.55</td>
<td>£43,681.09</td>
<td>£65,521.64</td>
<td>£87,362.18</td>
<td>£109,202.70</td>
<td>£131,043.15</td>
</tr>
<tr>
<td>Acute savings</td>
<td>£20,113.39</td>
<td>£23,967.61</td>
<td>£27,821.82</td>
<td>£31,676.04</td>
<td>£35,530.25</td>
<td>£39,384.46</td>
</tr>
</tbody>
</table>

**OPTION 3B**: 100% of the 1st activity goes through 3 normal INR follow-ups before being discharged into the...
community clinic. Per site this would be broken down as:-

Activity per site per month in community (transferring remaining f-up activity)

<table>
<thead>
<tr>
<th></th>
<th>1 site</th>
<th>2 site</th>
<th>3 site</th>
<th>4 site</th>
<th>5 site</th>
<th>6 site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2728</td>
<td>1364</td>
<td>909</td>
<td>682</td>
<td>546</td>
<td>455</td>
</tr>
</tbody>
</table>

Cost per activity per site per month (based on 15% reduction of 12/13 follow up tariff)

<table>
<thead>
<tr>
<th></th>
<th>1 site</th>
<th>2 site</th>
<th>3 site</th>
<th>4 site</th>
<th>5 site</th>
<th>6 site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>£54,558.03</td>
<td>£27,279.02</td>
<td>£18,186.01</td>
<td>£13,639.51</td>
<td>£10,911.6</td>
<td>£9,093.0</td>
</tr>
</tbody>
</table>

Therefore, savings projected for the year are as follows:-

Comparative savings made per year

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remaining 1st activity in acutes</td>
<td>722</td>
</tr>
<tr>
<td>Cost of remaining 1st activity</td>
<td>£44,987.82</td>
</tr>
<tr>
<td>Remaining f-up activity in acutes</td>
<td>2166</td>
</tr>
<tr>
<td>Cost of remaining f-up activity</td>
<td>£50,965.98</td>
</tr>
<tr>
<td>Total community activity</td>
<td>32,734</td>
</tr>
<tr>
<td>Total cost of community activity</td>
<td>£654,696.37</td>
</tr>
<tr>
<td>Acute savings</td>
<td>£131,793.83</td>
</tr>
</tbody>
</table>

Total savings £141,421.72

OPTION 3C:-

100% of the 1st activity goes through 9 normal INR follow-ups before being discharged into the community clinic. Per site this would be broken down as:-

Activity per site per month in community (transferring remaining f-up activity)

<table>
<thead>
<tr>
<th></th>
<th>1 site</th>
<th>2 site</th>
<th>3 site</th>
<th>4 site</th>
<th>5 site</th>
<th>6 site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2367</td>
<td>1183</td>
<td>394</td>
<td>99</td>
<td>20</td>
<td>3</td>
</tr>
</tbody>
</table>

Cost per activity per site per month (based on 15% reduction of 12/13 follow up tariff)

<table>
<thead>
<tr>
<th></th>
<th>1 site</th>
<th>2 site</th>
<th>3 site</th>
<th>4 site</th>
<th>5 site</th>
<th>6 site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>£47,337.85</td>
<td>£23,668.93</td>
<td>£7,889.64</td>
<td>£1,972.41</td>
<td>£394.48</td>
<td>£65.75</td>
</tr>
</tbody>
</table>

Therefore, savings projected for the year are as follows:-

Comparative savings made per year

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remaining 1st activity in acutes</td>
<td>722</td>
</tr>
<tr>
<td>Cost of remaining 1st activity</td>
<td>£44,987.82</td>
</tr>
<tr>
<td>Remaining f-up activity in acutes</td>
<td>32533</td>
</tr>
</tbody>
</table>
Cost of remaining f-ups £765,505.41
Acute savings £71,950.77

Total savings £80,304.51

There is a cost associated with whichever option is chosen relating to the training, clinical decision support software (CDSS) and clinical governance section for this service. A summary of a quote given by the Whittington Hospital, who will be providing this reviewing service, is given below:-

Assumptions:-
5 practices with average 100pts = 500 pts. 10% growth rate
10 clinicians requiring training = 2/practice
Clinical governance @ £20k/year

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>No patients</td>
<td>500</td>
<td>550</td>
<td>605</td>
<td>666</td>
</tr>
<tr>
<td>HeartBeatSPS @ £9/pt/year</td>
<td>£4,500</td>
<td>£4,950</td>
<td>£5,445</td>
<td>£5,990</td>
</tr>
<tr>
<td>Initial Training</td>
<td>£15,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Re-accreditation each 2 years</td>
<td>0</td>
<td>0</td>
<td>£7,000</td>
<td>0</td>
</tr>
<tr>
<td>Clinical governance</td>
<td>£20,000</td>
<td>£20,000</td>
<td>£20,000</td>
<td>£20,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£39,500</strong></td>
<td><strong>£24,950</strong></td>
<td><strong>£32,445</strong></td>
<td><strong>£25,990</strong></td>
</tr>
</tbody>
</table>

The quote has been given on the basis of the service running from five sites across Enfield which has been judged to be the optimum number for the proposed service. However, as the service is set up it may be the case that further sites are added. This paper is proposing that the costs over the first three years are met by the Primary Care Strategy and on-going funding is provided through the savings incurred through this activity not going into an acute setting.

8. Risks

- No GPs are interested in providing this service
- Engagement and buy in from acute providers (especially unknown with BCF at present)
- Possible re-negotiation of provider tariffs and acute provider costs with NMUH
- Establishing suitable pathway for patients requiring transport

9. QIPP Savings Identified for each option

- **OPTION 1** – DO NOTHING: - No savings will be realised.
- **OPTION 2** – EXTEND AND POSSIBLY EXPAND CURRENT NHS CONTRACT WITH CHEMI-CALL LTD: - £20,145.84 over 12 months assuming the existing provider will accept more activity for the same fixed cost
- **OPTION 3** – PROCUREMENT OF A COMPREHENSIVE ANTICOAGULATION COMMUNITY SERVICE FOR ENFIELD:
  - **OPTION 3A**:- £20,434.58 over 1 year.
  - **OPTION 3B**:- £141,421.72 over 1 year.
  - **OPTION 3C**:- £80,304.51 over 1 year.
### 10. Recommended option and Next Steps with timescales

**Recommended option:** Option 3 is recommended to progress further but no recommendation is given for which sub option is chosen in relation to the activity level that could be transferred. One option is to conduct a clinical audit to ascertain to clinically appropriate level of activity which could transfer to a community site(s).

**Next steps (based on option 3):**
- Audit and analysis of stable patients at both BCF and NMUH (August / September 2012)
- Sign off of PID and service specification (October Financial Recovery and QIPP Committee)
- Agreement of procurement timetable (October 2012)
- Start of new service (May 2013)
Primary Care Development

Business Case

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Minor Ailment Scheme (MAS) for Enfield</th>
</tr>
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<tbody>
<tr>
<td>Project Sponsor</td>
<td>Sean Barnett</td>
</tr>
<tr>
<td>Network Coordinator</td>
<td>Peter Lathlean</td>
</tr>
<tr>
<td>Date Started</td>
<td>October 2012</td>
</tr>
<tr>
<td>Completion Date</td>
<td>December 2012</td>
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</table>

**Purpose of this document:**

The purpose of this document is to outline the Business Case for implementing a Minor Ailment Scheme in Enfield.
## Approvals

<table>
<thead>
<tr>
<th>Area</th>
<th>Name</th>
<th>Date</th>
<th>Comments</th>
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</thead>
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<tr>
<td>Suggested Approvers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Enfield Accountable Officer</td>
<td>Liz Wise</td>
<td></td>
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<tr>
<td>CCG Chair</td>
<td>Dr Alpesh Patel</td>
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<td></td>
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<tr>
<td>CCG Vice-Chair</td>
<td>Dr Janet High</td>
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<tr>
<td>Primary Care Development Programme Lead</td>
<td>Sean Barnett</td>
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<td>Enfield Financial Director</td>
<td>Richard Quinton</td>
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<tr>
<td>PEC Lead</td>
<td>Dr Mo Abedi</td>
<td></td>
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<td>Primary Care Development Project Manager</td>
<td>Daniel Morgan</td>
<td></td>
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<tr>
<td>NCL Deputy Medical Director</td>
<td>Dr Angela Lennox</td>
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<tr>
<td>Patient Representative Group</td>
<td>John Lynch</td>
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<td>LPC</td>
<td>Gerald Alexander</td>
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<tr>
<td>LMC</td>
<td>Dr Manish Kumar</td>
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<td>NCL Programme Group</td>
<td>Helen Patterson</td>
<td>Sept 2012</td>
<td>Minor changes required for F,R and Q</td>
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<td>NCL Financial Recovery and QIPP Group</td>
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<td>Mr P. Gouldstone</td>
<td>Sept 2012</td>
<td>Formulary updated</td>
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<td>Health &amp; Well Being Board Sub-committee</td>
<td>Dr Mo Abedi</td>
<td>Sept 2012</td>
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<td>Clinical Network Leads</td>
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</tr>
<tr>
<td>Original Author(s)</td>
<td>Peter Lathlean</td>
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### Version History (convention is V0.1... for drafts then once confirmed/approved V1.0)

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<td>Peter Lathlean</td>
<td>First Draft Completed</td>
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<tr>
<td>0.2</td>
<td>11-9-12</td>
<td>Peter Lathlean/Sean Barnett</td>
<td>Various comments made</td>
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<td>0.3</td>
<td>18-9-12</td>
<td>Becky Kingsnorth</td>
<td>Amendments made</td>
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<td>0.4</td>
<td>31-10-12</td>
<td>Peter Lathlean</td>
<td>Amendments to measurability and caps</td>
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<td>0.5</td>
<td>1-11-12</td>
<td>Sean Barnett</td>
<td>Revisions</td>
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<tr>
<td>0.6</td>
<td>1-11-12</td>
<td>Linda Crawley</td>
<td>Revisions</td>
</tr>
<tr>
<td>0.7</td>
<td>2-11-12</td>
<td>Sean Barnett</td>
<td>Revisions to reflect approval processes to date</td>
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## Table Of Contents

### Contents

1. EXECUTIVE SUMMARY.......................................................................................... 5
2. REASONS ............................................................................................................. 5
3. BUSINESS OPTIONS ............................................................................................ 6
4. EXPECTED BENEFITS ......................................................................................... 6
5. EXPECTED DIS-BENEFITS .................................................................................. 7
6. TIMESCALES ....................................................................................................... 7
7. COST .................................................................................................................... 7
8. MAJOR RISKS ...................................................................................................... 9
1. Executive Summary

This paper provides the business case for implementing and operating a Minor Ailment Scheme in Enfield.

The main benefits for this scheme;

1. Utilise more effectively expertise of community pharmacists within the borough
2. Alleviate pressure/diverting minor ailments primarily from GP services to other providers
3. Increase patient access in GP practices
4. Supports the national NHS modernisation agenda for patient choice & Self-care
5. Support the Enfield Primary Care Strategy on improving access, experience and health outcomes
6. Support the Barnet, Enfield and Haringey (BEH) clinical strategy by increasing capacity within Primary Care to better absorb increased workloads.

The project Costs

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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>£60,000</td>
<td>£170,000</td>
<td>£170,000</td>
<td></td>
<td>£400,000</td>
</tr>
</tbody>
</table>

2. Reasons

Patients across the borough are accessing their local GP services to seek advice and treatments for conditions known:

- Not to be life-threatening;
- Not to pose major health risks;
- Typically they are uncomplicated and are easy for people to diagnose;
- They don’t last long;
- And don’t require hospitalisation.

It is estimated that nationally 18% \(^1\) of GP workload is managing minor ailments and findings of Healthcare for London, Unscheduled Care Study \(^2\) showed that, generally, as many as 3 out of 4 patients who presented at Accident and Emergency (A&E) were judged as suitable

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\(^1\) Minor ailment workload in general practice; December 2007; IMS Health.

\(^2\) Unscheduled Care Study. Healthcare For London.-- PA Consulting. March 2008
for treatment in primary care. An audit of the Enfield Out of Hours service (Barndoc) showed 18% of their activity was solely for minor ailments.

The aim of a minor ailments scheme is to support the self care agenda (a core theme in modernising the NHS) by enabling patients to access advice and treatment for minor, self-limiting conditions at community pharmacy providers at NHS cost, where appropriate. Streamline current capacities within individual GP practices enabling the services to deliver more care and consultations to patients with long-term health needs. As part of Enfield Primary Care Strategies multifaceted approach to access, the scheme will allow practices to absorb increased workloads predicted by the impending changes to A&E services by BEH clinical strategy.

This approach has already proved successful in schemes in Scotland, Wales & Northern Ireland and other parts of England where they have become integral to many Primary Care Trusts (PCT’s) for their demand management plans as they have been shown to be a cost-effective method of relieving pressure on other services, such as GP practices, WICs and A&E departments.

### 3. Business Options

**Option 1 – Do Nothing**

MA scheme is not implemented and the systems stay the same – fails to deliver improvements in primary care or capacity.

**Option 2 – Implement MAS in certain areas of the borough**

Implement MAS in certain wards/clusters/localities; focus on areas that have the potential to deliver most return on investment (ROI); targeted resources, narrows the health gap by increasing capacity where it is needed the most. Lower cost.

**Option 3 – Borough wide implementation**

Implement scheme across the whole borough. This option is the most expensive but the most equitable for patients across the whole of Enfield. Potential for wasted resources as patients who can afford self purchase use the scheme.

**Recommendations**

Option 3 was recommended and approved by the Health & Well Being Board subcommittee.

### 4. Expected benefits

- Removes cost barrier to patients who access other providers as a result of having to purchase medication
- Potential cost savings to PCT funds by providing a cost-effective alternative to attendances for minor ailments in GP practices, WIC and A&E departments
- To promote the appropriate use of services for unscheduled care by providing patients with increased access to non-complex care within reasonable timeframes, during and beyond “normal office hours”
- Directly support implementation of national and local policy directions by increasing capacity in GP practices to accommodate the increased level, range and complexity of activity planned for the future
- Meeting population needs for access to local advice and services by providing services closer to patient/s homes and/or place of work, thus taking account of patient convenience and choice
- Contribute to key targets of relevance to the PCT and GP practices e.g. access and waiting times at A & E
• Making better use of the skills and expertise of community pharmacists and supporting their role as an important ‘hub’ in the primary care service model

Quantifiable measurables (please see PID for details)
• Reduction in patients attending A&E 5%
• Reduction in patients using WiC and BARNDOC for minor ailments 5%
• Reduction of consultations in GPs West Localities 5% and East localities 15%
• Patient Satisfaction

5. Expected dis-benefits

• Patient who previously may have purchased medicines over the counter now access them free of charge from the MAS leading to an increase in cost for the CCG
• Duplication – patient might access both Pharmacy and GP services
• Patients do not buy into the service and do not change their self referring behaviour.
• Clinical risk that a significant illness is missed.

6. Timescales

<table>
<thead>
<tr>
<th>Date</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>20-9-12</td>
<td>Business Case presented to H&amp;WBB subcommittee for approval, if agreed Project Initiation documentation (PID) to be developed</td>
</tr>
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<td>Mid October</td>
<td>MAS workshop to finalise process.</td>
</tr>
<tr>
<td>November 2012</td>
<td>Constituent parts defined by PID created (passports, SOPs, service spec etc) and declarations of interest gained from pharmacists and GP surgeries. Advertisements send to inform stakeholders</td>
</tr>
<tr>
<td>1st December</td>
<td>First ‘pathfinder’ surgeries and pharmacies go live</td>
</tr>
<tr>
<td>Mid December</td>
<td>Full list of surgeries go live for target area</td>
</tr>
<tr>
<td>March 2013 – June 2013</td>
<td>Benefit Realisation audit</td>
</tr>
</tbody>
</table>

7. Cost

The Camden Minor Ailments Scheme is based on a payment to pharmacies of £5 per consultation plus the cost of the drugs dispensed. Haringey and Islington have slightly different models. The approximate costs of each scheme are shown below:

<table>
<thead>
<tr>
<th>Service</th>
<th>No. of pharmacies</th>
<th>Month 1 (11/12)</th>
<th>Month 2 (11/12)</th>
<th>Month 3 (11/12)</th>
<th>Month 4 (11/12)</th>
<th>Average per month per pharmacy</th>
<th>Projected total for one year (extrapolated from four months data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camden</td>
<td>60</td>
<td>£19,708</td>
<td>£16,449</td>
<td>£11,704</td>
<td>£11,184</td>
<td>£14,761</td>
<td>£246</td>
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<td>Haringey</td>
<td>27</td>
<td>£10,177</td>
<td>£7,529</td>
<td>£8,962</td>
<td>£12,491</td>
<td>£9,790</td>
<td>£363</td>
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<tr>
<td>Islington</td>
<td>48</td>
<td>£17,605</td>
<td>£17,245</td>
<td>£15,801</td>
<td>£21,936</td>
<td>£18,147</td>
<td>£378</td>
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</table>

Reimbursement for medicines accounts for approximately 40% of the total cost in each borough. Each borough has a small number of outlying pharmacies incurring significantly greater monthly cost; these do not appear to relate to areas where higher demand would be expected, suggesting that there is a need to use control mechanisms for unexpected patterns of spend. In the Enfield, a cap will be introduced; a maximum of £300 can be claimed by pharmacies per month.
### Project Start-up Costs

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<thead>
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<th>Description</th>
<th>Costs</th>
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</thead>
<tbody>
<tr>
<td>Project Management &amp; associated documentation Costs</td>
<td>£3,500</td>
</tr>
<tr>
<td>Training Costs</td>
<td>£3,000</td>
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<tr>
<td>IT software package (£35 per pharmacy annually)</td>
<td>£2,100 for 60 surgeries</td>
</tr>
<tr>
<td>Passports</td>
<td>£1,000</td>
</tr>
<tr>
<td>Vouchers</td>
<td>£2,000</td>
</tr>
<tr>
<td>Advertising</td>
<td>£3,500</td>
</tr>
<tr>
<td>Benefit Realisation Audit (Patient surveys, GP surveys etc)</td>
<td>£5,800</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>£20,900</strong></td>
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### Running Costs

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<th>Description</th>
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<tbody>
<tr>
<td>IT software package (£35 per practice annually)</td>
<td>£2,100 for 60 surgeries</td>
</tr>
<tr>
<td>Advertising, Vouchers and Passports</td>
<td>£2,100</td>
</tr>
<tr>
<td>Benefit Realisation Audit (Patient surveys, GP surveys etc)</td>
<td>£5,800</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>£10,000</strong></td>
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<table>
<thead>
<tr>
<th>Percent</th>
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</thead>
<tbody>
<tr>
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<td>Pharmacy</td>
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<tr>
<td>£90</td>
<td>£180</td>
<td>£300</td>
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<td>£1,080</td>
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<tr>
<td>30%</td>
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<tr>
<td>Pharmacies</td>
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<td>£5,400</td>
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<td>£64,800</td>
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<td>£64,800</td>
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</table>

*Table reflects potential monthly charges at different percentage markers.

*Table reflects costing if all 60 pharmacists partake in the scheme.

*Value is ‘worst case scenario’ and reflects the cost to the trust if all 60 pharmacies charge maximum value per month per year.

### Other recurring costs

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<tr>
<td>Advertising, Vouchers and Passports</td>
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<tr>
<td>Benefit Realisation Audit (Patient surveys, GP surveys etc)</td>
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<tr>
<td><strong>Total</strong></td>
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The £83,000 incorporates all known start-up costs and running costs starting in December,
running costs are reduced as it is not envisaged that all pharmacies will be up and running by mid December and nor requesting average payments.

The Primary Care Strategy has allocated £160,000 annually this equates to £222 per pharmacy per year plus no more than £10,000 for recurring costs identified.

**Predicted cost of service**

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<td>£170,000</td>
<td>£170,000</td>
<td>£400,000</td>
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</table>

**8. Major Risks**

- Quantifying benefits – due to the array of providers, it may be difficult to quantify accurately the outcomes of the scheme and if the shift from/to other providers is working due to different service suppliers reporting tools.
- Communication – Breakdown in communicating with various stakeholders
- Patients and GPs do not engage in scheme meaning lots of energy is devoted to setting up scheme with no benefit.
- Evaluating the project - NHS Enfield ran a pilot MAS involving 4 pharmacies in East Enfield between 2005-10, the pilot was never formally evaluated.
**Briefing paper for the LMC**

1. Evidence of need and how is it addressed
Around 500,000 people died in England and Wales in 2010 (ONS). National surveys consistently demonstrate that the majority of patients would prefer to die at home if given a choice, and that expression and documentation of a preference is more likely to result in achieving their preferred place of care and death (e.g. Gomes B & Higginson. Factors influencing death at home in terminally ill patients with cancer: a systematic review. BMJ 2006; 332:515-21; PRISMA survey 2010; End of Life Care Strategy, DH 2008).

However nationally 53% die in acute hospitals, 21% at home, 18% in care homes, 5% in hospices and 2% in other places (National End of Life Care Intelligence Network, NEOLCIN, 2008-10). There is also much geographical variation – London has the highest proportion of deaths in hospital (65.7%) with the south west of England having the lowest (53.7%).

Local authorities with the **highest proportion of deaths in hospital** [NB all of these are London boroughs]: Ealing, Enfield, Redbridge, Newham, Waltham Forest (66-70%)

Local authorities with the **lowest proportion of deaths in hospital**: Cambridge, Taunton Deane, Craven, Torbay, Mid Sussex (39-43%)

London also has the lowest proportion of people dying at home (17.6%) and the north east the highest, at 20.5% (Variations in Place of Death in England: Inequalities or appropriate consequences of age, gender and cause of death? NEOLCIN 2010).

This may also be linked with socioeconomic status; the NEOLCIN report ‘Deprivation and Death: Variation in place and cause of death (2012)’ suggested that people who live in deprived areas are more likely to die in hospital than those living in affluent areas.

The DH End of Life Care (EOLC) Strategy, 2008, recommended the development of electronic locality registers as a way sharing information and improving the coordination of care for people at the end of life and their families and carers. Other national policies/workstreams relevant to Coordinate My Care (CMC) are:

- **NICE Quality Standard for EOLC** (2012)
  - including identifying patients, communication of information, reviewing personalised care plans, and provision of consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are not aware of the person’s current medical condition, care plan and preferences

- **QIPP EoLC workstream**
  - using levers to support good EoLC, developing better intelligence about EoLC, helping clinicians
to start EoLC conversations, systematic care planning, including Advance Care Planning, for people approaching the end of life, and sharing successful good practice.

- **QIPP urgent care workstream**
  - maximising the number of instances when the right care is given by the right person at the right place and right time for patients, and aims for a 10% reduction in the number of patients requiring ambulance journeys and attending emergency departments.

- **National rollout of 111 as the urgent care number**, for which CMC is the EoLC pathway in London, aims to streamline calls so that they are dealt with by the most appropriate person. CMC enables immediate access to information by OOH providers.

- **Integrated care, frailty and long term conditions workstreams** are intrinsically linked to end of life care as many patients will transition as they deteriorate. CMC offers a system of capturing that transition and the discussions that have taken place along the way.

- **Find Your 1% Campaign (RCGP, Dying Matters Coalition)**
  - identifying the 1% of the population who are likely to die in the next year (given that the mortality rate is ~1%)

2. **What CMC does**

CMC is a clinical service provided across London which is underpinned by an electronic solution – providing 24/7 secure, web access to clinical information and the wishes of patients with life-limiting illnesses. The service coordinates care, gives patients choice and improved quality of life and allows communication and coordination of information across care settings in the acute and community settings, including out of hours services, 111 and the London Ambulance Service. It promotes early identification of patients approaching the end of their life, advance care planning and treatment escalation planning, in order to reduce the likelihood of crises and inappropriate hospital attendance – by doing so it is envisaged that patients will be more likely to receive the care that they need and die in the place of their choice.

3. **How CMC is going to achieve it**

The system can be accessed by a range of health professionals with a legitimate relationship with the patient, including GPs, community and acute nursing staff, London Ambulance Service and Out-of-Hours services, hospice staff and NHS 111 staff. There is standardised training, relating to both clinical aspects of end of life care (identifying patients, consenting, DNAR, having difficult conversations) and the IT system, which is required to be achieved before a username and password are administered.

4. **How is it funded**

CMC has been funded by NHS London, through MPET (multiprofessional education and training), to roll out across London by April 2013 alongside 111. Continued funding for post-April 2013 is currently being sought.

5. **What is the procurement and tender process for rolling it out**

The IT supplier was procured through the OJEU (Official Journal of the European Union) tendering process. The contract was awarded to McKesson. The new McKesson CMC has been in operation since May 2012. Individual localities do not need to procure CMC as it is provided through NHS London funding.
6. What information is required
The information required has been agreed with National Information Standard Board guidance (see attached document). More information can be found at http://www.endolifecareforadults.nhs.uk/strategy/strategy/coordinating-care/end-of-life-care-information-standard

Although the record is comprehensive, only 12 of the fields are mandatory (* denotes that ‘not discussed yet’ or ‘no decision made yet’ are valid responses for these fields, in order to ensure that the conversations happen at the patient’s pace and rather than the need for boxes to be ticked):

| • Surname | • Diagnosis |
| • DOB | • Preferred Place of Care* |
| • Gender | • Preferred Place of Death* |
| • Address | • CPR discussed with pt?* |
| • GP | • CPR discussed with family/carer?* |
| | • Should CPR commence?* |
| | • Prescribed strong opioids? |

Other examples of information which can be included where available are:
• Preferences and wishes
• Treatment escalation plans and ceiling of treatment
• Spiritual, religious or cultural information about care needs
• Communication difficulties
• Risks and other risks when visiting/caring for the patient
• DS1500 and care package status

7. How and which data are extracted
Please see questions 9b) and c).

8. How is consent obtained and how was this agreed
Patients are required to express explicit verbal consent prior to the creation of a CMC record. It is expected that following training, the GP or other clinician is able to discuss what this means in order for it to be informed consent. In addition clinicians are advised to offer a patient information leaflet, and offer the patient a paper copy of their record once it has been created. Agreement to having a CMC record created and shared includes having a senior clinician auditing individual records as part of quality control; and research to be conducted will only involve anonymised information.

The consensus to require verbal but not written consent was gained during the development of the DH end of life care register pilot projects. More information regarding consent is available from the National End of Life Care Programme document published in March 2012 – End of Life Care Coordination: Implementation Guidance (National Information Standard IS8 1580), found online at http://www.endolifecareforadults.nhs.uk/assets/downloads/EoLC___Implementation_Guidance_1.pdf

August 2012
For those patients who do not have the capacity to give consent, a best interests decision can be made and documented when the record is created. From the data thus far, 75% patients have given their consent and 25% have had best interests decisions made.

9. How is the information used

a) The live clinical information is used:
   i. in a similar manner to palliative care handover forms - communicating information about specific patients to out of hours and emergency services, in order for them to be able to be more informed when making clinical decisions overnight/on a weekend
   ii. during palliative care practice meetings to discuss those on the Gold Standards Framework/palliative care and supportive care register in a multidisciplinary setting (a work tray can be set up for an MDT or GSF meeting in order that a list of patients is generated that can be easily updated)
   iii. To quickly either view or update information about a palliative patient, particularly if he/she is being cared for by other professionals, e.g. community nurses, palliative care team

b) In addition GPs who have legitimate access to CMC are able to run reports on their own patients, e.g.
   i. Recently deceased patients
   ii. Recently added to CMC
   iii. Recently changed on CMC
   iv. Place of death
   v. No. of patients on CMC

c) The CMC team is able to:
   i. run reports at a London or borough level, looking at a variety of fields, e.g. numbers of patients with a CMC record, who created the record (ie GP, nurse, palliative care), diagnosis, CPR decision-making, place of death, achievement of preferred place of death if this had been expressed, in order to get an overview of current practice and identify areas in need of improvement. Patient identifiable information is not used for these purposes.
   ii. view individual CMC records (random sampling) as a means of quality assurance. Validity (within 3 months since last update), legitimacy of access (viewed by appropriate clinicians only) and quality of information (e.g. appropriate medication) are assessed by a senior clinician (palliative care specialist nurse or doctor) within the core CMC team. Any discrepancies are clarified by phoning the relevant professional involved in the patient’s care. Trends are logged and discussed within the team, as well as fed back to each locality, to NHS London and potentially as part of wider publications, without the use of any patient-identifiable information.

10. Where are the Caldicott principles applied
   i. Justify the purpose(s) of using confidential information – for improving communication of information about patients at the end of life, who are often seen by multiple healthcare providers, including those in out-of-hours services and emergency services who may have no other access to clinical records but need to make significant decisions about treatment and whether or not to transfer to hospital/carry out cardiopulmonary resuscitation.
   ii. Only use it when absolutely necessary – clinicians log in to view only as necessary for the August 2012
purposes of access information to care; this may particularly be the case if the patient/their
carer phones 999/111 or their out-of-hours GP or community nursing service
iii. Use the minimum that is required – there are few (5 demographic plus 7 clinical) mandatory
fields that must be completed (see question 6); all other information is provided according
what the clinician feels is relevant for handing over to other clinicians who may be called by the
patient/their carer
iv. Access should be on a strict need-to-know basis – clinicians are granted access depending on
their role. This may be viewing only, editing only, and may be restricted to a certain practice or
borough. The level of access is authorised by their manager.

v. Everyone must understand his or her responsibilities – all professionals undergo CMC training
prior to being given their user name/password. In addition there is an expectation that they
will have an understanding of information governance from their own employing organisation,
are bound by their own professional code of conduct, and are required to sign the CMC Access
Rights policy.

vi. Understand and comply with the law – as above

11. IT governance process
Please refer to the Information Sharing Agreement attached.

12. How is data protection and confidentiality addressed

Data protection principles regarding personal data:

i. Processed fairly and lawfully – informed consent; patient information leaflet; CMC training
before being given access; organisational information sharing agreement sign-off by IG lead;
professionals with access have viewing/editing rights according to their
role/department/geographical boundaries of work

ii. Processed only for specified purposes – CMC training; random sampling of records reviewed by
senior CMC clinician to include legitimacy of logins to access the record

iii. Adequate, relevant and not too excessive – data fields as agreed by Information Standards
Board and stakeholder engagement; mandatory fields kept to a minimum (see question 6);
patient offered a paper copy of their record

iv. Accurate and kept up-to-date – CMC training to advise searching for a patient record before
creating a new one; records should be reviewed and updated within 3 months in order for it to
be considered as valid; random sampling of records reviewed by senior CMC clinician to include
validity of patient record

v. Not kept for longer than necessary – patients who have given consent to have CMC record
created and shared, who then change their mind, can have their record closed down by the
CMC team so that the record is concealed from view. Records will be kept for 30 years from the
last entry or review of the record, as per DH guidance on NHS Records Retention and Disposal –
cce/DH_4131747

vi. Processed in accordance with the rights of data subjects – patients can be offered a paper copy
of their record at any time; patients who have given consent to have CMC record created and
shared, who then change their mind, can have their record closed down by the CMC team;
patients can request that access is restricted to specified parties

vii. Protected by appropriate security – secure login via N3 connection; access authorised by
employing organisation; individual username and password; IT system complies with ISB standards and IG toolkit.

viii. Not transferred outside the EEA without adequate protection – only available for viewing via N3 connection, ie within NHS.

13. Evidence and pilot evaluations

There are currently over 2000 patient records that have been created on CMC. Analysing the data post-migration, 50% of those have a non-cancer primary diagnosis. 75% of patients have given their consent with 25% having had best interest decisions made, due to lack of mental capacity.

Of those that have died and expressed a preference, 79.2% of patients with CMC records have died in their preferred place of death (i.e. preference 1 or 2 met). This is comparable with 76% in N Somerset, another area with an electronic palliative care coordination system (EPaCCS), as published in ‘What do we know now that we didn’t know a year ago?’ by the National End of Life Care Intelligence Network, NEOLCIN (2012) - http://www.endoflifecareintelligence.org.uk/resources/publications/what_we_know_now.aspx

In 2010, 53.3% of people died in hospital (NEOLCIN, 2008-10). For those recorded on CMC 22% of patients have died in hospital so far (Aug 2012).
Rationale:
Effective, accurate and timely communication between many agencies is essential in delivery proper care for
patients approaching the end of life (EoLC), and for many patients with chronic disease. The Coordinate my Care
(CMC) toolkit provides a mechanism for this.

Practice undertakings:
All GPs and other staff involved in care for relevant patients will attend CMC training, either at the practice or some
other agreed location.

GPs and other appropriate clinical staff at the practice will populate the CMC template should the decision that the
patient is now entering an EoLC pathway (by way of guidance, if a patient is not expected to survive more than six
months and is eligible for a DS1500 form should be considered for entry into the EoLC pathway). The patient (or an
authorised carer if the patient cannot give consent) will be given an information leaflet explaining CMC, invited to
give consent for data to be entered and this consent will be confirmed on the relevant part of the toolkit.

GPs and other appropriate practice staff will use the CMC toolkit to enter all relevant information about such
patients, keep the template updated, and use it as a primary means of communication with others involved in the
patient’s care.

GPs and other appropriate practice staff will cooperate with CMC IT suppliers and others in reporting problems,
suggesting improvements and implementing agreed changes.

Payments:
£100 for each GP and £50 for other practice staff for attending CMC training, payable on invoice with names of those
attending and date and place of training event.

£10 for each patient entered onto the CMC template by the practice, payable on invoice with pseudanonymised
patient identifier (eg using practice computer system ID number) and date of entry

£25 per annum for all patients on the CMC register paid pro rata, quarterly in arrears on invoice, with patient
identifiers as above, date of entry onto CMC register and date of death/leaving the register for other reasons.

Contractual arrangements:
This LES, income from which is to be considered NHS contractual income for the purposes of accounting, taxation,
superannuation and notional rent abatements, is for two years, reviewed annually. Termination by either party is at
six months’ notice, unless by agreement of all parties.

Signed:

.................................................................................. for the practice Date.................................

.................................................................................. for the commissioner Date.................................
### Present:

**LMC Chairs**
- Dr Paddy Glackin
- Dr Martin Lindsay (in the chair)
- Dr Yvette Saldanha

**Londonwide LMCs**
- Ms Leah Benson
- Mrs Jane Betts
- Mr Greg Cairns
- Dr Tony Grewal
- Miss Nicola Rice
- Dr Julie Sharman

**NCL Cluster**
- Mr Robert Evans
- Ms Trish Galloway
- Mr Tony Hoolaghan
- Dr Henrietta Hughes (items 5.3 and 8.1)
- Dr Angela Lennox
- Ms Helen Pettersen

### Item no. | Action | Organisation/person responsible
---|---|---
1.0 | Welcome and apologies for absence |  
Dr Yvette Saldanha was welcomed to her first meeting as the new Chair of Barnet LMC. Mr Rob Evans and Ms Trish Galloway were also welcomed to the meeting.  
Apologies for absence were received from Dr Robbie Bunt, Dr Claire Chalmers-Watson, Dr Manish Kumar, Ms Caroline Taylor, Ms Denise Tyrrell and Ms Anne Whateley

2.0 | Declarations of conflicts of interest |  
Dr Glackin advised that he was the Islington CCG lead for Substance Misuse.

3.0 | Minutes and matters arising: |  
3.1 | Minutes of NCL Chairs and Cluster Group meeting on 28 August 2012 |  
The minutes were agreed as a correct record subject to removing Dr Glackin’s name from the list of attendees.

3.2 | Matters arising: |  
3.2.1 | Emis web implementation (minute 4.3.2 refers) |  
Dr Lindsay noted that he was still awaiting feedback from Mr Thomas regarding his concerns about the need for GPs to have indemnification against possible hacking into EMIS Web and misuse of information by third parties. In addition he was still awaiting views regarding the LMC
Chairs’ request that patients should be made aware of EMIS web and given an opportunity to consent to having their data uploaded.

Dr Lennox confirmed that Mr Thomas had been taking forward the issues raised at the meeting which had taken place in August 2012 to discuss the LMC Chairs concerns and undertook to liaise with Mr Thomas to ask him to arrange a further meeting of the group.

Dr Glackin noted that some Islington practices were experiencing a problem in relation to the roll out of EMIS web in that their hardware was not fit for purpose. He further noted that the survey for hardware was only being done some 5 days before EMIS web was uploaded in some cases and suggested that there was an urgent need to check that hardware and cabling was fit for purpose.

Mr Hoolaghan undertook to feed this back to Mr Thomas but expressed concern as he understood that hardware in Islington practices had been updated not so long ago. Dr Glackin responded to advise that although the hardware was deemed to be appropriate at the time it was installed it did not now meet the specification required for EMIS web.

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### 3.2.2 Procurement of GP Practices (minute 4.4 refers)

Mr Cairns advised that a number of queries had been raised regarding the ITT documentation for the Camden procurement about which he would be writing to Mr Hoolaghan. In response to his query about who would hold the contract following the procurement and who LMCs would need to approach in the future regarding earlier involvement in the development of the specifications Mr Hoolaghan confirmed that it would be the NHSCB.

Mr Hoolaghan confirmed that all the APMS documentation had been reviewed in the light of the 142 Camden Road situation and that scoring has been weighted more to quality than price than in the past. He advised that the process for the Camden procurements could not now be halted but looked forward to hearing what the concerns were.

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### 3.2.3 Co-ordinate my Care (CMC) (minute 5.3 refers)

Dr Grewal advised that since the last meeting when he expressed concerns about CMC he had established that it was a bolt on system designed by the Marsden Hospital and funded by NHS London and was being seen as key to 111 and enhanced services for End of Life and palliative care.

He reported that he had met with a representative from CMC to discuss his concerns including the fact that it had appeared to have been developed without GP input and it had huge workload implications for GPs. He advised that he had suggested that it should not be a requirement of an End of Life Care LES that GPs had to use CMC and proposed that stand-alone LES be negotiated to reimburse GPs for using CMC. In addition he had asked that that it be acknowledged that GPs were beta testing a system which was not fit for purpose. He proposed that until these three criteria had been met GPs should be advised not to accept CMC.
Mr Hoolaghan confirmed that this would be fed back to the 111 CMC lead.

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<tr>
<td>4.0</td>
<td>Strategic issues:</td>
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<td>4.1</td>
<td>Report from Chief Executive</td>
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Ms Pettersen confirmed that the system had started to change on 1 October 2012 but that things were still evolving as not all the right people were in the right place and not all appointments had been made. Although the CCG appointments had been made half of the Commissioning Support Unit posts were still to be filled and there were complex HR rules that needed to be followed which took time.

Ms Pettersen noted that the development of the NHSCB Board, which was being controlled by Leeds, was taking the longest to do and there were problems in recruiting people to the most senior posts so interim appointments were being made such as the Interim Delivery Director for North Central North East London. Until the most senior posts were filled appointments could not be made to other tiers.

Ms Pettersen also advised that a debate was ongoing with local authorities about public health and funded allocations.

Dr Grewal expressed concern that some people who would be handling funding processes in the future did not understand the GP contract and enhanced services etc. They might not know how to develop enhanced services or be aware of the statutory requirement to consult the LMC and asked if there was any help the Cluster could give.

Mr Hoolaghan responded that the Cluster had done a lot of work on enhanced services and he undertook to talk to the Chief Officers of the CCGs. He considered that the work which the Cluster had done when reviewing enhanced services and which had led to the development of an approval process for LESs had resulted in appropriate checks and balances being put in place and that it was very much aligned to the guidance on AQP and conflicts of interest.

Dr Grewal requested that as soon as new people had been appointed to various roles their contact details be provided to practices. Mr Hoolaghan confirmed that the Cluster was aware of the need to communicate with practices but advised that the family health services and patient data departments would be lifted and shifted to NHS CB initially. The Patient Data staff would be based at Stephenson House and many people would not be changing. He accepted the need to keep practices informed when changes did occur. Dr Grewal advised that if the Cluster needed any help when it came to the handover the LMC office would be happy to do so.

| 4.1.2   | Finance |

Ms Pettersen reported that the NCL financial problems still remained and that the Cluster team was in the process of trying to combine the
transition with business as usual such as trying to get the run rate in balance. Ms Pettersen explained that some progress was being made although there were still concerns about the Barnet, Enfield and Haringey financial positions.

4.1.3 Commissioning Support Unit (CSU)

Ms Pettersen advised that only half of the posts had been appointed. There was a focus on planning for next year as the contracting round would start soon although the financial allocations would not be available until December 2012 and it was not clear what the allocation formula would be.

Dr Lindsay asked for an update upon the Haringey financial position to which Ms Pettersen advised that she did not have this information and suggested that the CCG be asked to confirm the position. Dr Pettersen understood, however, that Haringey was making better progress than Barnet and Enfield.

4.2 NCL Cluster Primary Care Strategy:

Mr Hoolaghan reported that the clinical and management network leads had started in most of the boroughs. He noted that a big focus of the strategy was network working and he considered that it was good, therefore, to have people in post funded by the primary care strategy. He advised that across the Cluster 50 staff had been appointed to implement the Cluster and primary care strategy plans.

He further reported that Practice Nurse leads had been appointed in each of the boroughs with one Practice Nurse lead appointed at the Cluster level. In addition the Cluster had secured money for additional university places for practice nurses and more funding and training for practices nurses had been made available. He acknowledged that the communication around the availability of training for practice nurses could have been better but he hoped that now that there were identified practice nurse leads this would help the cascade of information.

Mr Hoolaghan advised that the boroughs were working on productivity and access in different ways. In Barnet, Enfield and Haringey this was being done through Productive General Practice and the Primary Care Foundation. He further reported that all boroughs were implanting texting to improve access.

Dr Saldanha queried what the level of uptake was in relation to the Productive General Practice programme as she was concerned that the amount of time it would take a practice to participate in this could put people off. Dr Saldanha understood that it was expected that a lead partner would be required to spend the equivalent of one session a week on this initiative and an additional 20 hours admin time which she estimated could cost a practice between £20k to £24k. Mr Hoolaghan undertook to feed this back to the borough.

Mr Hoolaghan advised that the role of the Senior Responsible Officer for the primary care strategy would be taken over by Ms Siobhan Harrington, Ms Tessa Garvin would replace Denise Tyrrell in running the Programme.
office for the strategy and Dr Angela Lennox would be the Clinical Lead for the strategy.

Mr Cairns observed that not a lot of the primary care strategy funding was being used for front line service delivery but was being used to fund networks which he considered to be misdirected. Mr Hoolaghan reminded members that it was not the Cluster’s role to tell CCGs what to do but Mr Cairns noted that CCGs understood that they were required to do what the Cluster suggested regarding the primary care strategy.

Dr Lennox noted that in Enfield the GP clinical leaders had asked for administrative support in the form of 2 part time co-ordinators to support the work of the clinical leads in engaging with GPs to get an idea of what should be done in localities. Mr Cairns queried whether the focus of localities should be about driving up quality and less about developing structures. Dr Lennox responded to advise that it was up to the four localities in Enfield to decide how they should be shaped. The Cluster was letting them find their feet and sharing a common vision to understand where they wanted to get to. Dr Grewal expressed the view that he was not sure what services to patients or profits to practices these networks were meant to be delivering.

Mr Hoolaghan noted that the NCL Cluster had the worst performance in terms of access so there was a need to work on improving this and the Cluster was trying, therefore, to give funding to CCGs to address this. He noted that there was a huge emphasis on practices working together in relation to delivering services closer to home which would improve the quality of front line patient care.

Dr Lennox advised that the Primary Care Foundation was a resource which Enfield practices could use to become more organised in the way it could address access. Dr Lennox reported that 18 practices had come forward to date.

Dr Glackin suggested that increasing practices’ income would help to improve access to which Mr Hoolaghan responded that data suggested that where practices had more pounds per patient it did not necessarily follow that there was an improvement to the quality of access. He suggested that there were many things which could be done about improving access and what worked in one practice would not necessarily work in another.

### 5.0 Operational issues:

#### 5.1 Primary Care QIPP:

#### 5.1.1 PMS reviews

Mr Hoolaghan noted that a lot of work was being done in relation to the PMS reviews and thanked the LMC colleagues for working with the Cluster with this. He reported that the first borough workshops for PMS practices had taken place but considered that more needed to be held. He suggested that there was a need to keep up the momentum and that the point had been reached where the KPIs or menu of services needed
Mr Cairns advised that practices were struggling with the review as they did not have sufficient information to help them look at the options available to them such as a return to GMS and requested that relevant information be sent to them to help them consider this. He considered that this information would be necessary before any discussions about what KPIs would be put in place.

Mr Cairns also expressed concern that the timescale for completion of the review was unrealistic and that the feeling among the NCL PMS review group was that things were being taken forward at an inappropriate pace and some things had been taken forward which had not been agreed.

Mr Hoolaghan acknowledged that PMS practices needed information about their Right to Return and confirmed that the cluster was working on this. He suggested that the timescales be included as a substantial agenda item for discussion at the next NCL PMS Cluster Review meeting. He agreed that the transition should not be the thing which was driving the review which should be done in a fair and methodological way.

Mr Evans agreed that information needed to be sent out to practices and noted that he would like to aim to have an agreed framework in place before the new NHS organisation came into play even if the negotiations had not been completed.

It was agreed that it would be helpful for a joint communication to be sent to PMS practices to help allay their concerns over the timeline and Mr Hoolaghan suggested that it should also be emphasised that tapering would be applied once the review had ended.

5.1.2 List maintenance

Dr Lindsay asked whether the Cluster would be prepared to meet with the LMC chairs to discuss the discrepancies in the registered list sizes. Mr Hoolaghan advised that this would be something for the NHS CB to take up. He reminded the members that the Cluster had been required to do a list maintenance exercise and suggested that LLMCs talk to NHSCB about how list maintenance exercises should be done in the future.

5.2 Patient Choice Pilot LES

Mr Hoolaghan confirmed that there had been no take up of this LES and so the Cluster would circulate it again. He noted that if there were no takers the Cluster would want to come back to the LMCs to discuss a different approach.

5.3 Appraisals

Dr Hughes reminded members that revalidation was due to commence in December 2012. Dr Hughes considered that there were implications for GPs and that the situation was not helped with the transition so there was a big risk for NCL GPs if they did not have their appraisals signed off by
31 March 2013. Dr Hughes acknowledged that in the past appraisals could be delayed but this would not now be possible and her main concern was that GPs should be made aware that there was no scope for delaying their appraisals beyond 31 March 2012.

Dr Hughes noted that in North East London GPs were given a specific month in which they would have their appraisal but acknowledged that this would be too much of a significant change to introduce in NCL. Dr Hughes, noted, however, that 60% of appraisals in NCL got done historically in March but this would be a risk in the transitional year as it could result in getting a nil return.

Dr Grewal reminded members that notwithstanding the administrative problems appraisal would live on in its own right as a valued tool and should move seamlessly under the umbrella of the NHSCB. He noted that there might be valid reasons for delaying an appraisal and asked under which regulation it was stated that an appraisal had to be done in a financial year as opposed to once a year. Dr Hughes responded to advise that annual appraisals were needed on a financial year basis and that it was considered a significant event if a GP had not had an appraisal in one year.

Dr Grewal noted that the regulations required GPs to participate in appraisals to remain on the Performers List. The GMC guidance on revalidation was that appraisal was one of the arms which could be used by the Responsible Officer and the GMC but he noted that appraisal stood on its own and was not simply about revalidation. He noted that the discussion taking place was about administrative processes and he was not sure that the five LMCs had been consulted about the limitations being set down. He did not consider that it was appropriate for limitation to be set up due to meeting administrative processes.

Dr Hughes acknowledged that there had been much uncertainty about appraisals and revalidation and advised that she proposed to set up a working party with lead appraisers, LMC representatives and co-ordinators to discuss this further as there were a number of GPs lined up to have appraisals done in the first quarter of 2013. Dr Hughes considered that it would be valuable to have an LMC representative on the working group in view of the risks involved. Dr Grewal undertook to take this back to his Medical Director colleagues in the LLMCs office to suggest the name of an appropriate representative.

Dr Glackin noted that in retrospect perhaps it had not been advisable that CCG colleagues had been invited to participate in advanced revalidation this year given the amount of information they were required to collect. In addition he understood that CCG colleagues did not feel that they really had a choice and that they were expected to participate. Dr Hughes advised that an invitation had been sent out as she was aware that there were some GPs who wished to be among the first to be revalidated this year. Dr Hughes, noted that not all Board members had come forward.

Dr Grewal noted that the GMC had stated that it did not expect that all the tools for revalidation would need to be fulfilled by those GPs taking part in the first year and that there would be more flexibility than at later stages. Dr Hughes confirmed that if one year was being reduced to 9
months this would be taken into account and only a certain amount of evidence would be needed.

**Appraisal payments for PMS practices in Haringey**
It was noted that the issue of whether or not the payments for appraisals for PMS GPs had been included in the baseline still needed to be resolved. Mr Hoolaghan advised that information from the finance department indicated that money had been included in the baseline and suggested that Mr Rob Evans forward to the LMC office the relevant information. It was agreed that the issue needed to be resolved.

**Appraisal payments for locums**
Dr Hughes acknowledged that there was a need to discuss this issue and Dr Grewal suggested that the working group to be set up should discuss this issue also.

### 5.4 Premises:

#### 5.4.1 Improvement grants

Mr Hoolaghan reported that the recent Improvement Grant round had been successful and noted that Mrs Betts had been on the panel which had met over 2 days to look at the applications. He gave the following breakdown of applications which had been received:
- **Barnet** – 15 (3 rejected)
- **Camden** – 17 (3 rejected)
- **Enfield** – 14
- **Haringey** – 16
- **Islington** – 18

Mr Hoolaghan advised that it was proposed to have a second round of improvement grants once the data from the premises survey was available.

In response to a query from Dr Saldanha Mr Hoolaghan advised that the amount of improvement grant money which had been available to Barnet was £195k although he did not know how much would be available in the second round. He noted that although Barnet had the largest number of practices it had the second lowest number of applicants.

Dr Saldanha advised that this had been discussed at the Barnet Primary Care Strategy Implementation Group and there had been confusion about how much money would be available and how much would be allocated. Dr Saldanha expressed surprise that not many practices applied for a grant and suggested that this might have been as a result of poor communication to practices as there may have been a feeling that there was not much money available to justify the amount of work required when putting in applications. Dr Saldanha suspected that more might apply in the second round.

Dr Grewal asked whether practices had been reminded of the changes to the regulations around abatement and Mr Hoolaghan confirmed that this information had been included in the documentation sent out to practices.
5.4.2 Premises survey

Mr Hoolaghan advised that the work of surveying practices was ongoing with the majority of the visits have been booked or undertaken. Mrs Betts advised that the office had received information from some practices that Oakleaf were not giving them sufficient notice of the visits which meant that practices did not have enough time to pull together information required such as electricity usage. Mr Hoolaghan undertook to liaise with his colleagues in Estates.

Dr Grewal noted that under Regulation 77 practices were not required to produce the information themselves but to allow the PCT to obtain this. Mr Hoolaghan responded to advise that the survey was not being done in a punitive way and was aimed at trying to help practices get ready for CQC. He considered that it was a win win for practices and a win win for the Cluster. He was sorry to hear that practices felt that they were being put under pressure and suggested that if this was the case they should talk to the Cluster about any concerns.

5.4.3 PCT owned premises

Dr Grewal advised that it would be helpful to know how many PCT owned premises there were, who there were and how many had signed an up to date lease and/or service charges.

Mr Evans undertook to pick this up and provide an update.

5.5 Letter to practices regarding industrial action

Mr Hoolaghan advised that the Directors of Primary Care Strategy had agreed that no breach actions would be taken against any practices which took industrial action. He confirmed that a letter would be sent to practices putting a line under this once it had been approved by Capsticks.

5.6 PALS conciliation

Mr Hoolaghan confirmed that the Cluster would pay for conciliation services and asked Ms Galloway to convey this to PALS.

6.0 Future meetings

Mr Hoolaghan asked if LLMCs had considered what interface it would have with NHS CB in the future. Dr Grewal responded to advise that it was not clear what the level of engagement would be with the patch teams as it was not clear where the primary care decision making process would take place. As soon as relevant people were appointed the LLMCs office would arrange to meet with them.

It was agreed that in the meantime the December meeting should be kept in the diary and review nearer the time as to whether or not it should take place.
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<td>Dr Hughes advised that she had been in</td>
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<tr>
<td></td>
<td>touch with IPLATO with regard to</td>
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<td></td>
<td>mitigating the risks of the wrong</td>
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<tr>
<td></td>
<td>person getting text messages if mobile</td>
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<tr>
<td></td>
<td>phones had been passed on and that she</td>
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<tr>
<td></td>
<td>hoped to issue further guidance</td>
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<td></td>
<td>shortly once she had met further with</td>
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<tr>
<td></td>
<td>them. Dr Hughes confirmed that when a</td>
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<tr>
<td></td>
<td>practice requested the phone number of</td>
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<tr>
<td></td>
<td>a patient for contact purposes they</td>
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<tr>
<td></td>
<td>should also ask whether the patient</td>
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<tr>
<td></td>
<td>would consent to them using their</td>
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<td></td>
<td>number for texts also. A suggestion</td>
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<tr>
<td></td>
<td>had been made that when a welcome</td>
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<tr>
<td></td>
<td>text was sent to a patient they might</td>
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<tr>
<td></td>
<td>wish to put a PIN number on their</td>
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<tr>
<td></td>
<td>phone to stop people accessing texts</td>
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<td></td>
<td>inappropriately. Dr Lindsay pointed out</td>
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<td></td>
<td>that there was a problem in this in</td>
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<tr>
<td></td>
<td>that in Haringey people constantly</td>
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<td></td>
<td>changed phones.</td>
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<tr>
<td>8.2</td>
<td><strong>Christmas and New Year Opening times</strong></td>
</tr>
<tr>
<td></td>
<td>Dr Grewal expressed concern about Mrs</td>
</tr>
<tr>
<td></td>
<td>Whateley’s letter to practices advising</td>
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<tr>
<td></td>
<td>them that they should maintain their</td>
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<tr>
<td></td>
<td>usual core opening hours on Christmas</td>
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<tr>
<td></td>
<td>and New Year’s Eve which he considered</td>
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<tr>
<td></td>
<td>to be contrary to the regulations.</td>
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<tr>
<td></td>
<td>Furthermore he noted with the concern</td>
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<td></td>
<td>that Barndoc had implied that it had</td>
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<td></td>
<td>been told that it could not provide</td>
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<td></td>
<td>cover to practices in Barnet and Enfield</td>
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<tr>
<td></td>
<td>at all yet Harmoni was able to provide</td>
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<tr>
<td></td>
<td>cover for Camden, Islington and</td>
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<td></td>
<td>Haringey practices from 4 pm.</td>
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<tr>
<td></td>
<td>Dr Grewal referred Mr Hoolaghan to</td>
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<td></td>
<td>Regulation 20 which required practices</td>
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<td></td>
<td>to provide essential and additional</td>
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<td></td>
<td>services that meet the ‘reasonable’</td>
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<td></td>
<td>needs of patients during core hours and</td>
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<td></td>
<td>to have clear arrangements for</td>
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<td></td>
<td>emergencies. Dr Grewal contended that</td>
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<td></td>
<td>practices’ experience of demand on</td>
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<td></td>
<td>Christmas Eve and New Year’s Eve was</td>
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<td></td>
<td>that patients did not attend surgeries</td>
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<td></td>
<td>and so challenged the letter sent out.</td>
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<td></td>
<td>He requested, therefore, that the letter</td>
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<td></td>
<td>be reviewed and toned down or that a</td>
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<td></td>
<td>further meeting about this be arranged.</td>
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<td></td>
<td>Dr Lennox agreed that patients did not</td>
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<td></td>
<td>attend surgeries at those times and</td>
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<td></td>
<td>noted that in Leicester practices</td>
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<td></td>
<td>usually closed around 4 pm.</td>
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<td></td>
<td>Mr Hoolaghan agreed that this should be</td>
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<td></td>
<td>discussed further outside this meeting</td>
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<tr>
<td></td>
<td>and that Dr Grewal should meet with Ms</td>
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<tr>
<td></td>
<td>Galloway who would be leading on this.</td>
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<td></td>
<td>He concurred that a 4 pm close might be</td>
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<td></td>
<td>a pragmatic way forward but did not</td>
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<td></td>
<td>consider that it would be appropriate</td>
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<td></td>
<td>for practices to close at noon as</td>
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<td></td>
<td>had happened the previous year.</td>
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<tr>
<td>8.3</td>
<td><strong>Thanks</strong></td>
</tr>
<tr>
<td></td>
<td>Dr Grewal led the LMC Chairs in</td>
</tr>
<tr>
<td></td>
<td>thanking Mr Hoolaghan and his</td>
</tr>
<tr>
<td></td>
<td>colleagues who had worked in the</td>
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<td></td>
<td>Cluster and had attended these meetings</td>
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<td></td>
<td>and wished them well in the future.</td>
</tr>
</tbody>
</table>

T Grewal/T Galloway
Proposed meeting dates for Enfield LMC meetings in 2013
Last Monday of the month
Venue: Forest Primary Care Centre
Time: Part one – 13.30 to 14.45
      Part two – 14.45 – 15.30

25 February 2013
29 April 2013
24 June 2013

19 August 2013 – do members wish an August meeting?
28 October 2013
23 December 2013