

Kensington and Chelsea Primary Care Trust

10 Year Primary Care Strategy

July 2008 – July 2018

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A 10 Year Strategy for Primary Care

1. Introduction

This paper sets out Kensington and Chelsea PCT's vision for primary care over the next 10 years and how it will be implemented. A draft implementation plan is attached to the strategy. The strategy relates to General Practitioner (GP) services; community pharmacies; NHS dentistry and primary care optical services. The aims of the strategy are to:

- Deliver localised and integrated care where possible and centralise care only when necessary
- Promote Health Improvement and Well being where appropriate in the primary care setting
- Ensure equity of access to all services regardless of geography, gender, ethnicity, age or physical ability
- Create and maximise the opportunities for integration of health and social care services where appropriate

2. Drivers for Change

There are a number of different drivers for change that have influenced the development of the strategy. They are as follows:

2.1 Patient Expectations

The PCT commissioned the Picker Institute¹ to undertake 1,000 telephone interviews with residents from the borough on their experience of primary care. Overall patients report high levels of satisfaction with access to primary care. Four out of five patients stated that they were satisfied with their last GP visit. However 12% were dissatisfied enough to consider changing their surgery. They also expressed concerns about the quality of reception staff and how they are treated. (A summary is attached in appendix 1). The PCT is committed to improving both access and the quality of patient experience of primary care as part of the strategy. Patients have also expressed how much they value the personal relationship and continuity of care they receive from their doctor and highly value the 'cradle to grave' experience general practice offers. This strategy is committed to preserving this relationship between the GP and patient.

However, expectations of primary care are changing. People value the personal service but also:

- Have far higher expectations than previously of the quality, accessibility and personal competence of our local Medical / Dental / Pharmacy / Optometry practice and of nursing care.
- Expect a helpful response when worried about their health or when unwell, and expect a greater degree of seamlessness of service and help with navigating the health and social care system.
- Are increasingly happy to exert their right to choose and be better health care consumers but need that advice to come from someone they know and trust.
- Want to take more interest in their own health and well-being and expect a service that will help them to take more care of their diet, levels of physical activity and mental health.

The draft framework of the primary care strategy approved at the September 2007 PCT Board set out a number of principles that would underpin local engagement in the development of the strategy. Since the draft framework was prepared a number of patient involvement exercises have been commissioned and/or taken place. The outputs from all these exercises have been fed into the strategy. The details of the engagement events are outlined in appendix 2. Below are the key public involvement events that have taken place:

- (i) The PCT commissioned Picker Institute to undertake a targeted telephone questionnaire with 1,000 Kensington and Chelsea residents. The focus of the

¹ Picker Institute (June 2008) Access Telephone Survey Kensington and Chelsea Primary Care Trust.

- questions is access and primary care. A summary of the outcome of the questionnaire is outlined in appendix 1.
- (ii) Royal Borough of Kensington and Chelsea Residents' Panel² has interviewed 1,000 residents with specific questions relating to primary care, including out of hours provision and dental care.
 - (iii) The Kensington, Chelsea and Westminster BME Health forum commissioned a study on Black and Minority Ethnic communities' experience of access to GP Practices³. A summary of the recommendations are outlined in appendix 3
 - (iv) St Charles Hospital community reference group have discussed how they would see benefits from enhanced primary care
 - (v) A focus group with key voluntary sector providers discussed the draft strategy.

2.2 Policy

There are a number of different drivers for change that have influenced the strategy:

- a) *Health Care For London*⁴ led by Professor Darzi recognised that the standard and quality of healthcare across London is not uniform. 'A Framework for Action' sets out the need to develop new models of community based care at a level that falls between current GP services and the traditional district hospital. Part of this vision is to ensure patients get treated at the right time, by the right clinician, in the right place. By providing more care closer to home and enhancing primary and community provision, the role of the local hospital will change.
- b) *World Class Commissioning*⁵ is a framework set by the Department of Health to improve the commissioning and performance management of all services. PCTs are expected to develop a three year commissioning strategy that will address how we commission services across primary, secondary and mental health services. This will ensure the PCT improves and develops its commissioning capacity and capability across all departments including how we contract and manage independent practitioners. The development of a Primary Care Strategy is a part of this process
- c) *North West London Clinical Reference Group* set out a number of recommendations to improve clinical outcomes and improve the patient experience of care. The priorities identified were unscheduled care; paediatrics; obstetrics; long term conditions; standardising clinical practices; primary care and acute care. These recommendations are reflected in the direction of travel set out by Professor Darzi and the PCT 3 year commissioning strategy.

² Royal Borough of Kensington & Chelsea Community Strategy (2008) Residents' Panel Survey consult@rbkc.gov.uk

³ BME Access to GP Practices for Black and Minority Ethnic communities in Kensington, Chelsea Westminster PCTs (June 2008)

⁴ Health Care for London – A Framework for Action (2006) NHS London www.london.nhs.uk

⁵ World Class Commissioning (June 2008) www.dh.gov.uk/worldclasscommissioning

d) *Kensington and Chelsea PCT's Health Investment Strategy 2007-2013*⁶ set the strategic objectives for the PCT that included care closer to home and improved quality of health care provision

A local Clinical Reference Group was established to influence the development of the strategy and the local Medical, Dental and Pharmacy Committees were consulted as part of the process.

⁶ Kensington and Chelsea Primary Care Trust Health Investment Strategy 2007/2013 www.kc-pct.nhs.uk

3. The Vision for the Primary Care Strategy

The vision for primary care is that in ten years the registered population of Kensington and Chelsea will be able to choose and experience health care that is provided to the highest standards possible in modern, clean and accessible environments. Services will be integrated with social care where appropriate and responsive to patient need. The vision supports care closer to home and an increasing emphasis on prevention and self management.

The vision for primary care is to ensure that all patients are able to easily access consistently high quality responsive primary, preventative and community services. These services will cover a broader range of services than are presently provided by primary care and will include diagnostics, management of all long term conditions (LTC); out-patient clinics and integrated health and social care provision. The expectation is that patients will only attend acute hospitals when their care necessitates surgical, inpatient and medical facilities that primary and community services can not provide. The vision also includes promoting health and wellbeing and working closely with social care to identify when it is appropriate to promote integration across these services. The intention is also to reduce and minimise any existing health inequalities in accessing services. This vision has influenced the development of St. Charles Community Hospital and other major developments across the PCT's commissioning portfolio. We can achieve this vision by considering the following:

- Quality Standards
- Access
- Choice
- Integration

3.1 Quality Standards

In ten years time patients will experience a consistently high quality of performance from our local primary care organisations and experience less variation in the performance of individual practitioners.

In line with the vision for primary care the services to be commissioned will be of the highest standard and improve year by year responding to patient needs and expectations. The PCT will invest in primary care clinical champions, starting with a GP, Practice Nurse, Community Pharmacist, General Dentist, and Optometrist. These champions will be given a remit by the Clinician on the PCT Board with responsibility for quality and clinical governance to pro-actively visit practitioners, case-manage performance issues, share good practice to advise the PCT about commissioning training and education to drive to standards year on year.

The PCT will implement when available the expected revised strategy for the Quality and Outcomes Framework (QOF) as this is recognised as a key tool in driving up and sustaining quality improvements in general practice. This will include the new Patient Outcome Measures (PROMS).

The Personal Medical Services (PMS) review has raised the quality of care and provided a level of standardisation across PMS practices. It has provided a

mechanism for the PCT to commission from the 20 PMS practices 7 premium services based on improved health outcomes and access that will cover mental health; sexual health; alcohol misuse, vulnerable elderly older 85 years old; local public health needs and rough sleepers. It also ensures the 50 hours access. The premium services specifications have been benchmarked against enhanced services from other PCTs. The funding has been calculated on expected volumes of activity and anticipated consultation times, with there being a high and low banding mechanism. Initial financial assumptions indicate this will require an additional £470,000 that has been identified as part of the Investment Programme. The learning acquired from this process will be applied and adapted to develop more Local Enhanced Services for General Medical Services (GMS) practices over the next 18 months. It is estimated that an additional £530,000 will be required to fund the cost of these additional enhanced services.

The development and increasing sophistication of a primary care performance dashboard will be used to inform the primary care contracting team. This will include the analysis of resources in each independent practitioner's contract, the monitoring of activity measures for primary care organisations for value for money and quality measures that reflect the concerns of professionals and patients.

The PCT has always been responsible for the safe provision of primary care to its population. We will continue to use our contractual powers to monitor the standards of primary care so as to identify and rectify poor performance as soon as possible, where this is not possible, remedial action will be taken. This will be achieved by working in partnership arrangement with our neighbouring PCTs to create an audit team including clinical champions and lay members to undertake organisational audits, give feedback to each primary care organisation, help them develop improvement plans, and contribute hard and soft data towards a bigger picture of the quality in the Borough of its primary care organisations.

3.2 Access and Choice

In ten years time all parts of the Kensington and Chelsea registered population will have access to responsive services and exercise their choice in terms of where they access care and from whom.

Patients will soon have greater choice of when and how they 'get into' local services and care. All registered patients will be able to access a GP of their choice between 8:00 am to 8:00 pm Monday to Friday and there will be at least one location offering GP services from 8:00 am to 8:00 pm every day of the week. Our experience from the pilot exercise on extended hours has provided very popular with patients and is being offered to all practices as a Local Enhanced Scheme in September.

Access to a centre for unscheduled care will be available in the North of the borough at St. Charles Community Hospital by the summer of 2009. This will allow patients to access walk-in facilitates and booked appointments with the nurse and/or GP; community pharmacy services and access to up to date diagnosis treatments from 8:00 am – 8:00 pm seven days a week. A similar Primary Care led centre is being developed with Chelsea and Westminster NHS Foundation Trust in the South of the borough and is expected to be available in 2009/10. We will commission from

existing and new independent practitioners, including community pharmacy, to achieve these extended services.

Improved access is not just about opening hours. It includes a wider range of services that are more closely aligned to each other to ensure the patient pathway is as smooth and seamless as possible. For example the commissioning specification for the new Rapid Response Nursing team explicitly considers the relationships between district nursing, specialist nursing, social care, community rehabilitation and community mental health services are aligned to ensure that the patient's needs are the focus of the multi-disciplinary team effort and not just a partial slice of care. In the medium term further work will include supporting community midwifery, community based care of elderly, palliative care support, End of Life care, Stroke and the management of urgent care centres. Such new developments will be provided to the highest standard and will continue to improve quality, choice and access.

Royal Borough of Kensington and Chelsea's Residents' Panel Survey commissioned as part of the Community Strategy 2008 identified that disabled patients visited their GP six times more than non-disabled patients last year. Part of the strategy relates to the physical environment of local services and this is referred to in the section 3.5.3 later in the paper. It is critical that the needs of disabled people are considered both in terms of access but also their experience of health care services locally.

The recently published Black and Minority Ethnic (BME) Health Forum for Kensington, Chelsea and Westminster PCTs on access to primary care identified a number of difficulties issues their communities experience in registering and accessing local primary care, including the need to review the existing interpreting service. It is critical this improves for BME communities to receive quality services. As part of the primary care strategy we will work with Westminster PCT to consider and implement the recommendations. A full equalities impact assessment of the ten year strategy will be undertaken as part of the implementation plan.

It will be impossible to provide a World Class primary care service in Kensington and Chelsea without time and attention being spent on developing clinical leads and the primary care workforce. Along with colleagues from Practice Based Commissioning, the PCT is already looking at how we support and expand our current pool of clinical leads. This is referred to in greater detail in section 3.5.1.

3.2.1 Commissioning for Choice

Primary care providers often commit their entire careers to a locality and as a consequence are able to offer great insight into local communities as well as the longer term health requirements of the community. This is an enormously rich resource for the PCT and provides a welcomed stability to future planning. Therefore we will strive to develop and commission from within the existing workforce capacity. Independent small practices have provided health care to the population of Kensington and Chelsea since the inception of the NHS and have worked together to provide a very efficient in and out-of-hours care for the residents of Kensington and Chelsea both for health and dental care. They have also more recently been useful in the development of practice based commissioning which has

played a significant part in the negotiations with the Acute Trusts and demand management.

However as the PCT commissions an increased range of services from independent practitioners it is anticipated that it will be increasingly hard for smaller practices to work in isolation. Therefore the strategy will encourage and support practices in working together to provide extended opening hours as well as extended services. This is already happening in part through the community phlebotomy service, anti-coagulation services and PMS review. As this develops we anticipate that there will be increased need for a more sophisticated and skilled practice management of these larger groups. To support this we will be setting aside facilities to develop practice management skills to support these larger units. As outlined in the organisational development section, the primary care strategy recognises this as a critical success factor.

If the PCT considers it needs to stimulate greater choice and innovation into the market then it will look to commission new services from both within and outside existing GP providers. However there will be times in the future when the PCT will commission through a competitive tendering process via the open market to ensure the PCT is driving up standards, supporting innovation and ensuring value for money. The PCT is committed to commissioning new and enhanced services via competitive tendering where necessary. We will agree the nature of any new contracts as relevant to the expected service specification (eg GMS/APMS/PMS).

3.3 Integration

In ten years local people will experience a pattern of services that is a closely knit network of publicly funded services, and partly self-funded services; provided by a mix of different suppliers.

3.3.1 Primary care does need to find an acceptable way of actively 'knit together' the myriad of community based services that make up a local community's health and social care network. It also needs to envisage that such networks are partly made up of publicly funded services, and partly self-funded services; or provided by a mix of different suppliers.

The primary care strategy defines integrated provision as bringing together NHS, 3rd sector and Social Care staff into virtual teams that look after the same clients. From a primary care strategy perspective there are some important considerations when agreeing on what integrated care means:

- It is very likely that a client receiving social care will be well-known to their local GP / Practice Nurse; and also receiving care from a community nurse or therapist.
- Primary care works hard to keep patients at home by avoiding admission to an institution unless there is no choice. Most people in this category have a chronic illness / end of life need related to diabetes, respiratory illness or heart disease, and are increasingly being case-managed by a Community Nurse and /or receiving support from the third sector.

- Patients are encouraged to leave hospital as quickly as they are able to, and only to use A&E in an emergency. Therefore generalist clinicians (e.g. GPs and Practice Nurses) need specialist help (District Nurses, Social Workers, Therapists supported by Home Carers) to care for patients at home.
- Patients often do not see health and social care support as separate needs and hence the strategy has to ensure we create the environment for a seamless service. This is in line with the transforming social care agenda.

The joint work between Practice Based Commissioning and Adult Social Care on the rapid response nursing teams and community based mental health services illustrate how this is beginning to happen. Such teams will be expected to work on co-located sites. For the community based mental health teams we plan to commission them from 3 sites across the borough if possible. Such centres, or hubs, will hopefully have access to a full range of services as well as dedicated community mental health provision. There are also further opportunities to explore the role of home care workers in a number of key joint pieces of work. However for more and systematic integration between health and social care to succeed there needs to be a significant workforce redesign project, led at a senior level by Social Services and the PCT, to focus on creating integrated provider teams that support primary care's generalist, risk management role.

The PCT is keen to work with RBKC adult services to become a pilot site for Individual Budgets held by patients for their integrated care needs as part of promoting independence and well being.

3.3.2 The third sector is a key partner in providing care to a number of patients particularly those who are vulnerable e.g elderly, mental health patients. The PCT already has a working relationship with the voluntary sector as the First Stop Way Finder Service pilot scheme demonstrates.

The PCT has taken a significant step in approaching the third sector commissioning of community and voluntary organisations over the last year. We have moved away from traditional grant funding and have undertaken an investment process inviting bids across a range of service areas, issues and initiatives. This has moved commissioning of the 3rd Sector into our mainstream commissioning process and investment has been targeted across many organisations commissioning initiatives and programmes according to PCT priorities, for up to three years, allowing developmental and flexible approach to service delivery. Commissioning and contracting will be appropriate to the size of the contract but will focus on outcome measures, quality and develop the strengths of the organisations, adding value and helping to integrate at the interface between the medical and social models of services and interventions. The Investment process has encouraged smaller organisation into the market place and networked partnerships between small and medium organisations encouraging shared learning. The PCT is committed to on-going investment to the 3rd sector.

3.4 Practice Based Commissioning

In ten years there will be strong clinical leadership of locality teams holding budgets to commission integrated care pathways and a broad range of health and well-being interventions.

Practice Based Commissioning has the potential to transform services by putting clinicians at the heart of PCT commissioning and strategic planning and allowing groups of family doctors and other community practitioners to develop better services for their local communities. Kensington and Chelsea PCT has a healthy working relationship with its local PBC group and the primary care strategy aims to ensure this grows and is strengthened by promoting national and local incentives. The PCT will closely align the PCT commissioning, public health and information teams' capacity and capability to support the expansion of PBC.

Practice Based Commissioning (PBC), and the Kensington and Chelsea PBC Consortium in particular, has been a motivating force for primary care driving improvements in health care outcomes. Thus far, the Consortium has achieved the following:

- improve and standardise the range of care across the PCT through the introduction of new care pathways e.g Chronic Obstructive Pulmonary Disease, case management and Musculoskeletal Services
- introducing performance management by comparing acute commissioning information across all Practices - then using peer review to evaluate causes for different referral rates, acute emergency admissions etc
- admission avoidance and active case management of these patients to prevent readmission of vulnerable patients
- the development of more corporate behaviour amongst the independent practitioners as illustrated in the PMS review and the standardisation and review of appropriate referrals in to secondary care.
- developing an extended portfolio of local enhanced schemes that reflect PCT and PBC priorities for example End of Life Care
- developing integrated care pathways based on those outlined in Use of the Map of medicine etc to ensure consistent best practice in condition management across the PCT.
- reducing variability in quality and outcomes by designing a scorecard of quality measures – a primary care performance framework.
- supporting poor performers to improve where they can via peer review.

It is widely accepted that practice based commissioning will continue to have a future in the NHS. Part of the Primary Care Strategy is to ensure it grows and becomes more localised within a co-ordinated borough framework. PBC will work with its constituents to define and determine the specifics of operating as a network of locality commissioners of local health and social care provision. They are considered the key drivers to ensuring locality groups are formed around natural communities and common health care needs. PBC is producing a three year Business Plan to this effect.

3.5 Infrastructure

In ten years patients will be able to get more information about the quality of services, and receive those services from highly skilled, well trained and well motivated staff acting as champions for health and well-being. Where those services need to be delivered outside of the home they will be delivered in high quality carbon neutral environments.

The PCT is working closely the Royal Borough Kensington and Chelsea Planning Department which considers the strategic direction of the borough in terms of land uses and associated activities. To date there is no evidence of a significant expected growth in the population of Kensington and Chelsea. However if this was to change and a large development with an expected population increase of over 10,000 was planned we would look to commission new GP capacity through a competitive tendering exercise.

Overall Kensington and Chelsea PCT is recognised as not being an under doctored area (Information Centre for Health and Social Care: 61.7wte per 100,000 weighted population above the threshold of 57.89wte per 100,000). This will not restrict the PCT from commissioning additional capacity to respond to the expected increased demand on primary care. Initial workforce calculations predict that Kensington and Chelsea PCT will need to recruit a further 20 GPs and 5 nurses alone to be able to respond to the increased workload of improved care for people with long term conditions. This along with other factors like increased patient choice and more access will be fed into workforce planning projections for the next 10 years.

Before agreeing to commission more primary care from exiting services or a new provider, the strategy will consider how much additional GP capacity is necessary to warrant a full scale tendering exercise. For example if wish to commission an urgent care centre for example we would look to competitive tendering but we would not if it was in response to one doctor retiring with a list size of less that 2,000 patients.

3.5.1 Workforce, Human Resources and Organisational Development

Through the work of the local Clinical Reference Group a sub group has been established to develop the following work streams.

- *Developing local Clinical Leaders.* As already mentioned the success of a primary care strategy is highly dependent on a motivated and well skilled workforce. The future challenges to primary care demand that the PCT steps up its support and commitment to skills development of all primary care staff. To this end we will commission a detailed skills audit of our local GPs; how they would like to develop their portfolio and how this matches with the expected changing pattern of health care provision. From this piece of work we will develop a clinical sponsorship programme to ensure our existing clinical staff have the portfolio to deliver against the new clinical models of care. We will be working with the London Deanery and LMC on this piece of work. This will also help local GPs in the preparation for the future accreditation programme plan.
- *Practice Nurses* A similar exercise will be undertaken for our practice nurses as they also need investment in their clinical capability and capacity. Their training needs are not just about clinical skills which enable the practice to offer a wider

range of services, but about basic training for safe working (Health and Safety, infection control, anaphylaxis) and skills towards clinical leadership (teaching, audit, committee work).

- *Supporting Practices to manage their Business.* As the challenges to primary care continue and demands increase, practices need to be able to ensure they are fit for purpose. The role of the practice manager is critical in achieving this successfully. However the provision and quality of practice management is patchy across the PCT so we be offering a 1 day a week seconded role for an experienced Practice Manager to work with practices on mentoring, developing and sharing the expertise that Practice Management can bring to the success of primary care. The PCT will also look to work with networks of practices on how they can jointly develop and improve the overall business management of groups of practices as part of supporting the federal model of primary care discussed in section 5.
- *Customer Care.* The recently published Kensington and Chelsea BME forum report of Black and Minority Communities experience of access to local care was about how they are treated and received by practices. The role of the practice receptionist is very important in this experience. The standard of receptionists varies and as they are often the first point of contact for the patient, the PCT will commission a customer care training programme for all practices. We are looking at ways to ensure all practices support their staff on such programmes.
- *Workforce planning.* Over one third of Kensington and Chelsea GPs will be of retirement age within the next 10 years. The PCT is engaging on a 1:1 basis with local GPs to develop insight to individual's retirement plans. Where retirement is expected we can begin a recruitment plan to ensure we do not have gaps in provision. This will run in parallel with recruiting more GPs and nurses to respond to the increasing demand of more LTC being managed in the community and extended hours.
- *Organisational Development and Change Management.* The challenges facing a traditionally run general practice are immense and should not be underestimated. Independent practitioners are being asked to work in very different ways that traditionally many of them will not have done before. For some the change is an opportunity but for many it is a threat. The PCT will commission specific Organisational Development programme to work directly with practices to understand and respond positively to the changing environment around them in order to achieve the vision set out in the strategy.

3.5.2. Information Management and Technology (IMT)

To ensure all primary care is serviced and supported by the state of art IMT to ensure the delivery of local services is safe, efficient and effective as possible.

To support practices, community pharmacy and dentistry to work more smartly and efficiently in the future we will need an increasingly sophisticated IMT system. The PCT has started discussions with two of the major providers of IM&T in primary care – VISION and EMIS and we are aware of the development of web based primary care IMT system which we are hoping to introduce in to Kensington and Chelsea. The PCT is fully committed to the development and support of NHS NPfIT and accepts that for primary care to develop the IMT in Kensington and Chelsea will have to be of a high standard. We are also working with IM&T to see how these professional groups can work together so that pharmacists can communicate with

GPs and the future primary care groups can communicate directly with GPs. The implementation of electronic prescriptions will be introduced at St. Charles Community Hospital next year. At the moment the PCT is working with the Acute Trusts so that there is easier transfer of information with regard to prescriptions, discharge summaries and pathology results from the hospitals to primary care and back again. The PCT's IMT strategy has highlighted that support to independent practitioners as a key priority area and has identified additional capacity to make this possible.

Part of the IMT strategy is to improve the data capturing and analysis to support PBC in achieving World Class Commissioning standards and allow local practitioners to be activity understanding and managing local activity rates.

3.5.3 Estates

Our vision for the next ten years is to provide primary care services from the highest quality buildings as possible within a close proximity to patients' homes.

In preparation for this the PCT commissioned a survey of all GP, NHS dentists and community pharmacy facilities was undertaken to assess the level of Disability Discrimination Act (DDA) compliance; existing capacity and potential for expansion and distribution of practices versus need. From this work approximately one third of our GP premises needed further work to be DDA compliant consequently we propose the following:

- We will not commission any new or extended primary care services from buildings which are not fully Disability Discrimination Act compliant approximate one third of primary of care is provided from premises that are non DDA compliant.
- Where the survey has identified practices that with some investment would become fully DDA requirements the PCT will invest new monies on the understanding that extended services can also be provided. A practice improvement scheme is being created to support minor improvements and meeting DDA standards
- However it is quite clear that where premises are not DDA compliant and are unlikely to be able to be DDA compliant then the PCT will need to look for premises and practices elsewhere to deliver extended services.
- We would also expect all independent contractor premises to meet NHS guidelines for room size and to have adequate facilities, e.g. for hand hygiene, to ensure infection control and patient safety.

Findings from the previously mentioned Picker Institute survey of local residents identified that 79% of the sample currently walk to their GP and the vast majority walk from home (93%). Residents go on to express strong support for maintaining this close proximity to local services and it is the primary care strategy's intention to respect this. As part of the GP survey it assessed the distribution of existing practices and a 10 minute walking distance the registered population have to undertake to access primary health care. It demonstrates that the majority of our patients are within a 10 minute walk to practices however we have a number in 'hotspots' where availability is not matching population dentistry. These areas are

Earls Court and South Chelsea. This is illustrated in the map attached. Residents in the North of the Borough have a lot of choice of GPs for example circles 1 and 2. However for residents living in circles 5, 6 and 9, the choices are limited. These 'hotspots' will become the focus of our attention with the planning department of RBKC to work together to identify access to improved premises. The access to existing premises and walking distances has also informed the proposed models of care discussed later in the strategy.

In developing these potential new facilities the PCT would wish to ensure where possible:

- provide a minimum 6000 sq. ft of space
- provide accessible, safe, flexible and adaptable accommodation to meet the changing service needs
- Integrate with the local environment and promote regeneration
- Provide a high quality internal environment to support health and well being for users
- Reducing pollution and waste to avoid health and other impacts
- Using resources (e.g. energy and water) efficiently
- Where possible facilities should have good links to public transport
- Where access proves to be a problem due to people with limited mobility problems, the PCT will actively consider how best to provide community transport for those that need it.

4. Health Improvement

As described in the 2006 White Paper *Our Health, Our Care, Our Say*⁷ the primary care strategy is committed to providing more services available to people in their local communities or in their own homes to avoid unnecessary trips to hospital and to make services more personal and effective. The more recently published NHS Next Stage Review *Our Vision for Primary and Community Care* (July 2008)⁸ has further emphasised the role primary care has in creating opportunities to promote health and well being. Consequently we are committed to the following:

- **Influencing people's health behaviour**, we will use social marketing and communications techniques beyond the traditional skill set of public health to assist in gaining a better insight to influence people's behaviour. Therefore any such programme should be a well-constructed partnership between Communications, Primary Care, Public Health and a private partner such as the pharmaceutical industry, health improvement consultancy, health insurance industry or firm such as "Virgin Proactive."
- **The creation of a Health MOT health improvement service for employers and individuals in the borough.** Employers would value a service that reduces absence. A new model of commissioning and provision for health MOTs will be commissioned in 2008/09.

⁷ Our Health, Our Care, Our Say (2006) www.dh.gov.uk

⁸ Our Vision for Primary and Community Care (July 2008) NHS Next Stage Review www.dh.gov.uk/publications

- **A new Child Health Promotion Programme** that will integrate services for children by multi-professional groups working together more effectively for the benefit of the family. The role of the Health Visitor will be pivotal in the new child health promotion programme.
- **To promote the joint goal of a Borough where everyone has the opportunity to lead a healthy and independent life and can access good quality health and social care services when they need them.** This will be achieved via the Community Strategy the PCT has agreed with RBKC.

All of the above will be addressed through the whole systems partnership agenda, public health and the primary care being recognised as one of the delivery vehicles for health improvement.

5. Models of Primary Care

In ten years patients will be receiving a broader range of services closer to where they live from networks of primary care practitioners working on a hub and spoke model. The exact number and function of each hub and spoke will be determined over the next 12 months with an agreed number of networks confirmed with PBC, Local Medical, Pharmacy and Dental Committees and General Practices.

5.1 General Practice

The PCT, in partnership with the local Clinical Reference Group, identified the Hub and Spoke, often called the Federal model, as the model of primary care that is best placed to deliver the vision of the 10 year primary care strategy for Kensington and Chelsea.

The Hub and Spoke Model

Feedback from patient groups; local clinicians and other studies (Liverpool PCT Commissioning Strategy and the Picker Institute Survey) have all emphasised the need *not* to require people to travel longer distances than a 10-15 minute walk to access primary care services. This is a quality standard which the PCT has set itself to meet.

Such feedback has also confirmed that both patients and GP value the personal 1:1 relationship that GPs build up with their patients and the continuity of care this offers patients. The Picker Institute Survey specifically asked patients about how far they were willing to travel to receive additional services such as diagnostic tests or simple hospital procedures. 56% would definitely travel beyond the 10 minute walk to receive such services and just under half (49%) were happy travelling further than the 10 minute walk barometer if it meant they could see a GP when their needs were urgent or they could be seen without making an appointment.

Healthcare for London emphasises localised and personalised care where possible, maintaining close geographical proximity to the patient's primary care provider is a critical part of achieving this objective. A recent audit of all Kensington and Chelsea of GP consultations indicated that only 29% of GP consultations were referred onwards for diagnostics or to a consultant clinic (from a 312,000 GP consultations in 2006/07). This indicates that the vast majority of primary care needs are managed within the GP environment. This argues against bringing large numbers of GPs together and asking patients to travel large distances to access a great range of specialist services 71% of them do not need on a routine basis.

The 'Spoke' of the Hub and Spoke model is individual GP practices that will be commissioned to deliver high quality GP services that promote improved access and choice to patients within the minimum of the 8:00 am to 6:30 pm contractual requirements and essential, additional and locally enhanced services as outlined in appendix 4. A 'Spoke' can also be a community pharmacy working to enhanced services.

The '*Hub*' is larger practices or centres that provide to larger groups of patients, anything from 15,000 patients upwards, that offers access to diagnostics; community mental health teams; community diabetes services ect. We intend that these hubs develop over time to act not just as a focus for health services for that area, but that they can be developed by and for the local community into a valuable community resource.

Each hub will develop in response to the identified needs of its specific local population, however it is expected that each hub will have the following main functions:

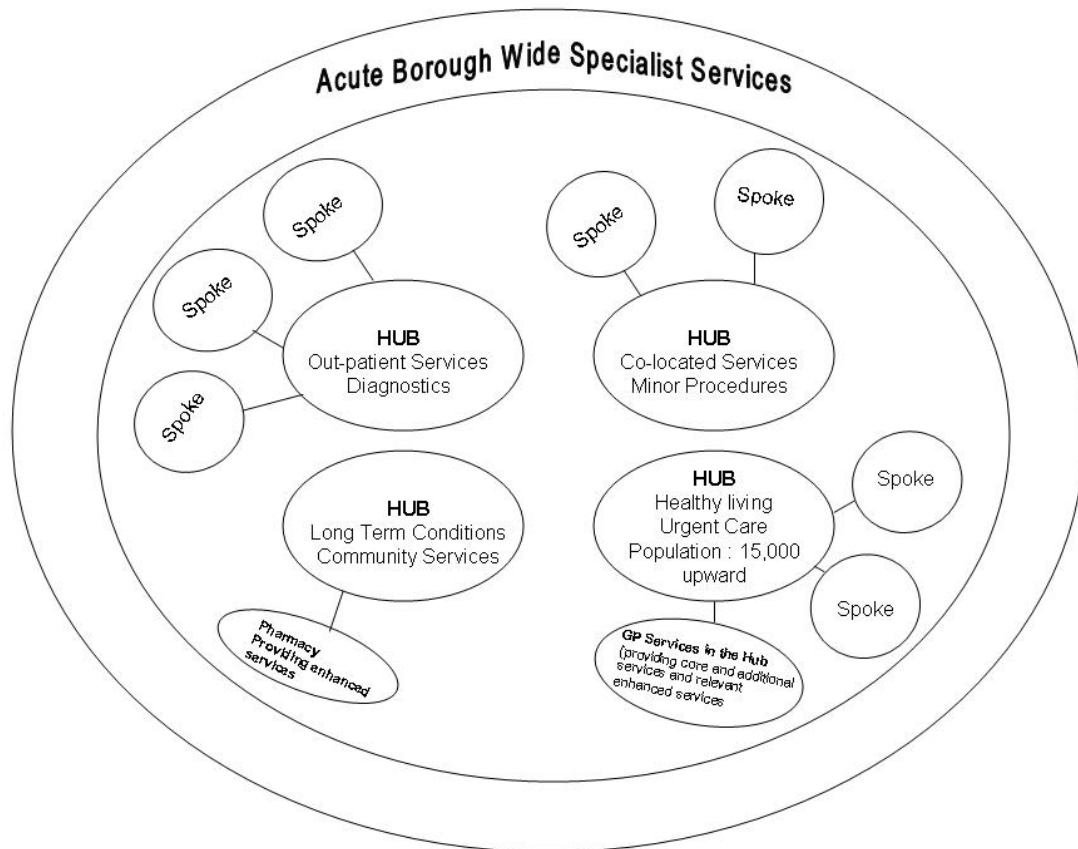
- They will provide general practice services to a minimum of 15,000 registered patients.
- They will provide a base from which a wider range of services can be offered to those registered with a GP at the hub **and** to the local GP spoke practices operating around the hub. This would include blood testing and other diagnostic testing, out patient appointments usually conducted in hospital and services to support long term condition management in a "one stop shop" approach.
- Practices that refer into the hub will operate as a network or federation of practices. This current is operating for phlebotomy and anti-coagulation services.
- They will provide a base from which other social care and voluntary services will be able to add value to health based interventions, e.g. Citizens Advice, social services linked to help at home, housing advice, fitness and exercise schemes.
- They will provide health promotion and prevention activities and programmes.
- At St. Charles Community hospital in the North of the Borough we will commission extended unplanned urgent care services for the locality – e.g. urgent care, minor injuries and out of hour's services over and above what will be provided in the GP practice spokes. A similar model is being developed for a urgent care centre in the South of the borough.
- Extended access in terms of opening hours across a range of services – for example general practice available 8:00 am – 8:00 pm per day and Saturday opening.
- A health and community resource which will engage the local community in its health and health services.

St. Charles Community Hospital is planned to be an example of the hub, where we expect to have 5 practices working together in the community hospital and 12 neighbouring practices, or spokes, referring into the community hospital and urgent care services.

We have not yet defined the geographical areas where the hub and spoke model will operate with the exception of St. Charles Community hospital. The PCT will work with PBC, the Local Medical Committee and local practices to identify the geographical locations that will support different hubs to reflect the different health needs and physical characteristics of the Borough. Every hub can and will be different for example some may include NHS dentistry and others more access to diagnostics. They will not all be the same but will cover the core functions described above.

This model also supports locality commissioning and so is attractive to support the development of PBC to devolve commissioning to a locality level. This will allow

local practices to become more actively engaged in commissioning on a local level and so truly reflect their localised health needs. In the absence of larger suitable premises this model is very attractive. This is especially true in the South of the borough where access to improved premises is proving to be more difficult. The model is illustrated below, the descriptions and numbers of hub and spokes is purely for illustrative purposes and the detail does not reflect what is being proposed.



5.2 Community Pharmacy

Building on the core principles and values of the community pharmacy network in Kensington and Chelsea PCT, the primary care strategy vision for community pharmacy services is focused on the development of 3 levels of community pharmacy service that support the hub and spoke model of care across the borough.

The dispensing of medicines will remain in the existing network of pharmacies with a separate arrangement for the supply of specialist medicines (i.e. those not normally distributed via the GP prescription route) to the polyclinic.

Level 1: Community Pharmacies Providing High Quality Essential Services

To maintain and improve the high accessibility and availability of essential pharmacy services from high street locations, our existing pharmacy network must provide all essential services to the standards required with the right skill mix and number of staff for the volume of work and from a high standard of premise that will meet basic standards for infection control, space, privacy and dignity.

Essential services:

- Dispensing
- Repeat dispensing
- Disposal of unwanted medication
- Promotion of healthy lifestyles (public health)
- Support for self-care
- Signposting of patients to other healthcare professionals
- Clinical Governance (including compliance with Disability Discrimination Act)

Level 2: Community Pharmacies Providing Essential Services and Some Advanced or Enhanced Services

These pharmacies will provide some additional services requiring a consultation area (to the national standard) of which some will be commissioned according to local needs.

Examples of additional services

- Medicines Use Review
- Smoking Cessation
- Supervised consumption of methadone
- Needle/Exchange
- Provision of basic screening kits (e.g. Chlamydia screening)
- Minor Aliments
- Vascular Risk Assessments

Level 3: Community Pharmacies Providing Essential Services and a Minimum of 5 Advanced or Enhanced Services

These pharmacies will have treatment rooms to a specified standard for consulting, diagnostic testing and administration of injections, with IT capable of interfacing with GP systems. There will be 5 or 6 located in high footfall locations in areas of need.

The services are likely to include some of those at Level 2, but are likely to be at a more advanced level. For example, in Level 2 there may be provision of Chlamydia screening kits, but a pharmacy in Level 3 would also be treating patients identified as being positive for Chlamydia. Some pharmacists will be prescribing medicines or supplying medicines under Patient Group Directions as part of the enhanced service. The pharmacies will employ a range of skill-mix, and it is likely that they will provide support to other pharmacies, and utilise new areas of development such as Pharmacists with a Specialist Interest (PhwSI).

Overtime it may be that more pharmacies are able to provide services at this level, as it becomes more common for pharmacies to provide such services, and the expectation of the public increases so that they expect such services from most pharmacies.

The PCT will develop a set of standards for the premises based on the future potential range of enhanced services that might be commissioned.

Advanced/Enhanced Services:

- Advanced compliance support and monitoring e.g. medicines reminder charts, telephone support, compliance aids, medicines use review
- Advanced promotion of healthy life styles through Windows campaign and supporting behavioural change
- Sexual health services: Chlamydia and Gonorrhoea Screening and Treatment, Supply of Emergency Hormonal Contraception
- Early identification diabetes
- Advanced minor ailments scheme
- Support to drug users: Needle/exchange, supervised consumption, instalment dispensing, health promotion/harm reduction
- Immunisation and vaccination

Specialist Pharmacy Services to Support a Hub or Cluster of Primary Care Services

Focusing on safe, high quality and cost-effective prescribing the specialist pharmacy service could provide the following:

- Prescribing advice and review of prescribing to the polyclinic/cluster
- Clinical pharmacy input to multidisciplinary clinics and team e.g. COPD, Falls Prevention, Diabetes, Mental Health, Full Clinical Medication Review.
- Provision of specialist medicines and clinical pharmacy support to support provision and administration of high tech healthcare e.g. IV therapy (antibiotics, chemotherapy, cytokine inhibitors).
- Supply of medicines to support administration of medicines in the polyclinic could be through a small satellite pharmacy linked to a main pharmacy e.g. Pharmacy at St Charles Hospital, Chelsea & Westminster Hospital.

It is expected that these services will also support pharmacies providing services in Levels 2 and 3 where appropriate, as well as other primary care providers. This could be through education and training, specialist advice, mentoring and/or outreach services.

There are a range of contractual models that the PCT could use to commission these services. The PCT will explore these to identify the model best suited for local needs, bearing in mind the need to also maintain a community pharmacy network that is accessible to the wider public. Work being carried out at a London and a national level which will help inform the PCT on the various models.

The PCT recognises that there is a variance in the standards of pharmacy premises, and for that reason is commissioning a review of current pharmacy premises. Anecdotal evidence suggests that some of the poorer premises are found in the areas of highest health inequalities. The premises review will help identify the need for support to improve premises.

5.3 Commissioning Dental and Oral Health Services

A full Dental and Oral Health Strategy was approved by the Clinical Executive Committee in April 2008. For the purposes of this document only the strategic aims and priorities have been included below.

- To significantly improve the oral health of the residents of the borough so that it matches that of the best performing PCTs in London and England.
- To increase annually the number of residents receiving NHS dental treatment in Kensington and Chelsea so that it matches that of the highest performing PCTs in London.

Strategic priorities

In order to achieve these two aims the following priorities has been identified for implementation. For all commissioned services the strategy will ensure that standards for clinical governance, infection control, decontamination and occupational health will be met. Such services will be commissioned as part of the hub and spoke model.

Priority 1 - To increase the numbers of people seeing a NHS dentist

- Ensure there is a year on increase in the number of residents of Kensington and Chelsea who see a dentist. We have set ourselves the target of 30% of the population using NHS dentistry in 2008-09, 40% in 2009-10 and to reach the national average of having 50% of the PCT's population using an NHS Dentist by 2010-11.

Priority 2 - To Promote Better Oral Health

- Improve the oral health of adults in the borough so that the number of Band 1 treatment increases and there is a reduction over the life of the strategy in the number of adults receiving Band 2 and Band 3 treatments. This will be achieved within the lifetime of the PCTs primary care strategy.
- Improve the oral health of children in Kensington and Chelsea and especially that of children under 5 years of age so that our Decayed, Missing, Filled Teeth (DMFT) rate (currently 2) becomes the same as that for London (1.6) and then the English average (1.45). This will be achieved within the lifetime of the PCTs primary care strategy.

Priority 3 - To Commission Specialist Services for Children

- To ensure that all children with special needs have access to NHS dental services and that their dental treatment is actively case managed by the PCTs CDS service by April 2009
- Maintain and improve the capacity of our Community Dental Service (CDS) services at Violet Melchett and St Charles Community Hospital to provide dental services for adults with disabilities, learning difficulties, and special needs during 2008-09.

Priority 4 - To Commission Services for Adults with special needs

- To ensure that all adults with disabilities, learning difficulties, and special needs have access to NHS dental services and that their dental treatment is actively case managed by the PCTs CDS by April 2009
- Maintain and improve the capacity of our CDS services at Violet Melchett and St Charles Community Hospital to provide dental services for adults with disabilities, learning difficulties, and special needs during 2008-09.

Priority 5 - To Commission a needs assessment and a Social Marketing campaign.

- Conduct and complete a needs assessment of the oral health of population of Kensington and Chelsea – to be commissioned and completed in 2008-2009
- Commission a social marketing campaign to support the take up of the NHS Dentistry and to educate people in the importance of oral health care.

5.4 New Optical Contract

From the 1st of August 2008 all Opticians in Kensington and Chelsea who wish to provide NHS optical services must have a contract with Kensington and Chelsea PCT. Similarly, from the 1st of August any Optician who wants to work in Kensington and Chelsea must be required to be on our Performers List or that of another PCT. This is a new responsibility for the PCT.

The PCT will have full responsibility for commissioning eye care services in both primary and secondary care. For example commission enhanced services, i.e. services beyond the mandatory ones set out in the contract, from our Optical Contactors. Examples of enhanced services would be commissioning Opticians to provide more diagnostics services at their practice. The PCT will use these new contractual regulations to commission enhanced services in 2009/10.

6. Investment Required

It is still difficult to predict the exact level of investment required to support the full implementation of a 10 year Primary Care Strategy. The following indicative budget has been prepared for 2008/09 and has been supported as part of the 2008/9 Investment Process. The Board are asked to approve this indicative budget of £2million. The increased dental and project support was approved separately by the Investment Process.

Indicative Budget 2008/09

	Recurrent / Non-recurrent	£
Community Engagement		
▪ Picker Institute Survey	Non-recurrent	25,000
▪ Voluntary /User Sector Engagement	Non-recurrent	25,000
Workforce and Organisation Development		
▪ Clinical Leadership	Recurrent	50,000
▪ Skills assessment	Non-recurrent	50,000
▪ Personal Best Training	Non-recurrent	50,000
▪ Practice Manager Support	Recurrent	50,000
▪ Organisation Development	Recurrent	50,000
Infrastructure (Estates IM&T, Other)	Non-recurrent	500,000
Community Pharmacy LES	Recurrent	100,000
Community Feasibility Study SCH and C&W, UCC	Non-recurrent	100,000
Sub Total		1,000,000
PMS contract – premium services	Recurrent	470,000
GMS contracts – enhanced services	Recurrent	530,000
Total		2,000,000
Increased Dental Activity (as previously agreed for 2008/9)		250,000
Project Infra-structure (3 posts – previously agreed)		146,000

7. Recommendation

The development of a 10 year Primary Care Strategy is a significant and ambitious step for the PCT. It reflects a commitment and belief in the benefits and value of commissioning for world class primary and community services to deliver services closer to home and to raise the standards of care. The Board are asked to approve this 10 year strategy for primary care, the indicative budget and the draft implementation plan and to receive six monthly progress reports.

Primary Care Strategy Draft Implementation Plan

Reference	Milestone/Objective	Action required	Risks/Issues/Control	Progress	Lead	Date	Risk	
1	Quality Standards	<ul style="list-style-type: none"> ▪ Clinical Champions indentified 	<ul style="list-style-type: none"> ▪ Named clinical leads from GP, Nursing, community pharmacy, dentistry and optometry 	<ul style="list-style-type: none"> ▪ Limited enthusiasm 		AS	8/8/08	Green
		<ul style="list-style-type: none"> ▪ Implement revised QOF and PROM 	<ul style="list-style-type: none"> ▪ Respond to national directive when available 	<ul style="list-style-type: none"> ▪ Ensuring local practices understand and respond positively to changes 		PH	12/08	Green
		<ul style="list-style-type: none"> ▪ Learning from PMS review rolled out 	<ul style="list-style-type: none"> ▪ Identify new LES for GMS practices 	<ul style="list-style-type: none"> ▪ Overload of initiatives in primary care 		FL	09/08	Green
		<ul style="list-style-type: none"> ▪ Primary Care performance dash board 	<ul style="list-style-type: none"> ▪ To confirm a revise performance dashboard 	<ul style="list-style-type: none"> ▪ Asks more than contractually required & hence resistance 		PH	12/08	Amber
		<ul style="list-style-type: none"> ▪ Shared audit for performance across PCTs 	<ul style="list-style-type: none"> ▪ To establish process to share performance management 	<ul style="list-style-type: none"> ▪ Organisational change distracts from core business 		FL	tba	Amber
2	Access and Choice	<ul style="list-style-type: none"> ▪ UCC at SCH and C&W 	<ul style="list-style-type: none"> ▪ Feasibility study to be commissioned 	<ul style="list-style-type: none"> ▪ Not enough activity to sustain UCC at SCH 	SCH commission group leading	FL	12/08	Red
		<ul style="list-style-type: none"> ▪ Implementation of Extended hrs LES 	<ul style="list-style-type: none"> ▪ To promote extended hrs across all practices 	<ul style="list-style-type: none"> ▪ Practices unable to find capacity to respond 	Evaluation of pilot complete	SR/YB	09/08	Green

Reference	Milestone/Objective	Action required	Risks/Issues/Control	Progress	Lead	Date	Risk	
		<ul style="list-style-type: none"> To implement BME recommendations 	<ul style="list-style-type: none"> To establish process for implement with WPCT for 	<ul style="list-style-type: none"> Organisational Change distracting Co-operation from practices 		PH	tba	Amber
		<ul style="list-style-type: none"> Equalities impact assessment of strategy 	<ul style="list-style-type: none"> To undertake EIA 	<ul style="list-style-type: none"> Disadvantaged communities do not gain greater access 		LH	Tba	Amber
3	Integration	<ul style="list-style-type: none"> Joint workforce redesign 	<ul style="list-style-type: none"> To understand and identify potential for joint work force 	<ul style="list-style-type: none"> Commitment from RBKC and PCT to implement 		MH/JD	Tba	Amber
		<ul style="list-style-type: none"> Individual Budgets Pilot site 	<ul style="list-style-type: none"> To agree why and how PCT can become a pilot site 	<ul style="list-style-type: none"> Tba 		JDFL	Tba	Amber
		<ul style="list-style-type: none"> Investment in 3rd sector 	<ul style="list-style-type: none"> To promote the 3rd sector a key provider 	<ul style="list-style-type: none"> Capacity to respond 	Non-acute investment programme in place	MC	06/08	Green
4	PBC	<ul style="list-style-type: none"> Sustainability expansion of PBC 	<ul style="list-style-type: none"> 3 year business plan 	<ul style="list-style-type: none"> Lack of engagement and incentives 	Discussions with steering group started	MS/FL	10/08	Green
		<ul style="list-style-type: none"> Incentives to sustain PBC 	<ul style="list-style-type: none"> To identify workable incentives 	<ul style="list-style-type: none"> Lack of enthusiasm & incentives weak 	OD workstream considering	AS/FL	10/08	Green
5	Workforce	<ul style="list-style-type: none"> Workforce Planning of GPs 	<ul style="list-style-type: none"> To investigate costs and efficiencies to increase GP capacity 	<ul style="list-style-type: none"> Limited Pool of GPs to recruit from 		MH/A S	12/08	Amber
		<ul style="list-style-type: none"> Develop clinical leaders 	<ul style="list-style-type: none"> To commission skills and training programme 	<ul style="list-style-type: none"> Expectations of GPs does not match needs 	Project officer recruited and OD group	LT	12/08	Green

Reference	Milestone/Objective	Action required	Risks/Issues/Control	Progress	Lead	Date	Risk	
				started				
	<ul style="list-style-type: none"> Develop role of practice nurses 	<ul style="list-style-type: none"> To develop capacity and capability of PW 	<ul style="list-style-type: none"> Lack of engagement 	Project officer recruited and OD group started	LT	12/08	Green	
	<ul style="list-style-type: none"> Development of practice management 	<ul style="list-style-type: none"> To develop capacity and capability of practices 	<ul style="list-style-type: none"> Lack of capacity and engagement by practices 	Tba	LT/FL	Tba	Amber	
	<ul style="list-style-type: none"> Customer Care 	<ul style="list-style-type: none"> To provide training for practice staff 	<ul style="list-style-type: none"> Lack of engagement 	Project officer recruited and OD group established	LT	Tba	Amber	
	<ul style="list-style-type: none"> OD Programme 	<ul style="list-style-type: none"> To identify appropriate OD play 	<ul style="list-style-type: none"> Time, capacity and commitment. Not forthcoming 	Tba	MH/FL/SS	Tba	Amber	
6	IMT	<ul style="list-style-type: none"> IM&T Strategy to identified primary care needs 	<ul style="list-style-type: none"> To ensure IM&T provides expertise and support to implementation of primary care strategy 	<ul style="list-style-type: none"> Maximising the opportunities IMT offers lost 	Primary care IMT workstream	EW/DH	Tba	Green
7	Estates	<ul style="list-style-type: none"> To provide modern and suitable facilities for primary care 	<ul style="list-style-type: none"> To identify facilities that will support the hub and spoke model of primary care 	<ul style="list-style-type: none"> Look of suitable facilities in Borough 	Estates survey commissioned and new role being rebuilt	DC/FL	Tba	Red
8	Health Implementation	<ul style="list-style-type: none"> To ensure health improvement programme into primary care 	<ul style="list-style-type: none"> To work with existing and new HI projects 	<ul style="list-style-type: none"> Not recognised as core business of primary care 	Tba	MS	Tba	Amber

Reference	Milestone/Objective	Action required	Risks/Issues/Control	Progress	Lead	Date	Risk	
9	Model of Care	<ul style="list-style-type: none"> To establish Hub and Spoke model 	<ul style="list-style-type: none"> To agree to detail and configuration of Hub and Spoke model To visit all practices 	<ul style="list-style-type: none"> Lack of support from Independent practitioners 	Tba	AS/FL	12/08	Amber
		<ul style="list-style-type: none"> Community Pharmacy integrated in to strategy, priority SCH 	<ul style="list-style-type: none"> To commission LES for community pharmacy and integration into Hub and Spoke model 	<ul style="list-style-type: none"> Maximising the opportunities available 	Pharmacy Implementation group established	EW/T C	10/08	Green
		<ul style="list-style-type: none"> Oral health and Dental strategy 	<ul style="list-style-type: none"> To implement oral health and dental strategy 	<ul style="list-style-type: none"> Incentives to delivery NHS dentistry week 	Dental Commissioning group established	EW/P V	Tba	Amber
		<ul style="list-style-type: none"> Optical Contract 	<ul style="list-style-type: none"> To maximise the opportunities offered by new optical contract 	<ul style="list-style-type: none"> Lack of engagement from local opticians 	Tba	EW	Tba	Amber

Picker Institute Access Telephone Survey Kensington and Chelsea PCT

June 2008

Summary

- This report will present findings from a survey of 995 Kensington and Chelsea residents. Its aim is to assess the use of NHS GP services amongst the population of the borough, satisfaction with those services amongst users and interest in the provision of certain new facilities.
- The survey was conducted via the telephone and all residents with a landline in the borough had an equal chance of being approached. Residents were very receptive to the survey; where interviewers were successful in getting through to speak to someone, approximately one in every two households agreed to take part. The demographic profile of respondents is broadly representative of the Kensington and Chelsea population and interestingly lines up very closely with that of two recent postal surveys.
- Amongst the 995 residents surveyed, 82% were registered with a NHS GP in the borough of Kensington and Chelsea. Once those registered with a NHS GP outside of the borough had been taken into account, it is possible to estimate that just 9% of the Kensington and Chelsea population are not registered with the NHS at all. Half of this group have private cover and the remainder have other provision (eg a doctor outside the UK) or have simply not had any reason to visit a surgery. This group tends to be young and tends to be of non British origin.
- Use of GP services is widespread, with 87% of those registered having made one or more visits in the last year. In general, perceptions of GP services are positive, with four in every five stating that they were satisfied with their last visit. Furthermore, 80% consider normal opening hours of 9am-6pm convenient. There are, however, some areas of dissatisfaction. Just over a tenth (12%) have at some point considered changing surgery because they were unhappy with their practice.
- Most residents in Kensington and Chelsea currently walk to their GP surgery (approximately 79%) and the vast majority travel from home (93%). Their journey tends to be short, with 73% stating it takes them 10 minutes or less to reach their practice. Just under a third would need to change their mode of transport if required to travel an extra 10 minutes.
- When residents were asked if they would be prepared to travel an extra 10 minutes for certain additional services, quite a large proportion would be willing to do so. Residents appeared most receptive to travelling an extra ten minutes for tests and procedures (56% would definitely travel for these services), while they would be least likely to travel if a surgery was open until 8pm in the evening (only 31% would definitely travel for this facility). In all cases, younger age groups were more positive than older age groups.

Summary of Engagement Events

Organisation	Method	Areas explored	Numbers
Picker Institute	Telephone questionnaire	Access to and experience of primary care	995 residents
Community Strategy, residents panel – Royal Borough of Kensington & Chelsea	On-line and telephone questionnaire	Appointment times and access for GPs and Dentists	511 residents
KCW BME Health Forum	1:1 and group interviews	BME experience of access to GPs	55 KCW residents
St Charles Hospital Open days x 2	Tour of SCH and evaluation forms	Experience and expectations of primary care and community care	375 residents
St Charles Hospital Community Reference Group	Focus groups	Experience and expectations of primary care	12 meetings since October 2007
Health Care for London Kensington and Chelsea consultation	Public meetings	Prof Darzi review and what it meant for Kensington and Chelsea	approx 50 residents
Patient experience evaluation from extended hours pilot	Patient questionnaire	Experience of extended hours in GP surgeries	Approx.300
3 practice patients groups	Focus group	Experience of primary care	Approx 35 residents
K&C Social Council Voluntary Sector	Focus group for 10 key Voluntary Organisations mainly from North meeting for South organisation being organised	Overall experience of primary care	10 organisations represented
Kensington and Chelsea Organisation Forum (VOF)	General discussion	Overall experience of primary care	Approx. 25
Kensington and Chelsea Voluntary Organisation for Older People	General discussion	Overall experience of primary care	Approx. 15
Practice Nurse Forum	Presentation	Future developments in primary care and their role	10
Local Pharmaceutical Committee	Presentation	Future developments in primary care and potential for community	15 people and 1 follow-up meeting

Organisation	Method	Areas explored	Numbers
		pharmacies	
Local Dental Committee	Presentation	Future developments in primary care and potential for NHS Dentistry	10
Local Medical Committee	Draft copy, representative at GP Forums	Future developments in primary care and potential for GPs	8
GP Forum including PBC and LMC representations	Presentation	Future developments in primary care and potential for GPs	30
Practice Based Committee Steering Group	General discussion	Future developments in primary care and potential for GPs	8
Royal Borough of Kensington and Chelsea Adult Service Team	Presentation at team meeting. Draft copy shared for feedback	Overall strategy and potential for integration	Approx 8
Royal Borough of Kensington and Chelsea Community Relations Forum on Health Care	General discussion	Overall strategy	Over 100
Kensington and Chelsea Primary Care Trust Clinical Executive Committee	Draft copy for discussion and feedback	Overall strategy	10
Local Clinical Reference Group	8 advisory meetings to influence draft strategy	Overall strategy	10 GPs including PBC and LMC and LPC representatives
Kensington and Chelsea Primary Care Trust Senior Managers brief	Presentation	Overall strategy	Approx 30 staff

**Access to GP Practices for Black and Minority Ethnic communities in
Kensington, Chelsea Westminster**

June 2008

Significant concerns about BME communities' access to GP services have been a feature of the findings of the BME Health Forum's work over the years. This report was commissioned to look into this in detail, to understand the barriers to GP access and identify how to overcome them. Other national and local reports, such as the 2007 national GP patient survey and the recent Department of Health report – "No Patient Left Behind" have also identified primary care access as major issue of concern.

This report highlights three main issues :

- A substantial minority group of BME communities are very dissatisfied with the process of registering with A GP and making appointments.
- A large number of patients are dissatisfied with their relationship with their GP and practice staff.
- Communication problems, caused by language and cultural barriers impede on the doctor-patient relationship. Interpreting services are not widely available and waiting for an interpreter to be booked limits access to services. Many people use unofficial interpreters, including children thus jeopardising the clinical outcome of the consultation.

From our findings it is clear that GP practices need to become more aware and flexible in responding to different patient needs in order to provide an equitable service and that the consequences of not doing so is poorer quality of services and poor health outcomes. Additionally, unsatisfactory relations between patients and providers, regardless of cause or responsibility, are likely to lead to increased visits and increased costs. This will either come through revisits prompted by lack of confidence in diagnosis, by inappropriate presentation at A&E or by patients presenting later in the course of their illness and therefore needing more care. It is therefore in everyone's interest to improve relations with all patients. The use of unofficial interpreters has implications for patient safety and clinical governance.

Our key recommendations demonstrate that it is the responsibility of all NHS stakeholders to address the issues highlighted in this report :

- The PCTs should ensure that they commission primary care services which are flexible and responsive to the needs of all groups. They should also commission community groups and the BME Health Forum to develop projects to improve access.
- The PCTs should undertake a full joint review, in partnership with all other stakeholders, to revise/establish standards for interpreting support across KCW.
- Practices should use patient groups/panels, local community groups and the BME Health Forum as a route for improving their understanding of local communities' understanding of NHS services and practices.

- The BME Health Forum should work with practices to identify and develop good practice in relation to providing interpreting support.
- The BME Health Forum and community groups should actively promote the availability of interpreting services to their members.

GP Contractual Requirements

1 Essential Services

“GMS Essential Services” are:

The management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable

- i) The general management of patients who are terminally ill
- ii) Management of chronic conditions in the manner determined by the healthcare professional in discussion with the patient
- iii) Note summarization (patient records)

2 Additional Services

Additional Services as defined by the New GMS (GMS) Contract (2003) Investing in General Practice are:

- i) cervical screening
- ii) contraceptive services
- iii) vaccinations and immunisations
- iv) child health surveillance maternity services – excluding intra partum care (which will be an Enhanced Service)
- v) minor surgery procedures of curettage, cautery, cryocautery of warts and verrucae, and other skin lesions

3 Enhanced Services

3.1 Directed Enhanced Services (DES)

The PCT will expect the new contractor to provide the following Directed Enhanced Services:

- i) Improved access to general medical services
- ii) Childhood immunisations
- iii) Influenza immunisation for those in the 65 and over and other at-risk groups –
- iv) Practice Based Commissioning
- v) Choose & Book
- vi) IT and IM

The following DES's are commissioned separately by the PCT

- i) DES minor surgery – though we would welcome proposals for the provision of DES minor surgery at World's End.
- ii) Services to support staff in dealing with violent patients

3.2. Local Enhanced Services

PBC LES, Smoking cessation, phlebotomy, Choice & Book, Sexual health, Alcohol prevention, stroke , rough sleepers, depression management for CMI, Lasting nad enduring mental health, End of Life, Obesity management, substance misuse, cardiac care, breast screening, Nursing home care.