The King's Fund

Ideas that change health care

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General practice in London

Supporting improvements in quality

Commissioned by NHS London

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Abbreviations

A&E	accident and emergency
ACSC	ambulatory care sensitive condition
APHO	Association of Public Health Observatories
AUDIT	Alcohol Use Disorders Identification Test
BMA	British Medical Association
BMI	body mass index
CCG	clinical commissioning group
CEO	chief executive officer
CHD	coronary heart disease
COF	Commissioning Outcomes Framework
COPD	chronic obstructive pulmonary disease
CSL	Commissioning Support for London
DES	directed enhanced services
FTE	full-time equivalent
GMS	General Medical Services
GP	general practitioner
GPC	General Practitioners Committee
GPOS	General Practice Outcome Standards
IM&T	information management and technology
IPPR	Institute for Public Policy Research
IT	information technology
LES	local enhanced services
LIFT	NHS Local Improvement Finance Trust
LMC	Local Medical Committee
MMR	measles, mumps and rubella
NCIN	National Cancer Intelligence Network
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NSAID	non-steroidal anti-inflammatory drug
OECD	Organisation for Economic Co-operation and Development
PCT	primary care trust
PCV	pneumococcal conjugate vaccine
PHOF	Public Health Outcomes Framework
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
SHA	strategic health authority
WHO	World Health Organization

Foreword

London is an extraordinary city. Its population is younger, more mobile and more diverse than elsewhere in England.

Despite these challenges, general practice in London has contributed to improving health and health care over the past decade. Yet it is clear from this report that care is not as consistently good as it could be. While there are excellent general practices in London, there is also significant variation in the quality of care and outcomes achieved between areas and practices. Our analysis suggests there is more to do to ensure that all Londoners experience high-quality care that is appropriate to their needs.

London is set to grow and become even more diverse in future. The needs of the population – as elsewhere in England – are also changing, with increasing numbers of people experiencing multi-morbidity and dementia. Primary care will need to meet a growing range and complexity of health needs. Demographic changes, along with the tighter financial context and cuts in local authority and social services budgets, pose risks to the quality of care. Changes are needed to the organisation and delivery of primary care to meet these challenges.

General practice in London relies heavily on GPs, some of whom are working in relative isolation; one in five practices are single-handed and the ratio of practice staff to GPs is lower than in other parts of England. Some parts of London have relatively fewer GPs per head of population, and almost 16 per cent of GPs in London are over 60 years old. And while there has been some investment in new facilities, some practices continue to operate from premises that are no longer fit for purpose.

If the quality of care is to improve and these challenges are to be met, primary care in London needs to adapt. General practice will need to work with a wider range of health and social care professionals to deliver more integrated care for patients with complex health and social care needs. GPs will also need easier access to specialist advice in order to effectively support and treat people in the community. Hospitals and community service providers will need to work more closely with general practice and develop models of shared care that ensure timely and appropriate access to urgent care for patients 24/7.

General practice makes an important contribution to promoting health and reducing health inequalities. But practices need to be more proactive in reaching out to high-risk groups and working with local authorities to tackle the wider determinants of ill-health and reduce the future burden of disease.

Realising this transformation will require major changes in the organisation and delivery of primary care. The King's Fund has argued elsewhere that the model of health and social care in England needs to be radically changed in order to respond to the changing needs of the population. Single-handed and very small practices will find it difficult to rise to these challenges alone. By working in networks, smaller practices can retain their identity and knowledge of the population they serve, while also enabling the provision of services they would find difficult to provide on their own. They will also need to make better and smarter use of information and technology, invest

in the development and training of new staff, and redesign care around the different needs of patients.

Change takes time, and it is important that staff are supported to engage in quality improvement and service redesign. Achieving change will require courage from leaders working in and with general practice to challenge the status quo and set out a vision that inspires others to believe that change is both necessary and possible.

We hope this report will encourage GPs and commissioners in London to lead the transformation of general practice to ensure that all Londoners enjoy good health and access to high-quality primary care.

Anna Dixon
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Executive summary

This report outlines the challenges faced by general practice in London and the improvements needed in order to address them. The report is aimed at those who have a role in leading quality improvement in primary care, namely GPs working in London and leaders of primary care providers, clinical commissioning groups (CCGs), and the London region of the NHS Commissioning Board. Prepared by The King's Fund and Imperial College London, it provides an independent assessment of the quality of general practice in the capital, using routinely available data sources.

We hope this report will inspire GP leaders and commissioners to think differently about the future of general practice in London, and encourage them to develop innovative, local solutions to ensure that all Londoners enjoy good health and access to high-quality care.

Introduction

Despite the demographic and socio-economic challenges facing general practice in London, it makes a hugely significant contribution to improving Londoners' health and the health care they receive. While there are examples of excellence in general practice in London, the quality of care and health outcomes vary markedly. These variations can have many causes – some warranted, others not. Practices and clinical commissioning groups (CCGs) will need to understand the reasons for local variations in order to take appropriate action.

Demographic changes in London and the unprecedented financial pressures facing the NHS present a phenomenal challenge for general practice in London. Here we summarise the key findings of our research:

A profile of London's population

- London's population is very different from the rest of England. It is younger, more transient, more ethnically diverse and growing more rapidly. Income and health inequalities are greater than in the rest of England.
- Compared with national averages, London has lower smoking prevalence but higher rates of low birthweight babies, teenage pregnancy, childhood obesity, HIV, serious mental illness, and suicide.
- London has lower cancer incidence than the national average (286 and 301 per 100,000 respectively); cancer mortality is also lower (106 and 110 per 100,000 respectively) but it varies twofold across London.
- London has a low estimated prevalence of cardiovascular disease but above-average mortality from cardiovascular disease (71.5 per 100,000 compared with 67.3 in England) and there are large variations (ranging from 46 to 115) between primary care trusts (PCTs) in London.
- Overall and premature mortality are lower in London than in other parts of the country. Life expectancy for men and women in London

(2008–10) was 79 and 83.3 years respectively, compared with 78.6 and 82.6 years for England.

- All these indicators vary significantly within London and between socio-economic and ethnic groups – for example, life expectancy varies by nine years between London PCTs, and infant mortality varies threefold.
- Some of the health gaps between London and the rest of the country (as well as inequalities within London) have narrowed over the past decade.

General practice in London

- London has a similar number of GP full-time equivalents (FTEs) as England per 100,000 unified weighted population (61 and 59.9); however, this varies twofold between London PCTs, and the distribution of GPs remains inequitable.
- The number of practice staff per GP is lower than in other regions. Changing the skill-mix of practices and maximising their efficiency must be a priority.
- Almost 16 per cent of London GPs are over 60 years old compared with 10 per cent nationally. Staff recruitment and retention will be important.
- London practices have smaller list sizes, reflecting the high numbers of single-handed practices. Almost 20 per cent of practices are single-handed compared with 13.8 per cent nationally.
- London practices have been early adopters of information technology (IT) but there is potential for greater use of IT to support patient care.

Clinical quality and outcomes

Health promotion/ill-health prevention

- Many London PCTs do worse than the England average on key indicators of ill-health prevention, including childhood obesity, childhood immunisation and flu vaccination, and breast and cervical screening. However, some PCTs in deprived areas have the highest immunisation rates in London.
- General practice already makes an important contribution to promoting health and reducing health inequalities, through primary and secondary prevention. General practice in London needs to work closely with health and wellbeing boards and local authorities to tackle the wider determinants of health.

Diagnosis

- There is evidence of under-diagnosis and unmet need with regard to some long-term conditions – for example, stroke and chronic obstructive pulmonary disease (COPD).
- London has a slightly higher than expected rate of emergency admissions for a first diagnosis of cancer than the England average:

ratio of observed to expected at 1.04 in London (national average as 1), and this ratio ranges from 0.88 to 1.22 between London PCTs. Many factors can contribute to emergency presentation, and the reasons should be investigated locally.

- There have been improvements in London in the identification and recording of risk factors, such as for heart disease.
- A more proactive approach is needed to target high-risk groups to improve uptake of preventive services and to encourage them to present early.

Referrals

- Variation in referral rates is to be expected, and it is difficult to establish referral thresholds objectively. However, there is a threefold variation across London practices in outpatient attendances, which merits further investigation to avoid the risks of both under- and over-use of specialist and secondary care.
- Urgent referral rates for cancer in London PCTs were mostly below the national average, and showed a more than twofold variation.
- London compares well with the national average in terms of meeting required waiting times for urgent referrals for cancer.
- London has a lower percentage of urgent referrals that result in a diagnosis of cancer (7.6 per cent compared with 9.8 per cent nationally), with London PCTs having some of the lowest rates, and a somewhat higher proportion of newly diagnosed cancers that do not arise through the two-week referral route.
- There is a need for GPs, together with colleagues in secondary and tertiary care, to understand and address the reasons for variations in referral rates.

Prescribing

- Several London PCTs are in the highest quintile for prescribing of anti-diabetic items; nationally, there is no correlation between PCT spending on insulin and non-insulin anti-diabetic drugs and the percentage of people with diabetes with controlled blood sugar.
- London spends less overall on prescribing and pharmaceuticals in primary care than other regions of England. This could be related to higher levels of undiagnosed disease, reflecting the population challenges faced by London practices.
- Studies show there are inequalities in prescribing by age, sex and ethnicity in London.
- There have been improvements in safe and appropriate prescribing of non-steroidal anti-inflammatory drugs in London.
- Further investigation of differences in prescribing rates and expenditure is needed and effective support to ensure that prescribing is in line with best practice. GPs must also seek to provide better

support for appropriate medicines management, particularly for older patients who are taking several prescription medications.

Acute, emergency and urgent care

- London has the highest A&E attendance rates nationally (340 per 1,000 population compared with 290 nationally) and intra-London variations are large (from 251 to 432 between PCTs).
- London's 28-day hospital emergency readmission rate is similar to the national average (11.9 per cent compared with 11.6 per cent) but there is significant intra-London variation between PCTs (from 9.3 per cent to 13.8 per cent).
- London PCTs have higher rates of bed days for people over 65, with 7 of the 31 London PCTs being among the 10 PCTs with the highest rates nationally.
- About 70 per cent of patients nationally are satisfied overall with out-of-hours GP services compared with 63 per cent in London.
- GPs need to work with others and through their clinical commissioning groups to ensure that patients' acute and urgent care needs are met, both during surgery opening hours and out of hours.
- Closer co-ordination of care with other services could reduce the need for emergency readmission and length of hospital stays among older people.

Managing long-term conditions

- London has a lower rate of emergency admissions for ambulatory care sensitive conditions (ACSCs) than the national average (428 and 436 per 100,000 respectively); however, there is fourfold variation between London PCTs (from 223 to 857).
- Although London's performance on some clinical quality indicators (eg, cholesterol control among patients with coronary heart disease, or blood pressure control among stroke patients) is similar to the national average, there are large variations within London, with some PCTs covering relatively deprived populations outperforming PCTs in more affluent areas. There is also evidence of inequalities based on ethnic groups.
- The National Diabetes Audit found that only 54 per cent of people with diabetes in England received all nine care processes. Among PCTs in London, the range was from 31 per cent to 63 per cent; again, some deprived areas in east London had the highest rates of people with diabetes receiving all nine care processes.
- Compared with the England average (29 per cent), London had a higher percentage (35 per cent) of households receiving intensive home care, although there is wide intra-London variation (from 25 per cent to 48 per cent).

- There is potential for exchange and learning across the capital's practices about how to transform services and deliver high-quality care, given the unique challenges London faces.
- The rising number of people over 85 requires general practice to be integrated with community services and social care to prevent unnecessary and costly hospitalisations or admissions to care homes for frail older people.

Mental health and dementia

- Prevalence of mental health problems varies twofold between the most and least deprived parts of the capital; use of secondary care community mental health services varies fourfold and admission rates for psychotic disorders vary eightfold.
- The admission rate for mental health problems among London's black population is 2.6 times higher than the national average.
- A third of GPs in London did not feel they had sufficient training to diagnose and manage dementia. There is a 10 per cent variation between London PCTs in the proportion of patients with dementia whose care has been reviewed in the previous 15 months.
- General practice in London is not doing as well as it could in promoting the physical health of people with severe mental health problems.
- Care of people with mental health problems could be improved by closer integration of mental health support with primary care and chronic disease management. Educational support for GPs is needed to ensure that they are equipped to diagnose and effectively manage people with dementia and support their families and carers.

End-of-life care

- London PCTs have relatively low rates for the proportion of all deaths that occur in the usual place of residence, and among the highest rates of deaths that occur in hospital among children aged 0–17 years with life-limiting conditions.
- There is a need for stronger community support services for palliative care in London and more information for GPs about services that are available locally.

Patient experience

- Patients in London report a less positive experience of using GP services than the national average across all domains of patient experience, although overall satisfaction levels remain high (80 per cent).
- The large variations in patient experience between London practices suggest that practices have much to learn from each other.

Access

- Londoners report being less satisfied than people in the rest of England on most dimensions of access to care, including the ability to book appointments, the ability to see a GP of their choice, and access to out-of-hours care.
- 78 per cent of Londoners said they were satisfied with their practice opening hours compared with 81 per cent in England overall.

Continuity of care

- In London, 56 per cent of patients report being able to see their preferred GP always or most of the time compared with 65 per cent nationally.

Patient engagement and involvement

- Although satisfaction levels remain high across most London practices, there are large variations within London. Londoners are somewhat less satisfied with the quality of consultations with their GP compared with the national average (84 per cent and 88 per cent respectively).
- Similar patterns are apparent for consultations with practice nurses.
- London has lower proportions of patients reporting that they have an agreed care plan to manage their condition than elsewhere in the country.
- All London PCTs (54 per cent on average) were below the national average (64 per cent) on the proportion of patients with a long-term health condition who felt supported by local services to manage their condition.
- However, there was relatively little difference between London and the England average in the proportion of people with long-term conditions who felt confident about managing their own health (91 per cent and 93 per cent respectively).

The future of general practice in London

Changing the skill-mix

- GPs need to be supported by a wider range of health (and social) care professionals.
- General practice needs to access specialist advice, either from GP colleagues with specialist interests or directly from consultants.

Shared care

- General practice has a pivotal role to play in co-ordinating care across care providers and settings, and helping patients, users and their carers to navigate the health and social care system.

- General practices, as active members of clinical commissioning groups, can influence the quality of care and treatment of their patients regardless of where in the system those patients are receiving care and treatment.

Partnership with patients

- Patients should be actively engaged in decisions about their care and treatment, and supported to self-care and self-manage as part of patient-centred care planning.
- Primary care should be the gateway to education and support for patients and carers.
- Patients with urgent care needs should feel confident that they will be responded to promptly during surgery opening hours and out of hours.

Meeting the health needs of the wider population

- Any expansion in facilities and staff needs to be matched to local needs and areas of undersupply.
- General practice needs to engage proactively with local authorities to seek new and innovative ways to prevent ill-health and tackle long-term and persistent inequalities.

The foundations of future general practice

Building effective networks of practices

- Effective networks of practices can enable practices to retain their identity and knowledge of the population they serve, while also enabling the provision of services they would find difficult to provide on their own.

Remodelling the primary care estate

- Strategic and innovative approaches are needed to maximise use of the buildings and land owned by the NHS, the wider public sector, and other community-based organisations, as well as looking at alternative locations for general practices while ensuring that they remain embedded within local communities.

Better and smarter use of information

- Data and information tools must be used by clinical commissioning groups (CCGs) and providers to identify and prioritise areas for quality improvement; general practice must own this information-driven, quality improvement agenda.
- Practices and CCGs will need to understand the underlying reasons for local variations in performance in order to take appropriate action.
- Ethnicity coding in general practice must improve to support monitoring of this important dimension of inequality.

- Primary care and CCGs must develop an open culture in which comparative and timely performance data are shared transparently (with professional peers, patients and the public), and the ability to challenge is balanced with the need for support.
- Exploiting the potential of IT to support patient care – for example, through record-sharing, linkage of patient records, and giving patients access to their records – should be a priority.

Developing the primary care workforce

- Investment in training and development needs to benefit new staff and existing staff, to ensure that GPs, nurses and other community-based staff gain the experience and confidence necessary to deal with the growing complexity of health care needs and to work together effectively in teams.
- The skill-mix in general practice must change further, with a greater role for nurse practitioners and a much wider range of professionals working alongside GPs in the community.
- Strong clinical leadership should be fostered in order to develop the clear vision and shared values through which effective collaboration and teamwork can flourish.

A commitment to change

- There is currently a strong focus on the reconfiguration of acute services; however, the transformation of care will not be realised without a similar focus on general practice and other community-based services.
- The health and social care system needs to keep pace with the needs and expectations of local people; incremental changes are unlikely to be enough and a bolder approach is needed.
- These are not easy transitions to make, and practices, networks and CCGs will need to exercise strong leadership to challenge the status quo and deliver a new vision for the future of general practice.

A summary of the key areas for improvement

- General practice needs to do more to promote health, prevent ill-health, and reduce inequalities, working closely with local authorities to tackle the wider determinants of ill-health as well as delivering primary and secondary preventive services for those at highest risk.
- General practice must adopt a more systematic approach to the early diagnosis of all chronic conditions and a more proactive approach to encourage high-risk groups to present earlier.
- There is a need for GPs, together with colleagues in secondary and tertiary care, to understand and address the reasons for variations in referral rates.
- Further investigation of differences in prescribing rates and expenditure is needed to ensure that prescribing is in line with best practice. GPs must also provide better support for appropriate medicines management, particularly for older patients who are taking several prescription medications.
- GPs need to work with others and through their CCGs to ensure that patients' acute and urgent care needs are met, both during surgery opening hours and out of hours.
- Although the rate of unplanned admissions for patients with long-term conditions is lower in London than elsewhere, general practice must ensure that it delivers care to patients with chronic conditions in line with best practice.
- The rising number of older people forecast for London requires general practice to co-ordinate care with community services and social care to reduce unnecessary and costly hospitalisations and admissions to care homes for frail older people.
- Care of people with mental health problems could be improved by integrating mental health support with primary care and chronic disease management. GPs need educational support to ensure that they are equipped to diagnose and effectively manage people with dementia, and support their families and carers.
- There is a need for stronger community support services for palliative care in London, and more information for GPs about end-of-life care services available locally.
- Although overall patient satisfaction levels in London remain high, London practices perform poorly on patient experience compared with practices elsewhere, and need to improve the experience of their patients and reduce variations. It is important that practices enable patients to have timely and convenient access and offer a degree of personal continuity.
- Inequalities in health and health care by age, ethnicity and socio-economic status persist in London, and need to be monitored through regular equity audits.
- While inequalities, population mobility and diversity present significant challenges, some areas in London are demonstrating that it is possible to improve the quality of care through a more systematic and co-ordinated approach.

1 Introduction

The importance of primary care

An effective primary care system is crucial to the overall effectiveness of a health system.[1] Countries and regions with a stronger orientation to health promotion, disease prevention, and the provision of universal and accessible primary and community care deliver better outcomes.[2,3,4,5] Strong primary care is associated with better and more equitable health outcomes, at lower cost.[6] A strong system of primary care is more important than ever. Demographic trends such as population ageing and changing patterns of disease mean there are more people living with long-term chronic illness and multi-morbidity.[7]

Primary care is often defined as the first point of contact between individuals, families and/or communities with the health system. It covers a wide range of community-based health professionals such as general practitioners (GPs), nurses, pharmacists, therapists, and dentists. General practice lies at the heart of primary care and is the main focus of this report.

The UK's model of general practice is acclaimed internationally for its delivery of universal access to free, community-based medical care, with GPs also co-ordinating patient care more widely and playing a gatekeeper role to specialist and secondary care services. The range of activities performed in general practice, and the intensity of work, has increased over the years. More than 90 per cent of all health care contacts in England and 300 million consultations annually occur in primary care.[8] In 2009, GP practices made 9.3 million referrals to secondary care, indicating that around 19 out of 20 consultations with GPs and other general practice staff were resolved within general practice.[9]

General practice plays a critical role in delivering high-value care – care that is both effective and efficient. Looking ahead at the tough financial situation faced by the NHS and the growing health care demands of London's population, it is clear that general practice needs to transform both the care it provides directly and also how it works with the rest of the health and social care system and wider community. Policy changes mean that general practice will have an important role in commissioning as well as providing care. This provides an opportunity to influence the future not only of general practice, but of the wider health care system.

The challenge of providing high-quality primary care in London

London is not simply a capital city, but a world city, and fifth among cities internationally in terms of gross domestic product (GDP). With a population of more than 8 million (more than seven times the size of Birmingham, the next largest city), one in seven of England's population are Londoners. About 270 nationalities speaking more than 300 languages reside in the city, a third of the population is foreign-born, 40 per cent are not of white British origin (30 per cent are non-white), and black and Asian children outnumber white British children in the capital's state schools. Many neighbourhoods are defined by the people who live there (for example, the Portuguese community of Stockwell, people of Turkish origin in north London, the Bangladeshi community of Tower Hamlets, and the Indian populations

of Harrow and Hounslow). Ethnic diversity is matched by religious diversity, making London home to sizeable Muslim, Hindu, Sikh and Jewish communities. London also has extremes of wealth and deprivation, with its richest and poorest residents often living in close proximity. Overall, this scale of diversity is unmatched in Europe. The 2012 Olympics celebrated the diversity of UK society, and nowhere is this exemplified more than in London. The health status and care needs of these groups vary enormously, as do their cultural and religious beliefs and expectations about health and health care.

Providing first-contact, frontline primary care services to a population and geography of such size, diversity and mobility as London's is a huge challenge. Providing patient-centred care is also challenging, given the plurality of languages spoken and the cultural and religious diversity. There are numerous examples of innovation in the way general practice in London has adapted to meet these challenges. That general practice in London has delivered significant health gains over the years is both impressive and laudable. The challenge for the future is to spread and accelerate these improvements across London and to all groups and communities in the capital.

Improving the health and meeting the health care needs of London's rapidly growing, increasingly diverse population will require different models of delivering primary care, especially given the financial challenges facing the NHS.

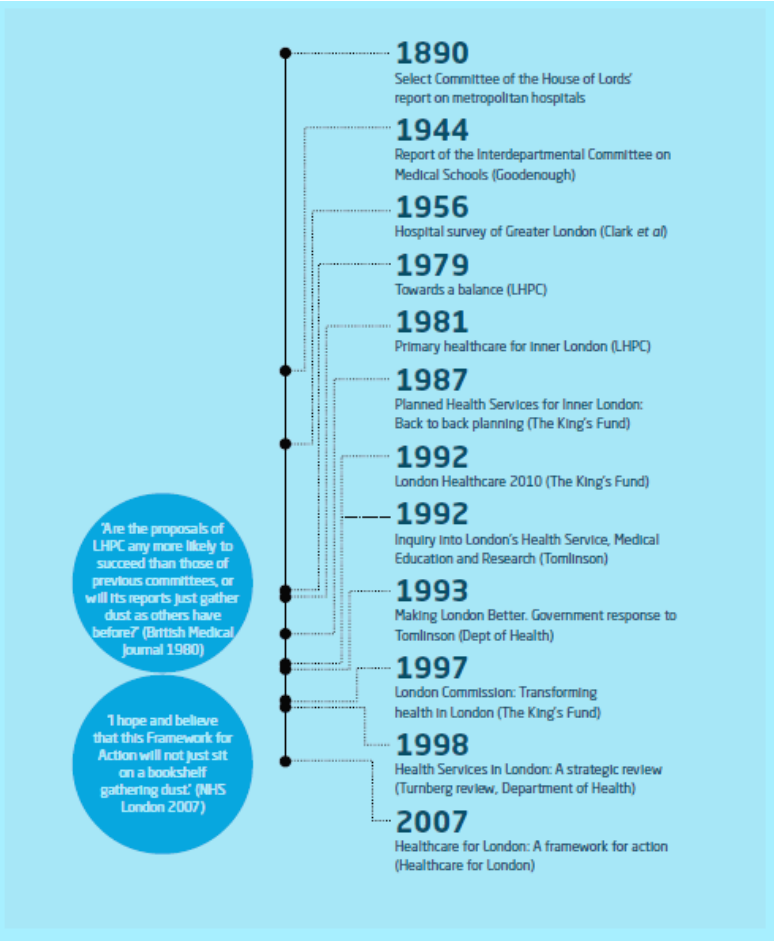
The need for primary care transformation in London

Many reviews over the years have highlighted concerns about the quality of health and health care in London (*see* Figure 1). A common theme is the variable quality of primary care across the capital, particularly within inner London.[10] The reviews have recommended action to redistribute services in relation to need, especially by ensuring higher and more consistent standards of primary care in areas with poor health.

Primary Health Care in Inner London recommended[11] incentives to develop group practices; discouragement of smaller list sizes; improved opportunities for GPs to work in the inner city; incentives for GPs to improve premises and take on new patients; and access to alternative primary care services for patients reluctant to use traditional GP surgeries. In the 1990s, two reports from The King's Fund argued that primary care needed greater investment. In *London Healthcare 2010,* we recommended that a £250 million investment programme was needed in primary and community-based services, alongside the rationalisation of hospital-based care.[12] Some of these recommendations were taken up in the Tomlinson report[13] and implemented through the London Implementation Group and the introduction of the London Initiative Zone. In 1997, at a time when London's health care system was under significant financial strain, *Transforming Health in London* reported on the patchy nature and often poor quality of general practice and the under-developed range of other services such as intermediate care and community mental health.[14]

The most recent review, *Healthcare for London: A framework for action*,[15] set out proposals to move hospital services to community-based locations

Figure 1: 120 years of London's health services



Source: Appleby *et al* (2011, p 2)[10]

through the development of polysystems. While there have been improvements in access, particularly geographical access, most of the new community-based services were on a small scale and are unlikely to impact on hospital activity.[16]

The 2011 report of an independent inquiry by The King's Fund concluded that there are significant opportunities for general practices in England to improve the quality of care they provide.[17] The key findings for professionals in general practice include: new responsibilities for assessing and meeting the health needs of the local population; new relationships with neighbouring practices and other local stakeholders to deliver high-quality care; and a more equal partnership with patients in which they are supported to become active participants in the care and services they receive.

An initiative to tackle the variation of quality in primary care began in 2011, led jointly by NHS London and London-wide Local Medical Committees (LMCs). The aim was to develop a web-based primary-care dashboard that provides general practices and their patients with a range of data and information about the quality of general practice. Experience in Tower Hamlets and wider research evidence suggests that this type of benchmarking and feedback can be a powerful driver of improvement.[18]

There is both excellence in general practice across London and significant variation in quality and outcomes. Recognising the need to improve the quality of primary medical provision, in 2010/11 lead GPs, NHS London, PCT cluster chief executive officers (CEOs) and the London-wide LMCs initiated a pan-London approach to drive outcome-based quality improvement by publishing a set of outcome standards for measuring quality, access, and patient experience in general practice, along with performance management guidance for PCTs and clusters. The General Practice Outcome Standards currently comprise 28 indicators, and are subject to ongoing development (the standards are available at: www.myhealth.london.nhs.uk).

The past decade has seen improvements in the quality of general practice across the UK, partly as a result of major investments in the workforce, including changes to the GP contract in 2004. There has also been investment in new community facilities. Much of the documented improvement has occurred among patients with common chronic conditions. For example, while two in every ten patients with diabetes had their cholesterol controlled to standards set out in clinical guidance in 1997, this increased to seven in ten during 2005.[19] The rising prevalence of multiple co-morbidities and the need to prevent as well as treat ill-health means the focus of quality improvement needs to go much broader than the areas covered by the Quality and Outcomes Framework (QOF). Practices will need to collaborate with each other and work jointly with other local agencies to improve the health of the whole population and drive improvements across all domains of quality for all patients. Indeed, this will be necessary if general practice is to contribute to the goals set out in the NHS Outcomes Framework and deliver against the Commissioning Outcomes Framework, which CCGs will be held to account for in future.

The imperative for change is all the more urgent given the unprecedented financial constraints facing the NHS. London's growing and increasingly diverse population, the demographic pressures of an ageing population, and the rising prevalence of long-term conditions demand a radical transformation in general practice. The NHS reforms offer opportunities for radical change, with general practice set to play a key role in the commissioning of health care services for local populations, in addition to its provider role.

This report

This report comes at a time when London has renewed its strategic commitment to primary care transformation. The aim is to support the transfer of good practice in primary care, to promote innovation, and reduce variation in the quality of care across London. This report is aimed at those who have a role in leading quality improvement in primary care in London, namely GPs and leaders of primary care providers, clinical commissioning groups (CCGs) and the London region of the NHS Commissioning Board. Changes being introduced as a result of the Health and Social Care Act 2012 mean that CCGs have a statutory duty to assist and support the NHS Commissioning Board in securing improvement in the quality of primary medical services.

By providing an up-to-date assessment of the quality of general practice in the capital, using routinely available data sources, this report highlights

areas that should be priorities for quality improvement for GPs and commissioners. Inevitably, given the short timescales and length of this report, we have had to be selective in the data presented. This report uses 16 indicators that are also included in the General Practice Outcome Standards; however, the data here are presented mainly at PCT rather than at practice level. Other indicators are also used in this report to give broader coverage of the services provided by general practice and to reflect the factors that contribute to positive health outcomes. Some of these factors are not within the direct control of an individual general practice and were chosen to help London identify issues that require whole system solutions.

The time constraints meant that we were unable to undertake secondary analyses, to bring added value to the data. For reasons of pragmatism, we have used national, regional and PCT averages as comparators to contrast the range of variation. However, these averages conceal much variation within them. Variations in the quality of health care and outcomes can have many causes – some warranted, others not. Practices and CCGs will need to understand the reasons for local variations in order to take appropriate action. While it is important that action is taken to address poor performance, it is also important to raise the overall distribution of performance.

The evidence presented is intended to provide the basis for a discussion on how general practice, with the right support, can contribute to improving quality. A key aim of the report is to stimulate the use of data by CCGs and their member practices to benchmark performance and identify areas for improvement. We hope this report will inspire you to think differently about the future of general practice in the capital and encourage you to develop innovative local solutions to ensure that all Londoners enjoy good health and access to high-quality primary health care.

The next section (Section 2) describes the context in which general practice in London operates and highlights some particular challenges that face the city. Section 3 describes the current provision of general practice in London, including the level of funding, the profile of the workforce, and the types of premises and facilities. Sections 4 and 5 examine the quality of clinical care and the experience of patients respectively. Section 6 draws some conclusions about the future of general practice in London and makes recommendations about issues that need to be addressed if the radical transformation in general practice that is needed is to be achieved.

The King's Fund and Imperial College London will also provide CCGs with more detailed data on the indicators used in this report, along with guidance on how to interpret and use the data, as a starting point from which to understand priorities at local level.

2 A profile of London's population

Key points

- London has a faster growing, younger, more mobile and more ethnically diverse population than the rest of the country, with some of the highest levels of deprivation, unemployment, child poverty and homelessness seen nationally. For example, one-third of the 10 per cent of English local authorities with the most deprived populations are in London, and non-white groups comprise 30 per cent of the capital's population compared with 13 per cent in England overall.
- Smoking prevalence is lower in London (19.5 per cent) than the rest of England (20.2 per cent), though there is an almost twofold variation across the capital (15 per cent to 29 per cent between London PCTs).
- London has the highest levels of childhood obesity (11.1 per cent compared with 9.4 per cent nationally) and a quarter of adult Londoners are obese. London also compares poorly for physical activity in adults (10 per cent compared with 11.5 per cent nationally).
- Rates of teenage pregnancy are higher in London (40.9 per 1,000 compared with 38.1 nationally), as are rates of sexually transmitted diseases (54 per cent higher) and tuberculosis.
- London has a marginally lower mortality rate (528 per 100,000 population) than the England average (553 per 100,000 population), lower than in the northern and midland regions, but higher than its southern neighbours. A similar pattern is seen for years of life lost due to premature mortality.
- Within London, mortality and premature mortality rates vary twofold between PCTs. As expected, higher mortality is clustered in the more deprived parts of London, with some of the worst outcomes nationally occurring in Newham, City and Hackney, Lambeth, Islington, and Tower Hamlets.
- London has a lower prevalence of depression and higher prevalence of serious mental illness. The prevalence of common chronic diseases such as diabetes and hypertension varies widely across London, reflecting differences in age and ethnic diversity.
- London has lower cancer incidence than the national average (286 per 100,000 compared with 301 nationally); cancer mortality is also lower (106 per 100,000 compared with 110 nationally). However, cancer incidence and cancer survival vary significantly within London and between ethnic and socio-economic groups.
- London has the lowest estimated prevalence of cardiovascular disease in England, but above-average mortality for cardiovascular disease (71.5 per 100,000 compared with 67.3 in England) and there are large variations within London (ranging from 46 to 115 between PCTs). High levels of undiagnosed disease, poorer risk-factor control of people with diagnosed disease, and a concentration of very deprived populations in some PCTs may account for some of this difference.
- Life expectancy varies by nine years between London PCTs, and infant mortality varies threefold. Significant inequalities in mental and physical health outcomes exist both between and within London PCTs.
- London's health profile underlines the importance of strengthening the primary care system which, working with local authorities, is best placed to reach all segments of the population, improve health, and reduce premature mortality and inequalities.

London faces a number of specific challenges. As *Healthcare for London* (2007) reported, the capital has, among other issues, higher rates of childhood obesity than the rest of England; it also has 57 per cent of England's HIV cases, one in four of England's adult drug users, and one Londoner dies every hour from a smoking-related disease. There is more deprivation, violent crime, homelessness, long-term unemployment and child poverty in London than elsewhere in England. London also has more low birthweight babies, higher rates of teenage pregnancy, and fewer children immunised (Table 1). More positively, educational achievement at 16 is better than elsewhere. London also has lower rates of smoking among adults and pregnant women, fewer obese adults, and Londoners eat more healthily than elsewhere in England.[20]

Many of the indicators in Table 1 align with the Public Health Outcomes Framework. The outcomes for which London is doing worse than the England average span three of the four outcome-focused domains of the framework, and it will therefore be important to monitor them in future.

Table 1: Indicators where London is different from the England average

	Better than the England average	Worse than the England average
Our communities	GCSE achievement	Deprivation Children in poverty Statutory homelessness Violent crime Long-term unemployment
Children and young people's health	Breastfeeding initiation Smoking in pregnancy Alcohol-specific hospital stays (<18)	Low birthweight babies Childhood immunisation Tooth decay in children aged 5 Obese children (Year 6) Teenage pregnancy
Adults' health and lifestyle	Adults smoking Obese adults Healthy-eating adults	Physically active adults
Disease and poor health	Hospital stays for self-harm Incidence of malignant melanoma People diagnosed with diabetes Hip fracture in those aged 65 and over	Drug misuse Acute sexually transmitted infections New cases of tuberculosis Hospital stays for alcohol-related harm
Life expectancy and causes of death	Male life expectancy Female life expectancy Smoking-related deaths Early deaths: cancer Road injuries and deaths Suicide	Early deaths: heart disease and stroke

This section describes the population served by general practices in London, including important facts about the underlying health status of the population. It covers the following aspects:

- demographics

- lifestyles
- mortality
- morbidity
- health inequalities.

Demographics

Population size and mobility

Data from the 2011 census show that London's population has grown faster in the past decade than that of other regions of England (by 14 per cent compared with 8 per cent nationally) (*see* Table 2).[21] The fastest-growing boroughs within London were Tower Hamlets (up 30 per cent to 254,100), Newham (up 26 per cent to 308,000) and Hackney (up 21 per cent to 246,300), respectively the first, third and fourth fastest-growing in England and Wales, and also among the boroughs with the most deprived and ethnically diverse populations. Much of the difference in the growth of London's population is the result of net inward migration from both within the UK and overseas. These figures obscure the large overall volume of inflows and outflows into the city. On average, 4.7 per cent of London's residents lived elsewhere a year earlier.[22]

Table 2: Increase in population from 2001 to 2011 census

Region	Percentage
North East	3
North West	5
Yorkshire and the Humber	6
East Midlands	9
West Midlands	6
East of England	9
London	14
South East	8
South West	7
ENGLAND	8

Projections suggest that London's population will grow by 13 per cent by 2031.[23] Such population growth will undoubtedly put pressure on London's services, particularly given the far higher population densities in London compared with all other regions. Final data from the 2011 census are likely to lead to significant revisions of these estimates.

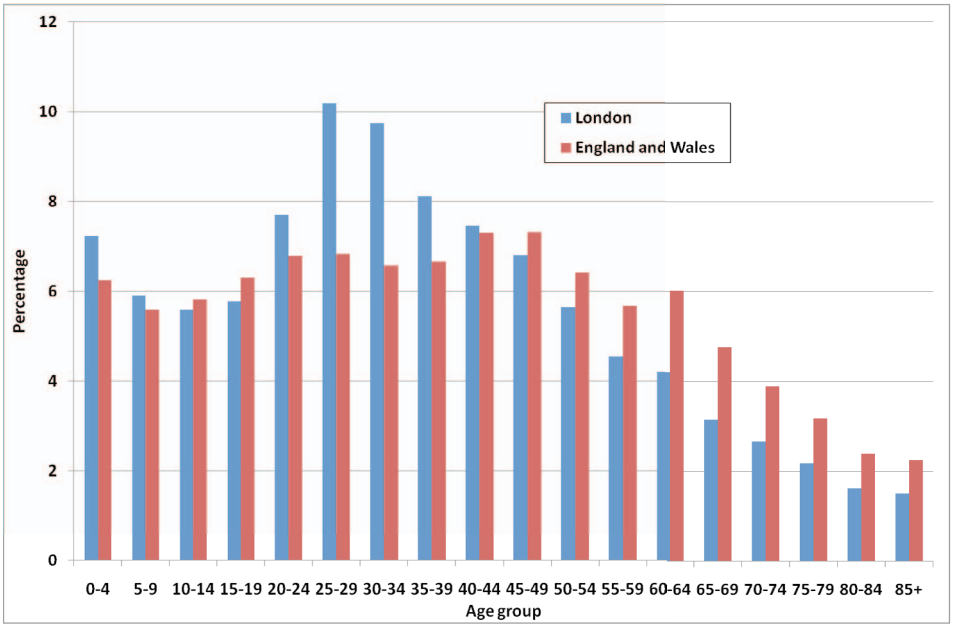
London's population is also highly mobile. The movement of residents within a borough –'internal churn' – varied from 36 per 1,000 in Havering and Redbridge to 61 in Wandsworth in 2008/9. The overall population turnover in a borough varies from 119 per 1,000 in Havering to 321 in Hammersmith & Fulham.[24]

The Greater London Authority estimates that 380,000 'undocumented migrants' live in London,[25] the main port of arrival from overseas; many are likely to be poor but unlikely to be included in official figures. They add to the population churn in London, especially in boroughs near the main airports.

Age

London has a relatively young population compared with the national average, with a particularly high proportion of people in their late 20s and early 30s (*see* Figure 2). The average age of a Londoner is 37 years compared with 40 years nationally. Londoners aged over 80 number around a quarter of a million, and are projected to increase by 40 per cent by 2031. Between 2011 and 2031, the size of the minority ethnic population in London who are over 80 is projected to almost triple, comprising about a quarter of the over-80 population by 2031.[26]

Figure 2: 2011 census population by age, London, and England and Wales



Data source: Office for National Statistics 2011 Census Quality Assurance Pack Data Tables
www.ons.gov.uk/ons/guide-method/census/2011/census-data/2011-census-data/2011-first-release/local-authority-quality-assurance/2011-census-quality-assurance-pack-data-tables.xls

Deprivation

London has more boroughs with deprived populations than other regions of England. Three of the ten local authorities nationally with the most deprived populations are in London (Tower Hamlets, Newham and Hackney). Of the 10 per cent (32) of local authorities in England with the most deprived populations, 10 are in London.[27]

Eight of the 10 local authorities in England with the highest proportion of children in poverty are London boroughs (Tower Hamlets, Islington, Hackney, Newham, City of Westminster, Camden, Barking and Dagenham, and Haringey). Child poverty rates across London vary from 11 per cent in Richmond upon Thames to 50 per cent in Tower Hamlets.[28]

Seven of the 17 local authorities nationally with the highest rate of long-term unemployed residents are London boroughs (Hackney, Haringey, Tower

Hamlets, Newham, Lambeth, Brent, and Southwark). The rates vary across London from 1.7 per 1,000 in Kingston upon Thames to 16.6 in Hackney. The rate across England is 5.7 per 1,000.[29]

There are very high levels of benefit dependency in east London: Tower Hamlets, at 32.8 per cent, has the highest proportion of people in households in receipt of selected means-tested benefits in England (2008), followed by Newham (2nd), Hackney (3rd), Haringey (6th), Barking and Dagenham (7th), and Islington (9th).[30] Newham, Hackney, Islington, and Tower Hamlets all have more than 40 per cent of children in families who are in receipt of key out-of-work benefits. In Tower Hamlets, this figure is 49.8 per cent.[31]

Ethnicity

Office for National Statistics (ONS) population estimates for ethnic groups in 2009 highlight the ethnic diversity of London's population.[32] Non-white groups comprise 30 per cent of the population in London, compared with 13 per cent in England overall. The intra-London range is vast, with non-white groups comprising the majority (55 per cent) in Newham, to an 89 per cent white population in Havering. South Asians comprise almost one-third of the population in Newham and Tower Hamlets, and one-quarter in Harrow. Black groups comprise almost 20 per cent of the population in Hackney and Lewisham.

Lifestyles

There are major inequalities in the prevalence of unhealthy lifestyles between different areas within London.

Smoking

London's adult population has a somewhat lower smoking prevalence than the England average (19.5 per cent and 20.2 per cent respectively in 2011).[33] Smoking prevalence in adult Londoners fell from 27 per cent to 19 per cent between 2000 and 2008; however, it varies almost twofold across London's local authorities, from 15 per cent in Harrow to 29 per cent in Hackney.[34]

Bangladeshi men have a 40 per cent smoking prevalence (compared with 2 per cent among Bangladeshi women); Pakistani men and Irish men and women also have higher rates than the national average.[35] Areas in London with large numbers of these ethnic populations will have a disproportionately high public health burden from smoking. On the other hand, smoking prevalence is low in women from several minority ethnic groups.

GPs play an important role in offering smoking cessation advice and referral to cessation support services. As well as targeting people with chronic conditions, it is important to target groups among whom smoking prevalence is high.

Alcohol misuse

London's hospital admission rate in adults attributable to alcohol is higher than the English average (1,912 admissions per 100,000 population compared to 1,895), although it is lower for young people. In London,

admission rates range from 1,350 per 100,000 in Kensington and Chelsea to 2,760 in Newham. The north central, south east and north east PCT clusters in London have higher rates than west London.

Alcohol-related harm is a major public health challenge. Guidelines from the National Institute for Health and Clinical Excellence (NICE) recommend that GPs provide brief interventions to people identified as engaging in harmful drinking.[36]

Obesity

A quarter of adult Londoners are obese, which is lower than in other parts of England. However, London has lower rates of physically active adults (10 per cent compared with 11.5 per cent nationally).[37]

London has the highest prevalence of childhood obesity.[38] Prevalence is higher than the national average in most areas of London, and ranges from 6.4 per cent in Richmond and Twickenham to 13.8 per cent in Southwark among children in reception year. Only south west London has a lower level of childhood obesity than the English average.

GPs can offer preventive advice and referral to support services in the community. It will be important that CCGs and members of the health and wellbeing boards work jointly with local authorities to increase opportunities for exercise, promoting healthier eating and tackling childhood obesity.

Teenage pregnancy

Most London boroughs have higher rates of teenage pregnancy than the English average (38.1 per 1,000 compared with the London average of 40.9, 2008–10), the rate being highest in south east London, but with marked intra-London variations. For example, the rate in Lambeth is more than three times that of Richmond and Twickenham (63 per 1,000 compared with 20).[39]

Sexually transmitted infections

London's rate of acute sexually transmitted infections (1,194 per 100,000 population) is 54 per cent higher than the national average (775), with 21 London boroughs doing worse than the England average.[40]

Mortality

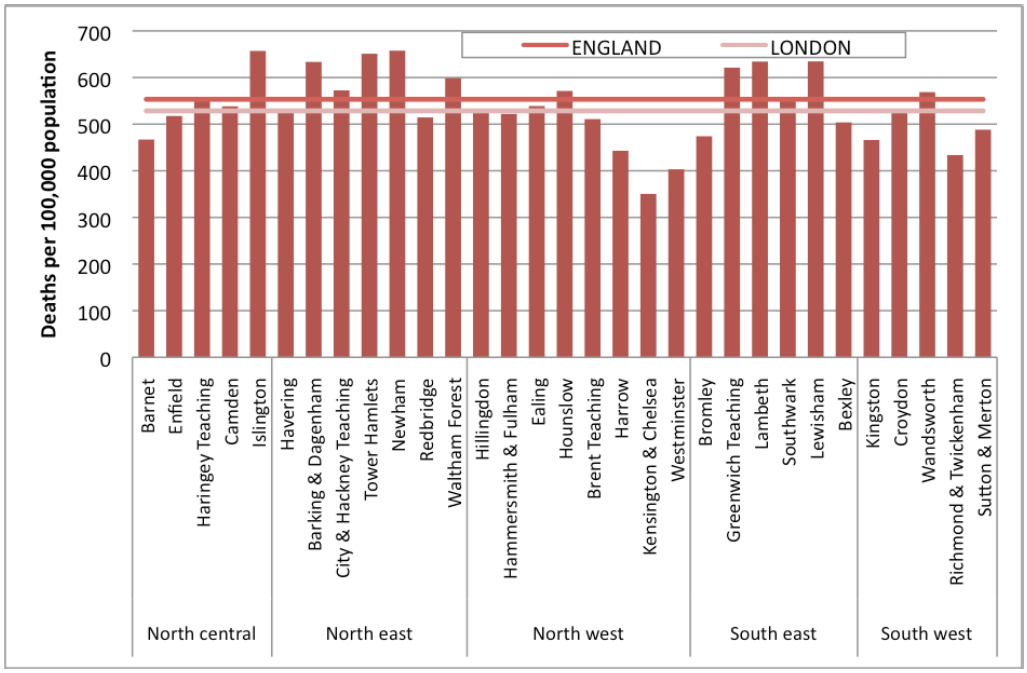
Overall mortality

Both male and female Londoners have somewhat lower mortality than the England average. Life expectancy in 2008–10 for males and females in London was 79 and 83.3 years respectively, compared with 78.6 and 82.6 years for England. The standardised mortality rate of 528 deaths per 100,000 population in London compared with 553 for England. London's mortality rate is lower than all northern and midland regions, but higher than its southern neighbours.

Within London, mortality varies almost twofold, from 351 per 100,000 in Kensington and Chelsea to 658 in Newham (*see* Figure 3). Areas with the highest mortality are clustered geographically, notably in north east and

south east London; the lowest rates are clustered in the north west and south west, with generally lower rates than England.

Figure 3: Directly standardised mortality rates per 100,000 population, London PCTs*, 2008–10



Data source: The NHS Information Centre Indicator Portal
https://indicators.ic.nhs.uk/download/NCHOD/Data/03C_073DR00++_10_V1_D.xls
*Data are grouped by PCT clusters in London.

A similar pattern is seen for years of life lost due to premature mortality (deaths under the age of 75 years).[41] London's rate of 408 premature years of life lost per 10,000 population was lower than the English average of 422 in 2008–10, but all surrounding southern regions have lower rates than London. However, the 70 per cent gender difference in premature mortality in London (516 years of life lost per 10,000 population in males compared with 303 for females) is even greater than the 45 per cent gender difference in overall mortality (635 per 100,000 for males compared with 438 for females). London has the largest gender difference in premature years of life lost of all English regions.

Premature years of life lost within London ranged from 290 per 10,000 in Richmond and Twickenham to 555 in Newham. The within-London clustering is even more notable for premature mortality. For example, every borough in the south west cluster sits below the English average.

Mortality from cancer

In recent years, cancer has overtaken cardiovascular disease as the leading cause of death in England. Along with cardiovascular disease, reducing premature (ages under 75 years) mortality from cancer is an indicator in both the NHS Outcomes Framework and the Public Health Outcomes Framework, and is included in the indicators proposed by NICE for the Commissioning Outcomes Framework (COF), against which the performance of CCGs will

be assessed. They will have joint accountability with local authorities for this indicator. It is therefore a high-priority area for outcomes improvement, and one where general practice can drive improvements in its role as both commissioner and provider.

Reflecting its lower incidence of cancer, London's premature mortality from cancer is lower than the national average (106 deaths per 100,000 compared with 110 in 2008–10). Cancer mortality shows a socio–economic gradient and has an almost twofold variation across the capital, from 78 deaths per 100,000 in Kensington and Chelsea to 140 in Barking and Dagenham. The south west and north west clusters have the lowest premature mortality rates, and some PCTs in the north central and south east clusters have the highest.

Mortality from cardiovascular disease

Cardiovascular disease is the second largest cause of death in England. Premature (ages under 75 years) mortality from cardiovascular disease is also an indicator in both the NHS Outcomes Framework and the Public Health Outcomes Framework. It is included in the NICE recommendations for COF indicators and, as with the premature cancer mortality indicator, CCGs will have joint accountability with local authorities for this indicator.

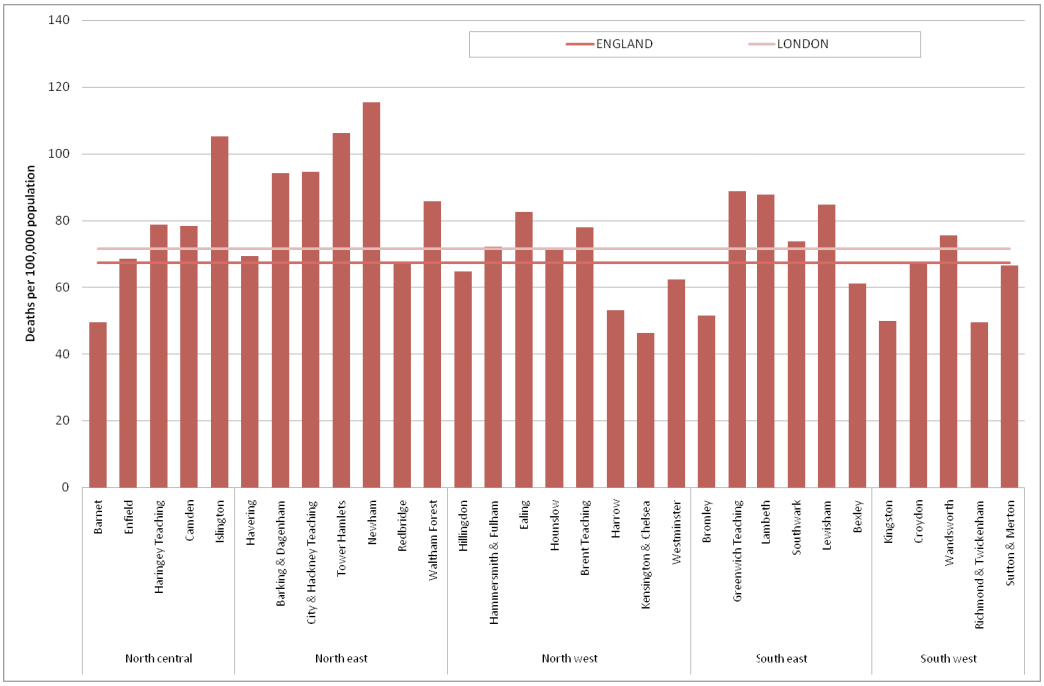
In contrast to cancer, London has above-average premature mortality from cardiovascular disease (71.5 deaths per 100,000 compared with 67.3 in England in 2008–10), with only the three northern-most areas of England having higher rates. Like cancer, cardiovascular disease mortality shows a socio-economic gradient and varies more than twofold in London, from 46 deaths per 100,000 in Kensington and Chelsea – the lowest rate nationally – to 115 in Newham (*see* Figure 4). The north cluster has the highest mortality, with the south west having the lowest.

The pattern of higher cardiovascular disease mortality in London is inconsistent with estimated prevalence of cardiovascular disease, where London has the lowest rate in England (9.7 per cent in adults compared with 11.7 per cent in England). So mortality should be correspondingly lower in London. Despite its comparatively low estimated prevalence, QOF-registered prevalence is disproportionately low in London, suggesting cases may not have been diagnosed.[42] It is also possible that higher premature mortality from cardiovascular disease in PCTs covering the most deprived populations contributes disproportionately to London's rate.

Infant mortality

Infant mortality – the death rate in babies aged under one year – is a key marker of child health, and is higher in London than the national average (4.7 compared with 4.3 per 1,000 live births in 2010). Deprivation and the higher infant mortality rates in some minority ethnic groups contribute to London's higher overall rate. For example, in London, infant mortality among the black group was more than double that among white groups in 2005/6,[43] and is also much higher in Pakistani-born mothers. Infant mortality also varies widely within London, reflecting intra-London differences in these determinants, from 2.7 per 1,000 in Islington and Richmond and Twickenham

Figure 4: Directly standardised premature mortality rates for cardiovascular diseases (ages <75) per 100,000 population, London PCTs, 2008–10



Source: NHS Information Centre Indicator Portal
https://indicators.ic.nhs.uk/download/NCHOD/Data/06A_076DR0074_10_V1_D.xls

to 7.7 in Lambeth. South west London has uniformly lower infant mortality compared with the London and English averages.

Morbidity

Morbidity in London shows a similar pattern to that of mortality, with the London average concealing marked local variations. London has fewer people reporting the presence of a limiting longstanding illness compared with the rest of the country (21.8 per cent at ages 16 years and over compared with 23.3 per cent in England, 2007–9).[44] London also has relatively fewer people reporting an inability to work due to a longstanding illness (90.3 per 1,000 compared with 96.2; 2001 census). Within London, there is an almost threefold variation (46 per 1,000 in Richmond and Twickenham compared with 147 in City and Hackney).

London has a lower incidence of cancer in people aged under 75 than the national average (286 per 100,000 in 2007–9 compared with 301 for England). London had the second lowest cancer incidence rate of all strategic health authorities (SHAs). Within London, cancer incidence varies from 229 per 100,000 in Kensington and Chelsea to 346 in Lambeth and 351 in Islington. The north west cluster had the lowest rates and the south east cluster the highest.

Diabetes and hypertension are two of the most common chronic diseases. Diabetes prevalence in London in 2010/11, as recorded in the QOF, is similar to the England average of 5.4 per cent. Within London, the prevalence of diagnosed diabetes ranges from 3.3 per cent in Richmond and Twickenham to 7.3 per cent in Harrow, and is generally highest in the most ethnically

diverse areas and those with large South Asian populations, including Ealing, Brent, Harrow, and Newham. The prevalence of diagnosed hypertension in London is 11.0 per cent, lower than the England average of 13.5 per cent. Within London, it ranges from 8 per cent of the registered general practice population in Tower Hamlets to 13.5 per cent in Bromley. Much of this pattern is likely to be driven by age, as areas with the oldest populations, like Havering and Bromley, have the highest prevalence.

26 London boroughs are doing worse than the national average on the rate of new cases of tuberculosis, with Newham and Brent having the highest rates in England. Tuberculosis is an uncommon diagnosis in general practice and easily missed. Given the increasing numbers of both tuberculosis and drug-resistant tuberculosis cases, it is important that London GPs are vigilant about detecting the early symptoms and following recommended guidance on the diagnosis, management and prevention of tuberculosis in the community.[45]

London presents a mixed picture for mental health. The prevalence of serious mental illness (defined in the QOF as schizophrenia, bipolar affective disorder and other psychoses) in London is higher than the national average (1.0 per cent and 0.8 per cent respectively). Prevalence ranges from 0.6 per cent in Havering to 1.5 per cent in Islington. PCTs in the south west London cluster generally have a lower prevalence of serious mental illness, even compared with the national average.[46] London's rate of detentions under the Mental Health Act is two to three times higher than other regions – the commonly accepted explanation being the link between high deprivation boroughs in London and the prevalence of psychosis. However, detailed analysis by borough indicates a relationship between transport hubs (eg, King's Cross, Euston, and Hillingdon) and detention rates.[47] Variation in the prevalence of serious mental illness in the capital could, in part, reflect the demographics of London's population: high levels of deprivation and ethnic diversity, population churn, London being a major transport hub and the main entry point for overseas migrants, etc.

In contrast, London has a significantly lower prevalence of depression among the adult population (aged 18 years and over) – 7.8 per cent of the registered general practice population compared with 11.2 per cent in England. Only two London areas have higher prevalence than the national average. Prevalence varies almost threefold in London, from 4.6 per cent in Barking and Dagenham to 12.6 per cent in Islington. This could also reflect higher levels of undiagnosed disease and unmet need in the population.

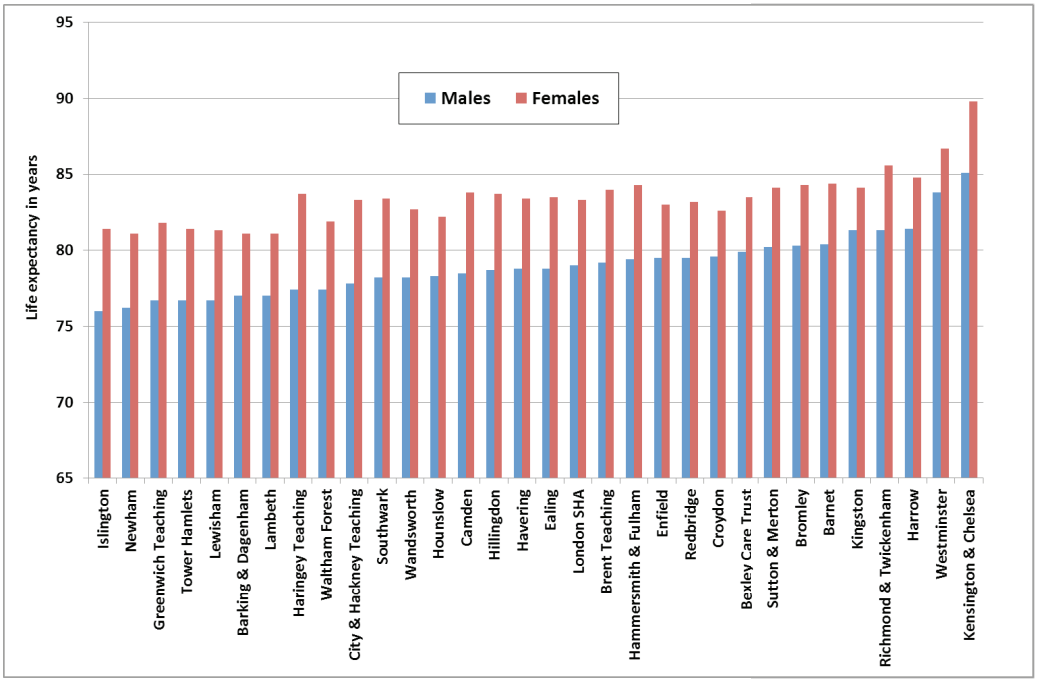
Epidemiological differences in disease patterns among ethnic groups partly explain some of the variations within London, and the diversity of the population is an important driver of local health needs. For example, the burden of cardiovascular disease, diabetes and mental illness is higher among some ethnic groups.[48,49] Men of Pakistani and African origin have a 20 per cent and 40 per cent higher incidence of stroke respectively than white men.[50] The increased risk of stroke among black African and Caribbean women is largely associated with raised blood pressure. Evidence suggests that risk factors partially account for these differences in cardiovascular disease outcomes, but that ethnicity also independently impacts cardiovascular disease risk.[51] On the other hand, the incidence of cancer is markedly lower in some minority ethnic groups. For example, South Asians have a significantly lower incidence of the four major cancers (breast,

prostate, lung and colorectal) than white groups, and black groups are at lower risk of breast, lung and colorectal cancer.[52]

Health inequalities

There are significant geographical inequalities in the mental and physical health outcomes of Londoners. The well-known Tube map comparison in *Healthcare for London* (2007)[53] exposed a seven-year difference in life expectancy between Westminster and Canning Town, just eight stops on the Jubilee line. Raising life expectancy for the bottom half of London boroughs to the current London average would save 1,300 lives every year. The latest (2008–10) data on life expectancy at birth for London PCTs show that the difference has increased by a year since the Tube map comparison was published: the difference between PCTs with the lowest and highest life expectancy is now 9.1 years for males and 8.7 years for females (*see* Figure 5).

Figure 5: Life expectancy at birth, London PCTs, 2008–10



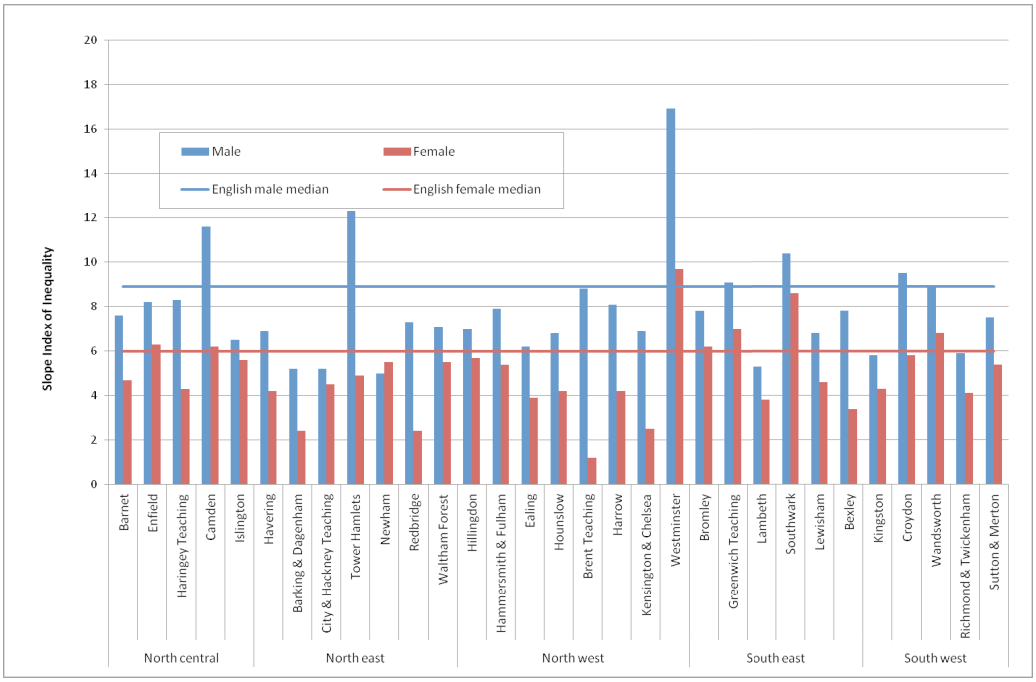
Source: NHS Information Centre Indicator Portal
https://indicators.ic.nhs.uk/download/NCHOD/Data/03E_186NOP1_10_V1_D.xls

Life expectancy differences within PCTs are higher than between them. The slope index of inequality for life expectancy is one measure of within-PCT (local authority) inequality (*see* Figure 6). The higher the number, the greater the within-area inequality.

Implications for primary care transformation

This profile shows the extraordinary diversity of London's population and the health needs of Londoners. The population can be characterised as younger, more transient, more ethnically and culturally diverse, and growing more rapidly than in the rest of England. General practice has to meet the twin

Figure 6: Slope index of inequality for life expectancy, London PCTs, 2006–10



Source: Health Inequality Indicators for Primary Care Organisations, Association of Public Health Observatories
www.apho.org.uk/resource/item.aspx?RID=110507

challenge of providing care to the young, transient section of the population, which has infrequent contact with the health service, and increasing numbers of older people with multiple morbidities who require enhanced support with care co-ordination and self-management. Meeting the health needs of London's rapidly growing and increasingly diverse population will require an expansion in and diversification of the models of primary care available.

Although on some indicators of mortality and morbidity Londoners are, on average, healthier than people in other parts of the country, there are stark inequalities between areas within London. The greatest public health challenge for London is how to close the gap between areas of deprivation and affluence. This underlines the importance of strengthening primary care, which is well placed to reach all segments of the population and reduce health inequalities.[54]

GPs will need to work with local authorities to address the wider determinants of health as well as undertaking more primary and secondary prevention in practices. The development of health and wellbeing boards provides an opportunity for GPs to work jointly with public health colleagues to engage more proactively with the prevention agenda and seek innovative ways to prevent ill-health and tackle long-term and persistent inequalities.

Although adults in London are less obese and smoking rates are lower than in other parts of England, the health of children is a major concern. London has some of the highest rates of childhood obesity and some of the lowest rates of childhood immunisations. Some GPs could be more proactive in identifying those at risk of ill-health. They will also need to target communities and groups where there is a higher prevalence of disease and risky behaviours with more holistic interventions to ensure that inequalities do not widen.

3 General practice in London

Key points

- London has a similar number of GP full-time equivalents (FTEs) to England per 100,000 unified weighted population (61 and 59.9); however, this varies twofold between London PCTs, and the distribution of GPs remains inequitable.
- London has the lowest level of practice staffing (131.4 per 100,000 unified weighted population compared with 148.1 nationally) and the lowest number of practice staff per GP (2.1 compared with 2.5 nationally); changing the skill-mix of practices and maximising their efficiency must be a priority, and will be key for meeting future demands on primary care in London.
- Almost 16 per cent of London GPs are over 60 years old (1 in 4 in north east London, where there are already shortages in supply) compared with 10 per cent nationally. Workforce shortages, combined with an ageing primary care workforce, highlight the importance of recruiting and retaining more staff.
- London practices have a smaller list size than the national average (5,789 compared with 6,651 nationally). The proportion of single-handed practices is higher (19.9 per cent compared with 13.8 per cent nationally), and this varies from 5 per cent to 40 per cent across London PCTs.
- The quality of practice premises needs to improve. However, patient satisfaction with ease of access and cleanliness of surgery premises is high in all London PCTs (more than 90 per cent), but Londoners were more likely to have concerns about a lack of privacy.
- General practices in London have been early adopters of information technology (IT). The proportion of practices that were live with the summary care record, and with electronic prescription services, was higher in London than the national average. Greater exploitation of IT – for example, to support record-sharing across providers – can support quality improvements and reduce costs.
- More formal networks of practices will be required to deliver some of the services likely to be devolved from secondary care. Practice networks will also be important for reducing professional isolation and helping to facilitate improvements in clinical quality across all practices.

Historically, there have been concerns about the quality of premises and a shortage of GPs in areas of high need.[55] This section describes the state of general practice in London and covers the following dimensions:

- workforce
- practice characteristics
- information management and technology.

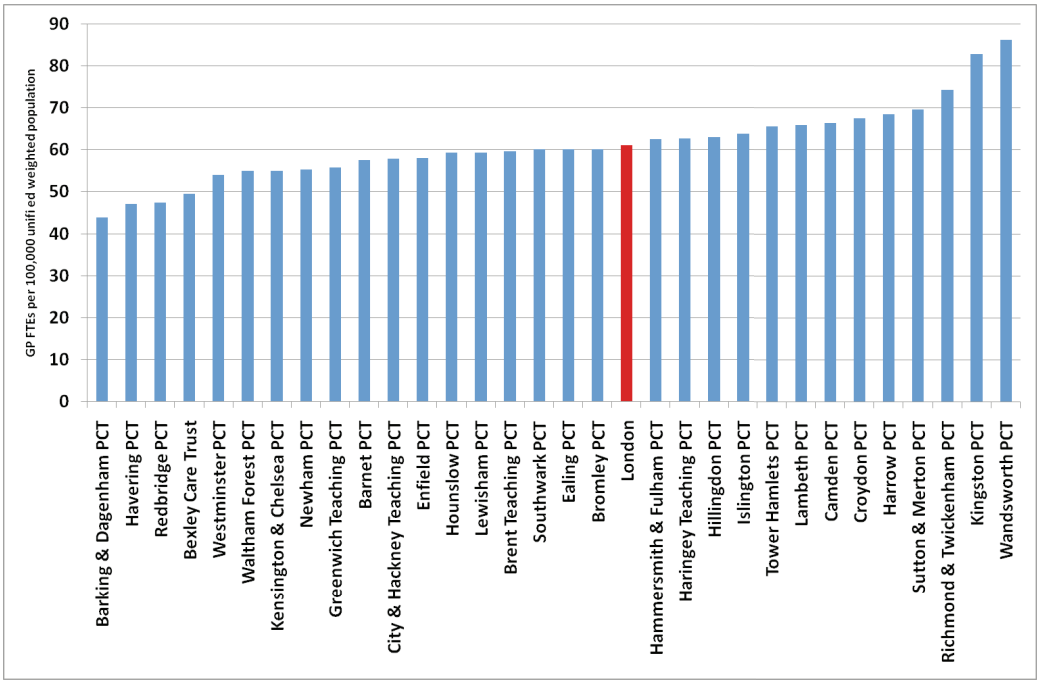
Workforce

GP staffing

The number and distribution of GPs is vital for ensuring that primary care meets the needs of local people. Ready access to GP surgeries is important for many reasons, including improving patients' experiences of primary care services, improving the health of local populations, reducing health inequalities, and reducing inappropriate (and often more expensive) time spent in secondary care. There are wide geographical variations in the availability and proximity of general practices.

London has a similar number of GP full-time equivalents (FTEs) to England per 100,000 unified weighted population (61 compared with 59.9). However, this number varies significantly (twofold) between London PCTs (*see* Figure 7).

Figure 7: GP FTEs per 100,000 unified weighted population, London PCTs, 2011

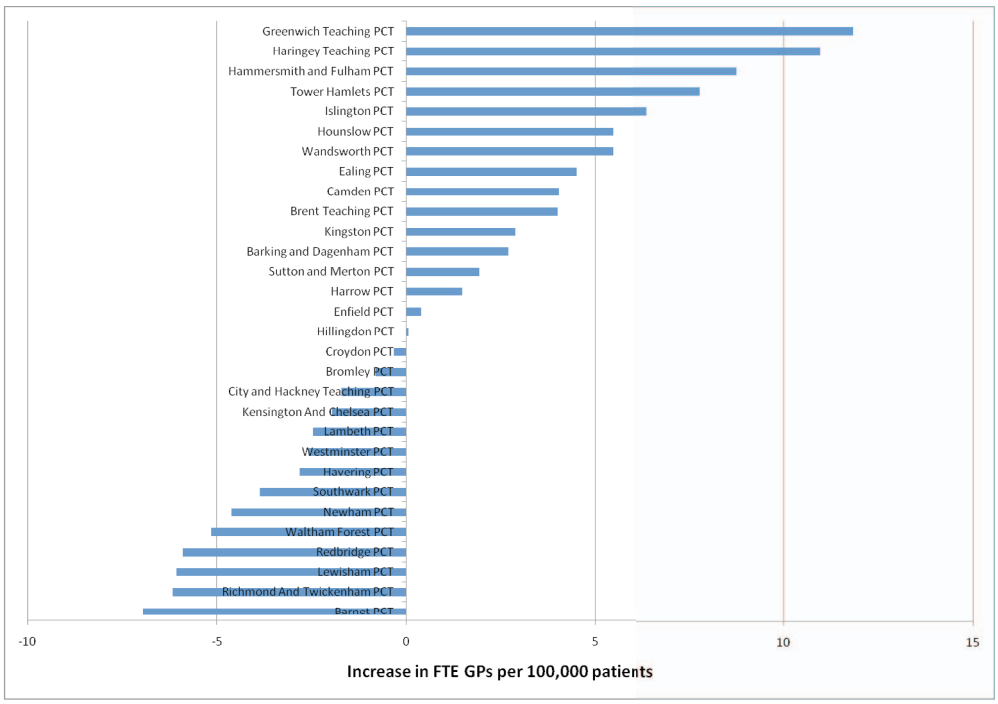


Data source: NHS Information Centre, Workforce section, www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-general-practice

Figure 8 shows the change in FTE GPs per unweighted 100,000 patients over the period 2006–11. Most PCTs with a poor supply of GPs in 2011 have increased staffing since 2006, with some exceptions (for example, Havering and Redbridge). While overall GP FTEs increased by 276 across London between 2006 and 2011, some PCTs actually reduced GP supply.

There are no clinically set standards for the ratio of GPs to patients, nor has the ideal skill-mix in general practice been established. This depends on the needs and complexity of the patients and population served, and factors such as the level of experience of staff and their competencies. Goddard *et al* (2010) found that geographical equity in the supply of GPs relative to need in

Figure 8: Increase in FTE GPs per 100,000 patients 2006–11



Data source: NHS Information Centre, Workforce section, www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-general-practice

England rose between 1974 and 1994 but then decreased, and in 2006 it was below the 1974 level.[56]

Primary care skill-mix

Data on FTE practice staff per 100,000 unified weighted population in 2011 show that London has the lowest levels of practice staffing among SHAs in England (131.4 compared with the national average of 148.1). Furthermore, there is substantial variation in practice staffing levels within London, from less than 100 practice staff per 100,000 population in Camden to 160 in Greenwich.

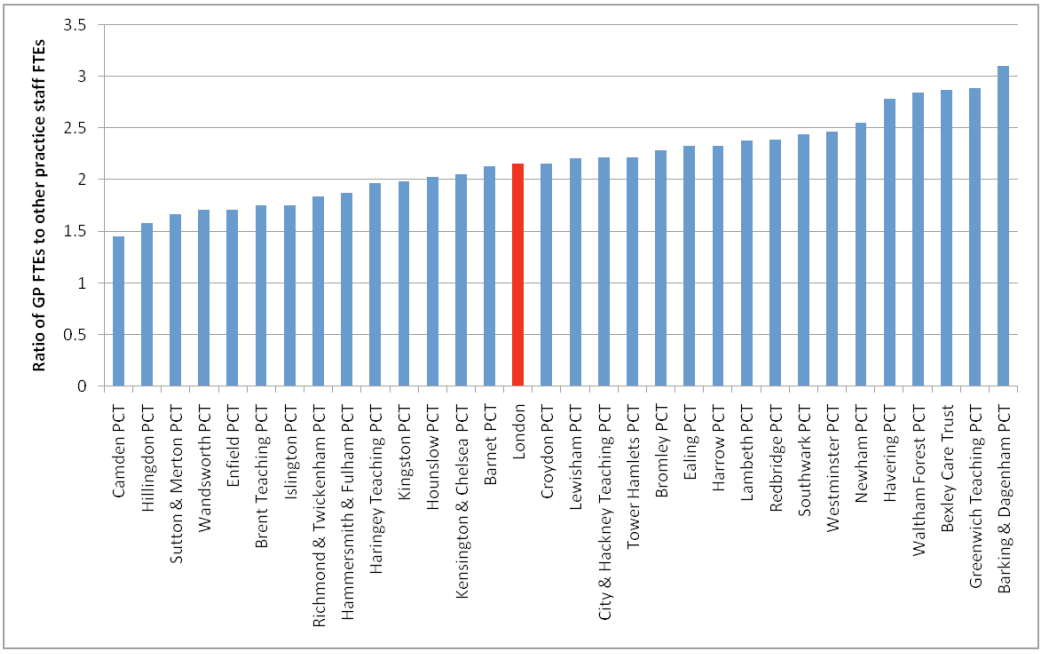
London GPs therefore work with fewer practice staff than elsewhere in the country. The FTE GP to practice nurse ratios in 2011 were lowest in London, with only a little over two practice staff per GP compared with 2.47 nationally and as many as 2.70 in the north west of England. Furthermore, there is twofold variation across London, from 1.5 practice staff per GP in Camden to over 3 in Barking and Dagenham (*see* Figure 9). PCTs where there are fewer GPs per population appear to rely more on other practice staff to deliver services.

Age profile

The proportion of GPs who were aged 60 years and over in 2011 is highest in London (15.6 per cent compared with the national average of 10.1 per cent). The high proportion of older GPs in London represents a risk that the supply of GPs relative to population may drop in future years. This is especially significant given that, as we have shown in Section 2, London's population is growing faster than the rest of England. The proportion of GPs aged 60 years

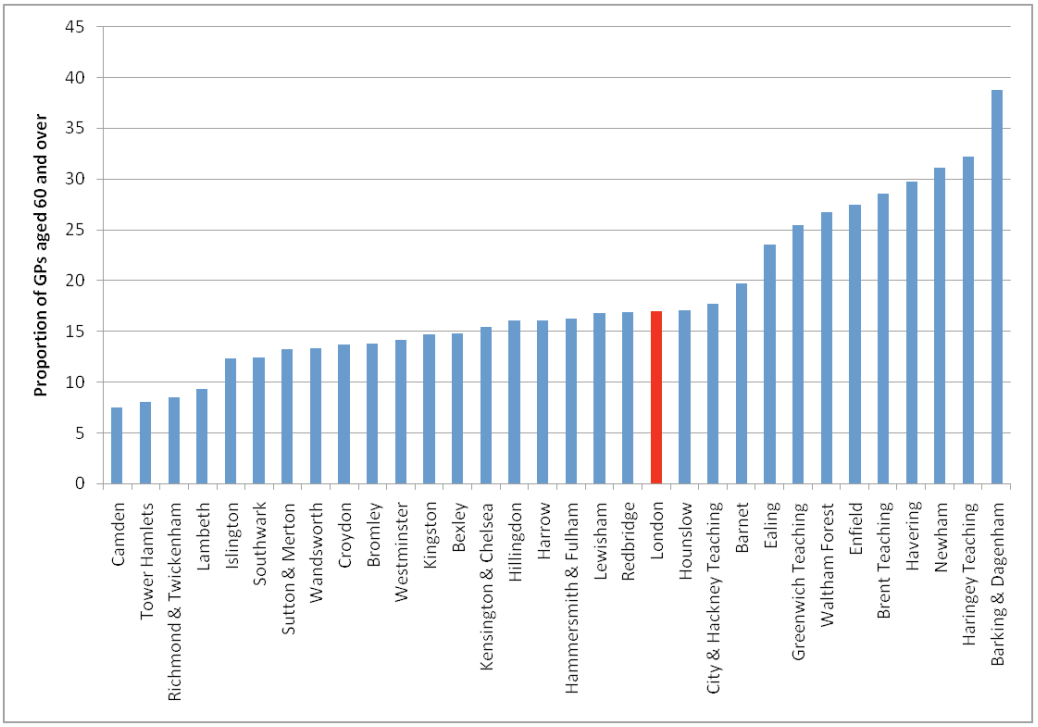
and over varies sixfold within London (*see* Figure 10). Of particular concern is the high proportion in outer north east London (about one-quarter), where there are already shortages in supply.

Figure 9: Ratio of GP FTEs to other practice staff FTEs, London PCTs, 2011



Data source: NHS Information Centre, Workforce section, www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-general-practice

Figure 10: Proportion of GPs aged 60 and over, London PCTs, 2011



Data source: NHS Information Centre, Workforce section, www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-general-practice

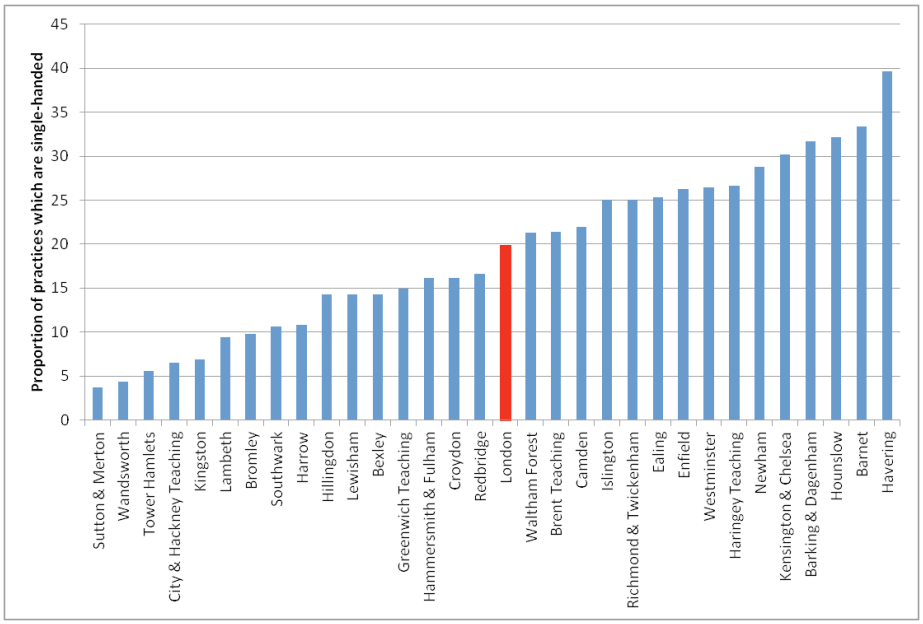
Practice characteristics

Practice size

Practices in London have a lower average list size than the average for England (5,789 compared with 6,651 patients). It is well known that London has a comparatively high proportion of single-handed practices, because of both historical practice patterns and the higher cost of buildings. In 2011, one in five (19.9 per cent) London practices were single-handed compared with 13.8 per cent nationally, with other SHAs ranging from 3.6 per cent in the South Central region of England to 17.7 per cent in the West Midlands. In addition, 21 per cent of London practices are two-handers, compared with 17 per cent in England. The proportion of single-handed practices varies eightfold between London PCTs (*see* Figure 11), ranging from less than 5 per cent in Sutton and Merton, and Wandsworth, to around 40 per cent in Havering.

There is conflicting evidence on the ability of small practices to deliver high-quality care. On the one hand, practices with smaller list sizes have been found to have greater perceived physician availability, and longer consultation time, which can improve patient satisfaction and compliance.[57,58] Being a single-handed practitioner can, however, be isolating, and the range of services smaller practice units can offer on site will necessarily be constrained. On the other hand, Ashworth *et al* (2011) identified in national data a cohort of 2.7 per cent practices which remained in the lowest decile for total QOF scores in the four years following its introduction.[59] These practices were more likely (almost 14 times) to be single-handed, non-training practices, and located in deprived areas. GPs in these practices were more likely to be aged 65 years or more, male, UK qualified, and with small list sizes. However, there is other evidence suggesting that quality of care may be comparable in small and larger-sized practices, including for cardiovascular disease and diabetes management[60,61] and in uptake of the new NHS Health Check programme.[62]

Figure 11: Proportion of practices which are single-handed, London PCTs, 2011



Data source: NHS Information Centre, Workforce section, www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-general-practice

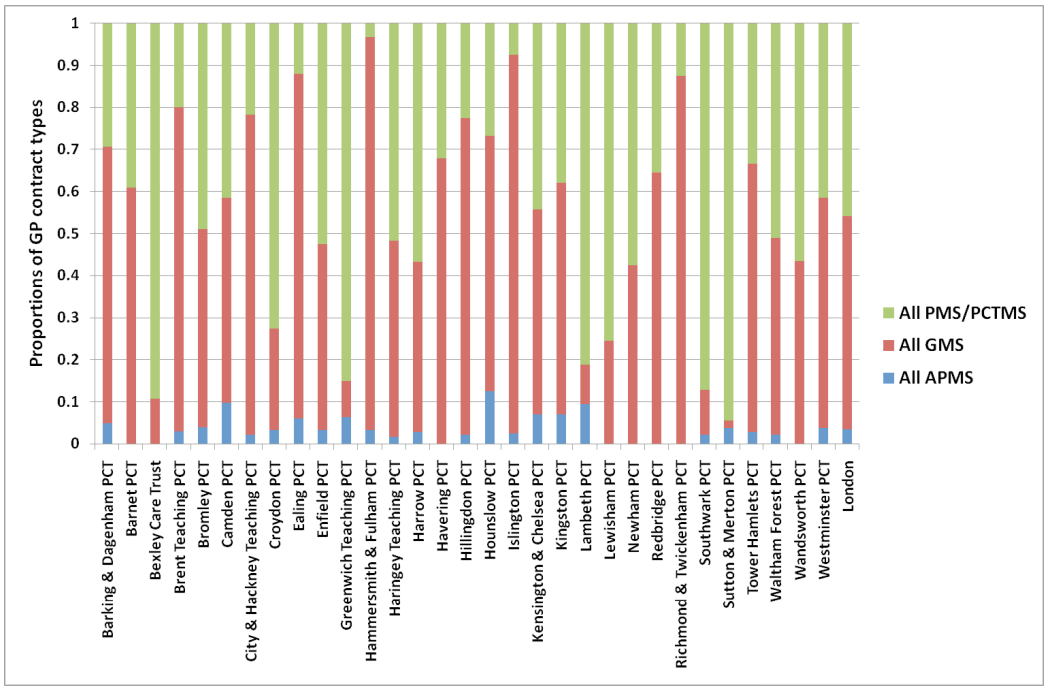
GP contracts

There are four main types of contract for GP services:

- GMS – General Medical Services
- PMS – Personal Medical Services
- APMS – Alternative Provider Medical Services
- PCTMS – Primary Care Trust Medical Services (only a few remain in London and this contract model will be phased out by April 2013).

Where the contract-holder is seen to be a 'private' company – ie, limited by shares – this is included within the main contract types. However, PCTMS contracts are the only category held by the PCT/NHS – in effect, 'public' ownership. Almost all other contracts are held by one or more GP 'partners' and so also essentially 'private' in nature. There is some variation between SHAs in the proportions of PMS versus GMS contracts. London is quite similar to the rest of England, with about 40 per cent of contracts being PMS. However, there is large variation between London PCTs, with up to 90 per cent of contracts in 2011 being PMS/PCTMS in areas such as Bexley, and Sutton and Merton (*see* Figure 12).

Figure 12: Proportions of GP contract types, London PCTs, 2011



Data source: NHS Information Centre, Workforce section, www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-general-practice

Premises

In 1992, the Tomlinson report highlighted the poor standard of general practice premises in London. At the time, 46 per cent of premises in four inner boroughs were below minimum standards, compared with 7 per

cent nationally. It is difficult to assess the current state of general practice premises in London due to an absence of recent London-wide audits.

In 2010, a Freedom of Information request by Pulse to PCTs suggested that 59 per cent of GP surgeries in London fell below the minimum standard set by buildings inspectors; many were unfit for disabled people or were too cramped to provide proper treatment, while others needed washing and heating facilities upgraded.[63] A third of practices in London were 'dangerously below standard'. All 27 surgeries in Hammersmith & Fulham were below statutory requirements and 8 were 'dangerously below standard'. In Barnet, 49 per cent of surgeries were below standard, and in Camden, 62 per cent.

Across England as a whole, in 2009 the Department of Health reported that 50 new GP-led health centres were open, and 65 new GP practices had opened in under-served areas. However, it is not possible to get a breakdown of where these are situated. The evaluation of polyclinics in London looked at seven polyclinics or polysystems, of which four were hub and spoke model (which involved development of existing health centres) and three were new-builds.[64] Not all the planned polyclinics were built.

Data on premises are currently not available at borough level in London. However, these data may be more readily available locally as CCGs and PCT clusters will have estates strategies, strategic services development plans (SSDPs), commissioner investment and asset management strategies (CIAMS) or audit data (details of CIAMS data can be found at: www.healthcareestate.co.uk/CIAMS).

Data from the 2011/12 GP Patient Survey suggest consistently high levels of patient satisfaction in relation to 'ease of access' and 'cleanliness' of surgery premises in all London PCTs (more than 90 per cent). Londoners were more likely to have concerns about a lack of privacy in the surgery than patients in the rest of England, with 27 per cent reporting that they were unhappy about being overhead in the reception area. This percentage varied from 19 per cent of patients registered with practices in Bromley to 34 per cent in Wandsworth.

Information management and technology

There has been high penetration of electronic medical records in UK primary care since the 1990s. A number of London PCTs sought to harness the potential of electronic medical records to improve quality by gaining agreement from practices to hold part of the patient record centrally. This permits regular and timely feedback of practice performance on indicators benchmarked to other practices in the area. Innovative local pay-for-performance schemes, such as QOF+ in Hammersmith & Fulham, have used this data to provide financial rewards to practices to achieve locally determined quality indicators.[65]

Some information management and technology (IM&T) indicators for primary care from The Information Centre show that:

- the proportion of practices that were live with the summary care record in 2011/12 was significantly higher in London (70 per cent) than in other regions in England (average 53 per cent). A practice is considered live if it has commenced uploading patients' summary care

records to the national Spine, which can then be viewed electronically in urgent and emergency care settings

- the proportion of general practices involved in the electronic prescription services (phase 1 or 2) in 2011 was slightly higher in London than the national average.[66]

Greater exploitation of IT can support quality improvements and reduce costs. IT developments are increasingly permitting secure sharing of patient records to facilitate seamless management of patients at different practices. For example, GPs in Newham are currently exploring the possibility of using EMIS Web to support patients in a network being able to be seen at any practice. Linkage of patient records across primary and secondary care is increasingly being undertaken, including in parts of London. This can support more effective multidisciplinary working as well as risk stratification and delivery of integrated care. Increasingly, patients are being offered access to their GP records, which can support self-care and management. The Department of Health's *The Power of Information* strategy commits to all NHS patients having online access to their GP records by 2015.[67]

Implications for primary care transformation

This section has illustrated the differences between general practice in London and other parts of the country as well as the differences between areas within London.

Workforce shortages in some parts of London, combined with an ageing primary care workforce, highlight the importance of recruiting and retaining more GPs, practice nurses and other support staff in the capital. Recruitment and retention strategies need to be adequately planned to ensure a more balanced skill-mix (at present, there are fewer practice staff per GP in London compared with the rest of England). Changing the skill-mix in practices will be key for meeting future demands on primary care in London from a growing, increasingly diverse population with diverse health care needs, and in order to manage the growing number of patients with multiple chronic diseases. Addressing these issues will require practice-wide, borough-wide and London-wide strategies for workforce investment and development.

GP practices in London are smaller on average than in the rest of England, with well over half having only one or two GPs. By developing networks and partnerships, general practice has the potential to extend the services it can make available to patients in the community. Practice networks can facilitate this. Working as part of federations, networks or superpartnerships can also reduce professional isolation and help facilitate sharing of best practice and quality improvement initiatives between practices.

General practices in many parts of London are early adopters in using IT to improve patient care. Data-sharing and knowledge-sharing can increasingly be facilitated by developments in information technology that now permit secure sharing of patient records between practices. CCGs should build on this to facilitate greater sharing of general practice data (ideally, holding this centrally) to permit regular and timely feedback of quality indicators to practices. Giving patients access to their GP records – a government commitment for 2015 – can also support self-care and management, especially among patients with chronic conditions.

4 Clinical quality of general practice in London

In this section, we examine a number of dimensions of the clinical quality of general practice in London. Inevitably, we have had to be selective but, nonetheless, we attempt to assess the overall quality of care and suggest key areas GPs and CCGs might focus on for improvement.

Outcomes can be affected by multiple factors, including the socio-demographic profile of the populations served by general practices, and some indicators reflect, in part, how the whole system is performing rather than general practice in isolation. Variations that exist within London, and between London and other parts of England, should be seen as the basis for further exploration as to why such variations exist and what can be done – by GPs alone or GPs working with others – to improve care.

The evidence presented looks at the following issues:

- health promotion and ill-health prevention
- diagnosis
- referrals, with a specific focus on referrals for cancer
- prescribing
- acute, emergency and urgent care
- managing long-term conditions
- mental health and dementia
- end-of-life care.

We also illustrate the geographic inequalities that exist in London and some inequalities between socio-economic and ethnic groups.

Health promotion/ill-health prevention

London has seen big improvements in important public health indicators:

- Infant mortality – the improvement is greater for London than for England, and inequalities between London boroughs have narrowed.
- Childhood immunisations – there has been a substantial increase in the proportion of children immunised against measles, mumps and rubella (MMR).
- Teenage conceptions – London's rate has fallen and the gap between inner and outer London has narrowed.

Key points

- The proportion of patients with long-term conditions in London who are offered smoking cessation advice or referral is high (93 per cent).
- However, many London PCTs are doing worse than the England average on key preventive measures.
- London has poorer performance in childhood immunisation compared with national averages. Intra-London variations are large. However, Tower Hamlets is notable for having high coverage.
- London has marginally lower flu vaccination rates for under-65 high-risk groups than the national average (48.3 per cent compared with 50 per cent nationally); however, within London the variation ranges from 35.3 per cent to 61.5 per cent between PCTs.
- 22 of the 25 PCTs with the lowest breast screening rates nationally are in London, and rates of cervical screening are also low.
- General practice will need to take preventive action to tackle London's higher rates of childhood obesity and physical inactivity in adults.
- Although smoking prevalence is comparatively lower in London, cessation advice and services should be proactively offered.
- Infectious diseases are a special challenge in London, given its demographic profile, with high rates of tuberculosis and sexually transmitted infections.
- Health promotion and primary prevention by London CCGs as commissioners working in partnership with local authorities and health and wellbeing boards, and with general practice as providers, will be key to reducing morbidity, premature mortality, health inequalities, and the future burden of disease in the capital.

Primary prevention

Given that more than 90 per cent of all health care contacts occur in general practice, and the frontline role that GPs and practice staff play in health care, they are well placed to offer preventive advice and, where appropriate, referral to other services.[68] This is especially important in London, given the wide socio-economic and ethnic disparities in health in the capital, and therefore the imperative for general practice to play a proactive role in reducing the disease burden overall and health inequalities. CCGs have a statutory duty to reduce health inequalities; extending and strengthening preventive services to disadvantaged groups, in partnership with local authorities and health and wellbeing boards, will be vital in this context. Proactive primary prevention interventions in general practice can also help to reduce health care costs for CCGs.

GP practices tend to be reactive rather than proactive in providing patients with advice and interventions to help them give up smoking.[69] QOF 2010/11 data show that the percentage of patients with a range of long-term conditions who are offered smoking cessation advice or referral is relatively high in London (93 per cent). Intra-London variations are small (91–95 per cent between PCTs), as are practice-level variations. Thirteen per cent (203) of the 1,504 practices in London did not achieve the 90 per cent benchmark where full points are awarded for this QOF indicator. Overall, the exception reporting rate for this indicator is low (1 per cent for England).

While the QOF incentivises support for smoking cessation in those patients with chronic disease, such support is equally important among those without a long-term condition, especially among groups in which smoking prevalence is higher, such as people from deprived areas. The QOF 2012/13 includes an indicator on the offer of support and treatment for people aged 15 years and over who are recorded as current smokers. It will be important for general practices in London to pursue this actively, with ongoing monitoring of smoking status and cessation where possible.

Similarly, general practice can offer advice and support to tackle obesity among the capital's children, and promote physical exercise in adults through, for example, referral schemes. QOF indicators relate only to the recording of body mass index (BMI) in patients with diabetes, and having a register of patients aged 16 and over with a BMI greater than 30. These measures may not give general practice enough incentive to actively promote healthy eating and physical exercise, but this should be a priority in view of the high diabetes prevalence among London's large socio-economically deprived, South Asian and African-Caribbean populations. Obesity is a risk factor in many health problems, including arthritis, stroke, heart disease and cancer.

There are no national measures targeting excess alcohol consumption in general practice; however, such schemes do exist locally. London PCTs have a local enhanced services/directed enhanced services (LES/DES) for case-finding in newly registered adults using the World Health Organization (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaire, and assessment for those who screen positive. This DES aims to deliver advice to help reduce alcohol-related risk and consideration of specialist referral for dependent drinkers. Lewisham PCT's evaluation of a pilot DES showed that the 32 practices participating in the DES in 2006/7 identified more than 1,100 hazardous drinkers using the AUDIT tool and 2,500 through history and interview. More than 3,500 patients received brief interventions for alcohol misuse.[70] NHS London has collected this data for the majority of practices in London and plans to publish it shortly in the General Practice Outcome Standards.

Since 2009/10, the QOF has included two primary prevention indicators relating to cardiovascular disease, for patients with a new diagnosis of hypertension and excluding those with pre-existing coronary heart disease, diabetes and stroke/transient ischaemic attack (TIA). The indicators measure cardiovascular disease risk assessment and advice on physical activity, smoking cessation, alcohol consumption and diet. The QOF does not include other indicators relating to primary prevention, hence there are no other direct measures of how general practice is addressing health promotion and risk-factor modification in the general population.

Immunisation

Childhood immunisation

General practice plays a key role in providing immunisation services and ensuring protection of at-risk groups against infectious disease. Data on childhood immunisation for diphtheria (D), tetanus (T), pertussis (whooping cough – aP is the acellular pertussis vaccine), polio (IPV is inactivated polio vaccine) and Hib (*Haemophilus influenzae* type b) vaccines, meningitis C

(Men C) vaccine, pneumococcal conjugate vaccine (PCV) and MMR (measles, mumps and rubella) show the following.

- Across a range of childhood immunisations, London has the lowest coverage (*see* Figure 13). MMR vaccination coverage was 89.3 per cent compared with 93.4 per cent across England.
- For vaccination before the age of one, most London PCTs (29 out of 31) have coverage below the England average, ranging from 81 per cent in Newham to 97 per cent in neighbouring Tower Hamlets. The pattern is similar for immunisations scheduled before the age of two, with Tower Hamlets having the highest coverage (95 per cent). The high immunisation rates in Tower Hamlets are impressive, given its high levels of deprivation and minority ethnic populations. There may be strategies here that can be emulated by other London practices where immunisation rates are low.

Figure 13: Percentage of children immunised by their second birthday, SHAs, 2010/11

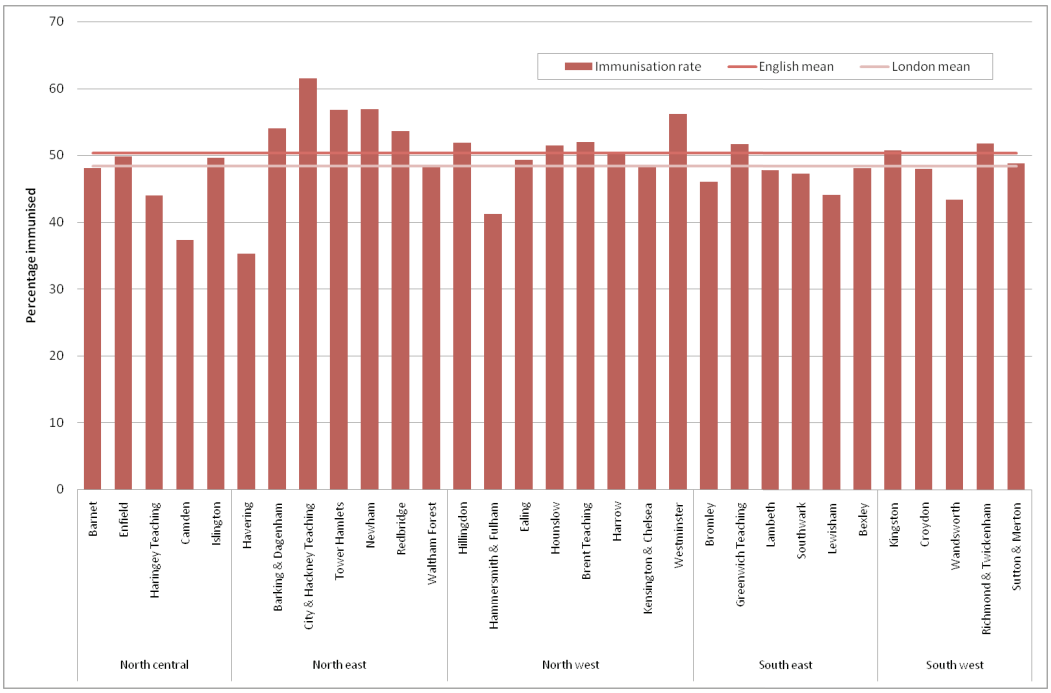
Data source: NHS Cover of Vaccination Evaluated Rapidly (COVER) data www.ic.nhs.uk/cmsincludes/_process_document.asp?sPublicationID=1316783415427&sDocID=7751

Flu vaccination

Influenza is a major cause of morbidity and mortality. Vaccination against influenza is offered annually to people under 65 in clinical risk groups identified by the Department of Health,[71] in addition to all those aged 65 years and over and health care workers. London has marginally lower flu vaccination rates in the under-65 at-risk groups (48.3 per cent) than England as a whole (50 per cent). Many London PCTs (19 out of 31) have lower rates than the England average, ranging from 35.3 per cent in Havering to 61.5 per

cent in City and Hackney. PCTs in north east London have the highest rates while areas in north central London have the lowest rates (*see* Figure 14). Improving uptake of flu vaccination in high-risk groups will be important for reducing premature mortality and emergency hospital admissions, both of which are priorities in the NHS Outcomes Framework.

Figure 14: Influenza immunisation in high-risk groups aged under 65, London PCTs, 2010/11



Data source: Seasonal influenza vaccine uptake among GP patient groups in England, Department of Health
https://indicators.ic.nhs.uk/download/Quality%20Outcomes/Data/Spreadsheet%20Immune%20at%20risk.xls

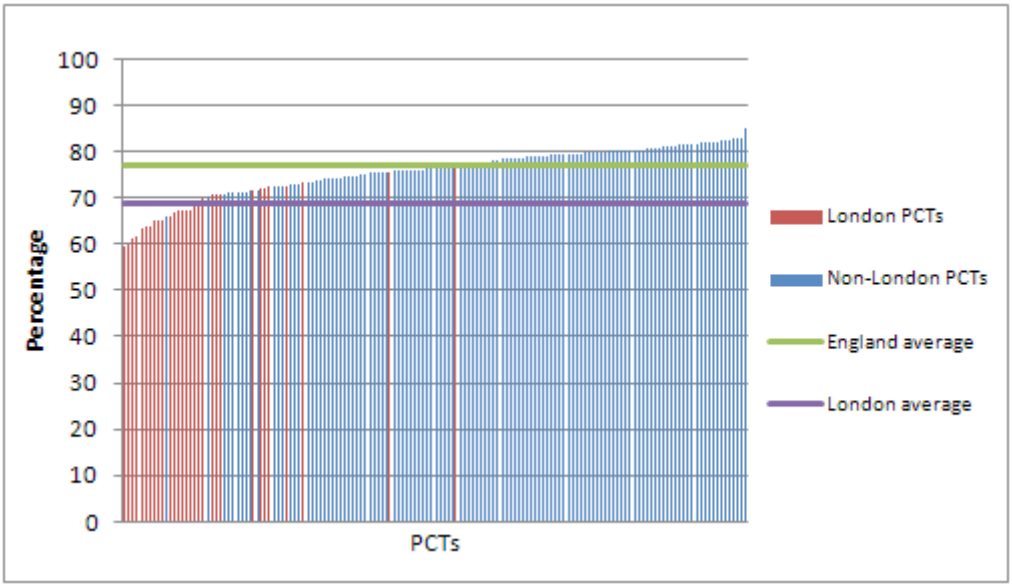
Cancer screening

General practice plays a key role in the early detection of cancer. Breast and cervical screening is important for early diagnosis of cancer and improved outcomes. Breast screening rates are low in London (68.9 per cent in 2011) relative to the rest of the country (national average of 77.2 per cent). With three exceptions, the 25 PCTs with the lowest screening rates nationally were in London (*see* Figure 15). Similarly, London has the lowest cervical cancer screening rate for women aged 25–64 years (74 per cent in 2011 compared with 78.6 per cent nationally); several London PCTs have among the lowest cervical screening rates nationally. Given that cancer is a priority in both the NHS Outcomes Framework and the Public Health Outcomes Framework, improved uptake of prevention and early detection measures will be vital.

Implications for primary care transformation

London achievement is below the England average on many of the key preventive indicators reviewed here, reflecting the population challenges that London faces. Reducing premature mortality and health inequalities – stated

Figure 15: Breast screening coverage (less than 3 years) of women aged 53–70, England PCTs, 2011



Data source: The NHS Information Centre Indicator Portal
https://indicators.ic.nhs.uk/download/NCHOD/Data/16E_426PCP2_11_V1_D.xls

priorities in the NHS Outcomes Framework and the Public Health Outcomes Framework – will require general practice to do more to promote health and prevent disease. General practice has a significant preventive role to play in terms of the provision of advice, screening, immunisation, and referral to support services in the community. GPs, through their participation in health and wellbeing boards, will have an important role in working with local authorities to identify initiatives to promote health in the populations they serve.

Diagnosis

Key points

- Underdiagnosis of some long-term conditions such as stroke and chronic obstructive pulmonary disease (COPD) is significantly greater in London than in other areas. Unmet population need is likely to lead to worse outcomes and higher costs.
- London has a slightly higher than expected rate of emergency admissions for a first diagnosis of cancer (ratio of observed to expected at 1.04 in London), and this ratio ranges from 0.88 to 1.22 between London PCTs. Many factors, including late presentation and diagnosis, can contribute to emergency presentation. The reasons should be investigated locally, as late diagnosis is a key factor in poorer cancer survival.
- There have been improvements in London in the identification and recording of risk factors, such as for heart disease, but a more systematic approach to prevention is needed for other chronic conditions and high-risk groups.
- A more proactive approach is needed to target high-risk groups to improve uptake of preventive services and to encourage them to present early.

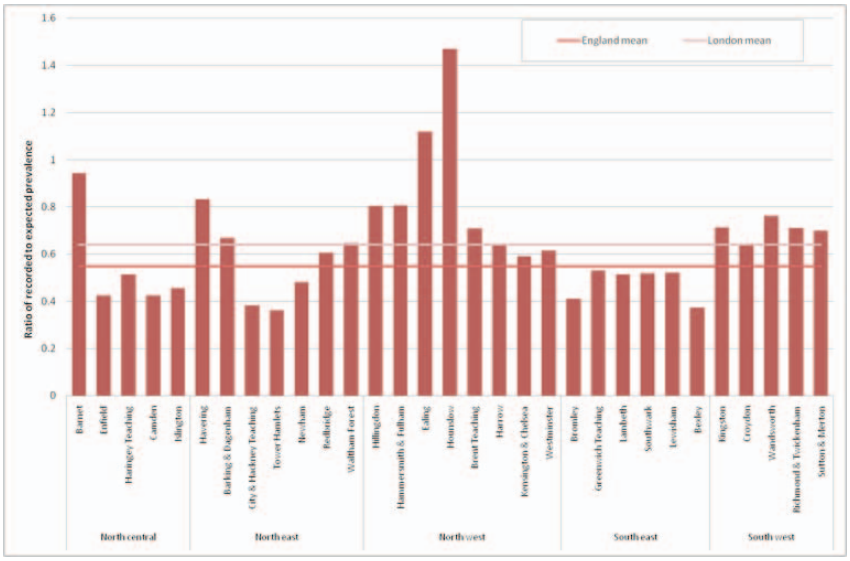
Long-term conditions

Early diagnosis of long-term conditions is important for improving patient wellbeing and outcomes, and reducing secondary complications and use of health care resources, including secondary care. *Health Checks*, a population-wide prevention programme introduced during 2009, aims to measure and manage cardiovascular disease risk factors among people aged 40–74 years in England. A study of 14 practices in north west London found that the completeness of blood pressure, smoking, body mass index (BMI) and cholesterol recording differed significantly between practices due to patient characteristics.[72] Hypertensive and older patients, for example, had better recording of blood pressure, BMI and cholesterol; and recording of blood pressure and cholesterol was better among South Asian patients. The potential workload implications of the programme for general practice are considerable, particularly in deprived, culturally diverse settings.

While there have been efforts to improve identification of cardiovascular disease through the *Health Checks* programme, there is evidence that underdiagnosis of some other long-term conditions is greater in London than in other areas. Underdiagnosis of COPD is greater in urban areas in England generally, and is particularly acute in London.[73] London has the lowest ratio of recorded to expected cases of COPD. Many London PCTs have less than half the expected prevalence of COPD diagnosed (*see* Figure 16), the ratio being lowest in Tower Hamlets with just over a third (0.36) of expected COPD cases diagnosed. Similar analyses for stroke show higher levels of underdiagnosis clustered in and around London.[74]

A qualitative study of COPD patients in south east London found that patient contact was influenced by perceptions of ease of access, quality of relationship with their GP, and perceived disease severity and threat.[75] Some patients wanted to avoid bothering the doctor or found travelling to the surgery too difficult. The authors concluded that factors other than need influenced patterns of health service use. Expectations of difficulty in access, and poor relationships with the GP, may have delayed help-seeking in acute exacerbations.

Figure 16: The ratio of recorded to expected prevalence of COPD, London PCTs, 2010/11



Data source: The NHS Information Centre Indicator Portal

Research also suggests that misdiagnosis of acute illness occurs due to the diffuse presentations encountered in general practice.[76] It is important that the most experienced GPs are available to deal with patients presenting with acute, undifferentiated symptoms in order that a prompt diagnosis is made. GPs also need to have easy access to specialist advice when they need it to support them in decision-making. This can complement other online decision support mechanisms for clinicians, such as protocols and guidelines.

Cancer

The earlier cancer is diagnosed and treated, the greater the likelihood of survival. Improving survival rates to match the best in Europe could translate to saving the lives of 1,000 Londoners each year.[77] Late diagnosis is a key factor in poorer cancer survival rates in the UK. Most symptomatic patients present first to the GP. Barriers to early diagnosis include:

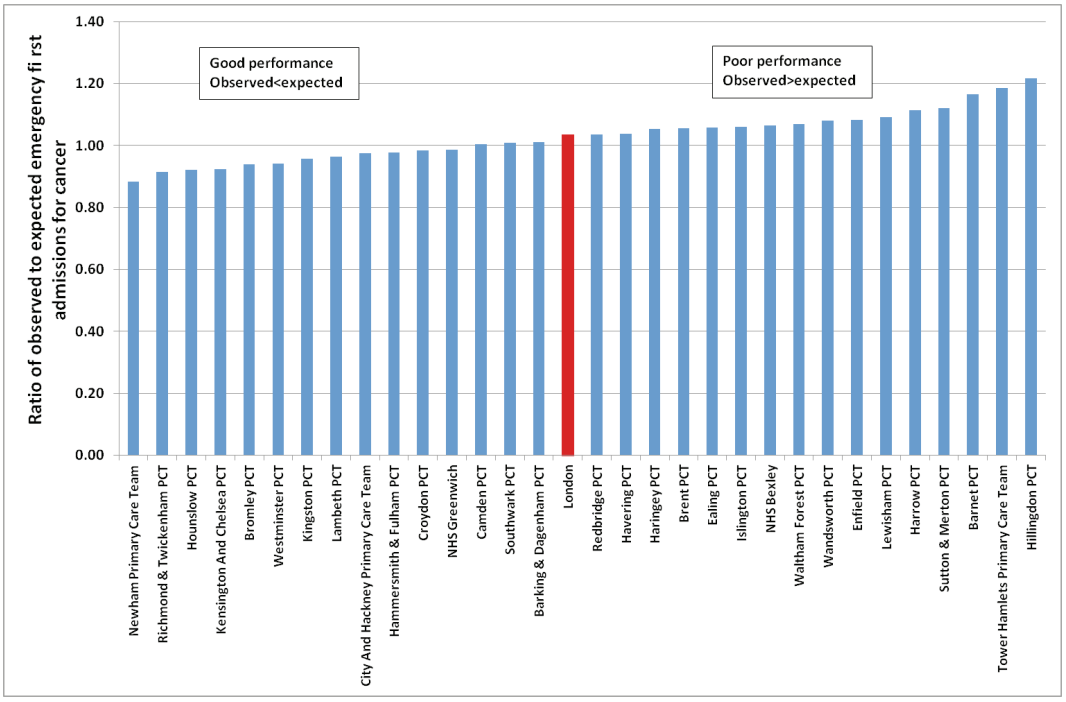
- low uptake of screening (*see* previous section)
- poor recognition of cancer signs and symptoms, and late presentation
- delays in access to primary care
- delays in referral to diagnostics and secondary care (*see* following section on referral).

Delays in diagnosis can be considered in three phases: delay in presenting to the GP, delay between the first consultation and GP referral, and delay between referral and diagnosis. Delay in the second and third phases may relate to the practitioner or the system (eg, in obtaining diagnostic tests).[78]

Data examined by the National Cancer Intelligence Network (NCIN) suggest that, nationally, 25 per cent of cancers are diagnosed via the emergency route. An analysis of patient and practice characteristics associated with first admissions for cancer found that the unplanned (emergency) proportion of cancer admissions ranged from 13.9 per cent (patients aged 15–44 years) to 44.9 per cent (patients aged 85 years and older).[79] Higher QOF performance was protective against unplanned admission, and being less able to offer appointments within 48 hours was associated with a higher risk of unplanned admission. Such analyses can help to identify patient groups susceptible to late diagnosis and suggest the underlying reasons. For example, some types of cancer only present symptoms when in the advanced stage and are more likely to present as an emergency. In some cases, emergency referral is the best way of getting specialist advice and diagnostic tests – for example, in childhood cancers and brain tumours. The findings suggest that primary care can play a lifesaving role by examining this further and learning from case reviews where cancer referral appears to have been delayed.

London has a higher ratio of observed to expected emergency admissions for a first diagnosis of cancer than other regions in England (1.04 versus 1). Having fewer observed admissions than expected (ratio <1) is better. Within London, the ratio of observed to expected emergency admissions for a first diagnosis of cancer ranges from 0.88 in Newham to 1.22 in Hillingdon (*see* Figure 17).

Figure 17: Ratio of observed to expected emergency first admissions for cancer, London PCTs, 2007/8–2009/10



Data source: Original analysis by Imperial College London using data from HES 2007/08 to 2009/10, Index of Multipel Deprivation 2007, ONS rural/urban calssification and QOF

Implications for primary care transformation

Improvements in the identification and recording of risk factors associated with cardiovascular disease suggest that primary care in London has adopted a more systematic approach to prevention. It is important that this approach is implemented for other conditions that may not have had the same attention. The under-diagnosis of some chronic conditions in London means there is unmet need in the population, which is likely to present later, leading to worse outcomes and higher costs. This indicates the need for a more proactive approach to population health that targets high-risk groups to understand the signs and symptoms, encourages them to present early, and makes access easier.

There is some evidence that in London, patients with cancer are more likely than in some other parts of the country to be diagnosed via the emergency route. Earlier diagnosis and prompt referral can improve survival rates for cancer patients. Improvements in this area will need to be based on an understanding of the underlying reasons, as emergency presentation can reflect many factors – eg, late presentation, the need for further training or decision support for GPs, lack of access to diagnostics and specialist support, etc. As commissioners, CCGs will also have a role, together with local authorities, in improving cancer screening rates in London.

Earlier diagnosis of chronic diseases such as diabetes and COPD, and infectious diseases such as tuberculosis, through improved symptom identification and screening, is essential to improve outcomes.

Key points

- Variation in referral rates is to be expected and the appropriateness of referrals is difficult to establish objectively.
- However, there is a threefold variation across London practices in outpatient attendances, which merits further investigation to avoid the risks of both under- and over-use of specialist and secondary care.
- Urgent referral rates for cancer in London PCTs were mostly below the national average, and showed a twofold variation.
- London compares well with the national average in terms of meeting required waiting times for urgent referrals for cancer.
- London has a lower percentage of urgent referrals that result in a diagnosis of cancer (7.6 per cent compared with 9.8 per cent nationally), with some London PCTs having among the lowest rates.
- Taken together, these findings suggest the need to identify and address the reasons for such variations in urgent referrals.

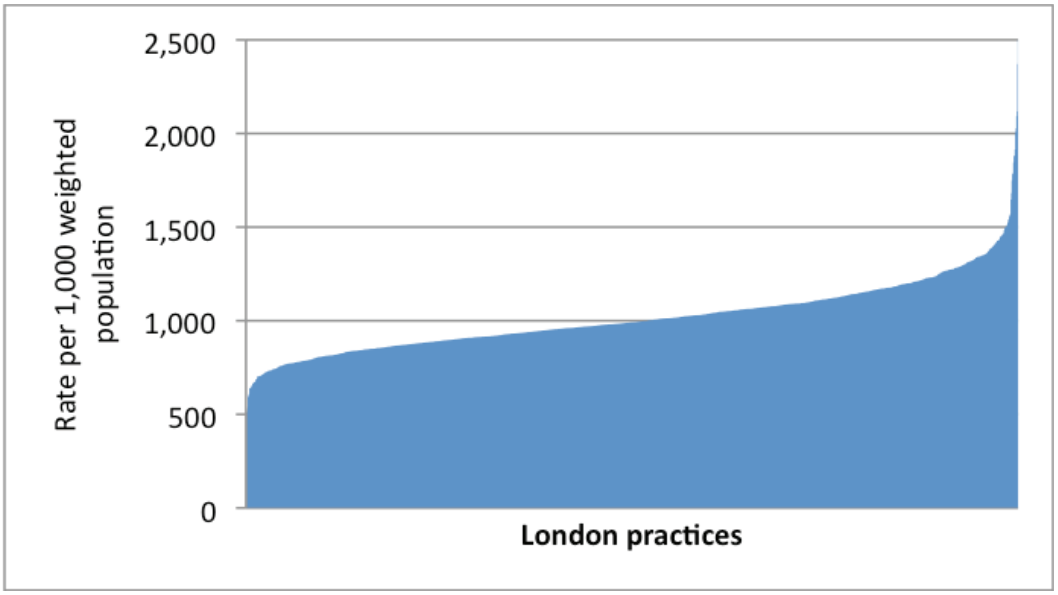
The King's Fund report on the quality of GP diagnosis and referral[80] examined quality across four aspects of referral: necessity, timeliness, destination, and process. Although the majority of GPs refer within recommended timeframes, it suggested that a proportion of referrals made in general practice could be managed in other ways and that there is scope for improvement in identifying the most appropriate destination. In this section, we focus particularly on referrals for cancer, for which there are good data. Other sources of data and methods are needed to assess the process of referral, and whether referral is to the appropriate destination.

Rates of referrals

There is a threefold variation in referral rates for outpatient appointments across GP practices within London (*see* Figure 18). This variation merits further investigation to avoid the risks of both under- and over-use of specialist care.

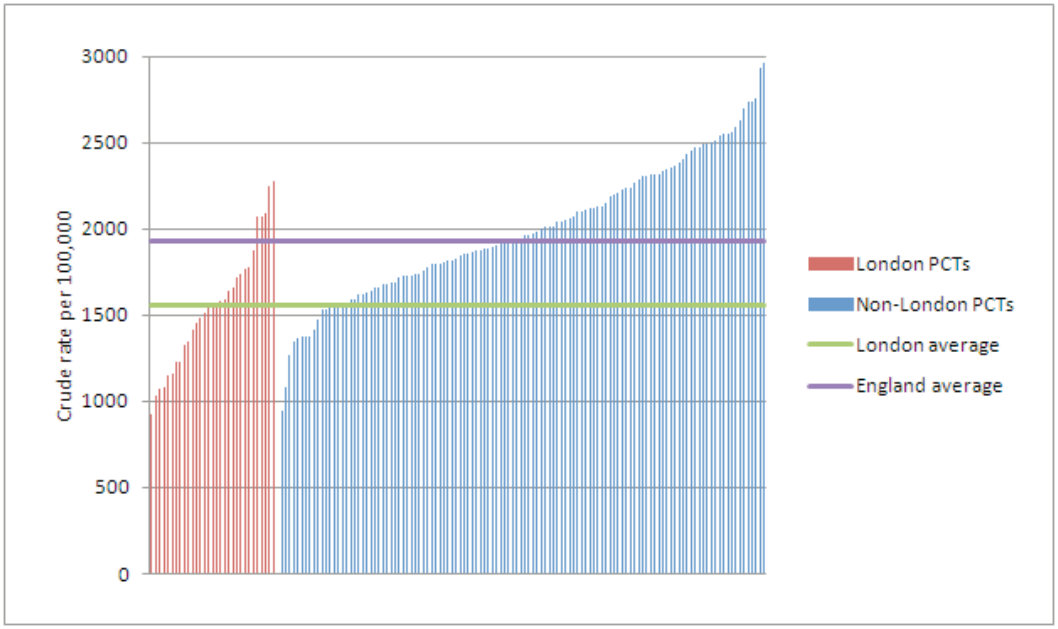
Across England, about 1 million urgent GP referrals are made for suspected cancer each year. On average, a GP will make around 25 urgent referrals a year. The rate of urgent GP referrals for patients with suspected cancer shows a more than twofold variation between PCTs (*see* Figure 19). Most PCTs with high referral rates are known to have higher cancer incidence, because they have a high proportion of elderly residents or high rates for risk factors such as smoking. However, it is unlikely that such wide variations in urgent referral rates can be explained entirely by differences in underlying cancer incidence. Referral rates for London PCTs were mostly below the national average.

Figure 18: Outpatient appointments per 1,000 weighted population, London practices, 2010



Data source: The NHS Information Centre Indicator Portal
https://indicators.ic.nhs.uk/download/Impact%20on%20NHS%20resources/Data/Total_outpatient_appointment_per_1000_population.xls

Figure 19: Urgent GP referral rates for cancer per 100,000 population, England PCTs, 2010/11



Source: NCIN, 'Urgent GP referral rates for suspected cancer', www.ncin.org.uk/publications/data_briefings/gp_referral_rates.aspx

Timeliness of referrals

Reducing waiting times is a key part of the strategy for achieving earlier diagnosis and improved cancer survival in England. Achievement of waiting time targets in 2010/11 was high overall, but shows some variations.[81] The percentage of patients attending an outpatient's appointment within two

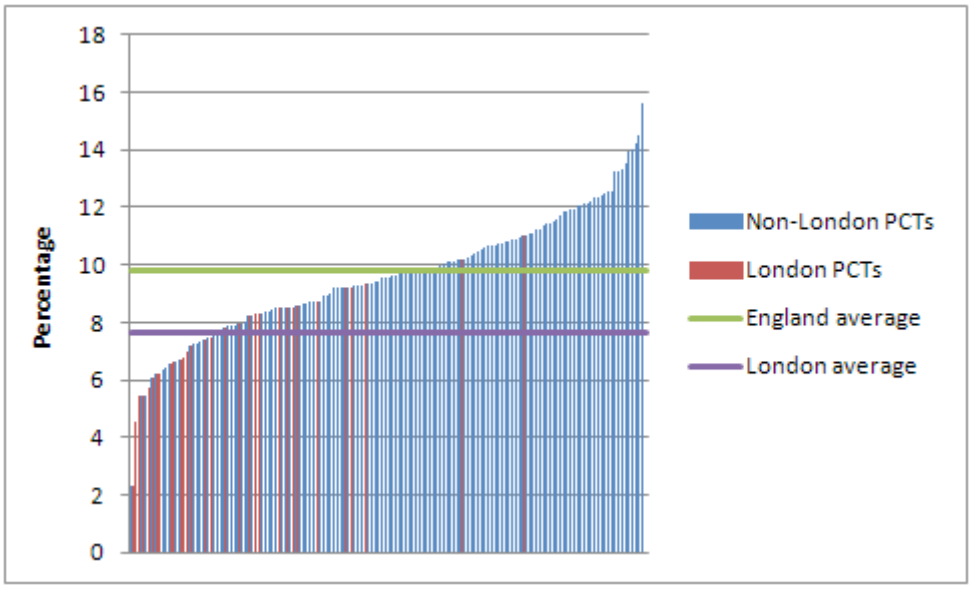
weeks of urgent referral by their GP was 95.5 per cent in England, 96.6 per cent in London, and ranged between 94.3 per cent and 99.8 per cent in London PCTs.

Appropriateness

The proportion of patients referred who are diagnosed with cancer also varies widely (*see* Figure 20). It has previously been shown that, compared with the national level, London has a lower percentage of urgent referrals that result in a diagnosis of cancer.[82] Recent data show that the percentage of two-week wait referrals with a cancer diagnosis was 7.6 per cent in London, compared with 9.8 per cent nationally, and that London PCTs had some of the lowest rates (Figure 20).[83] Many factors influence referral and diagnosis rates, and there are no 'right' thresholds. Persistent variations should be investigated, for example, by reviewing the implementation of NICE referral guidelines in primary care or undertaking audits with local secondary care teams of the appropriateness of referrals.

The proportion of newly diagnosed cancers that do not arise through the two-week referral route is somewhat higher in London (55.7 per cent compared with 54.1 per cent nationally) than other regions of England (which range from 52.7 per cent to 54.8 per cent, with the exception of Yorkshire and the Humber, which is on a par with London).

Figure 20: Percentage of two-week wait referrals with cancer diagnosis, England PCTs, Q4 2011/12



Source: NCIN, 'Primary Care Trust (PCT) Profiles', www.ncin.org.uk/cancer_information_tools/profiles/pctprofiles.aspx

Implications for primary care transformation

Given that the appropriateness of referrals is difficult to establish objectively, some variation in referral rates is to be expected. However, the magnitude of variation suggests the need for further investigation. There is a need for discussion between GPs and practices to establish what explains the

variation, whether such differences are justified, and what (if any) action should be taken to reduce the level of variation. Timeliness of referral is also critical for some conditions, and should be monitored.

Cancer data suggest that the sensitivity of urgent referrals in London is lower than in other areas, as the proportion of people referred who are then diagnosed with cancer is lower. These data are difficult to interpret as these levels may be appropriate if GPs are referring urgently to ensure that patients with suspected cancer are rapidly given a diagnosis. On the other hand, over-referring patients with suspected cancer can cause unnecessary anxiety for patients and their families. Together with data which suggest that more patients in London than in other areas who have not been urgently referred by their GP are receiving a cancer diagnosis, this suggests that more attention needs to be paid to the ability of GPs to identify and appropriately refer patients who they suspect have cancer.

Prescribing

Key points

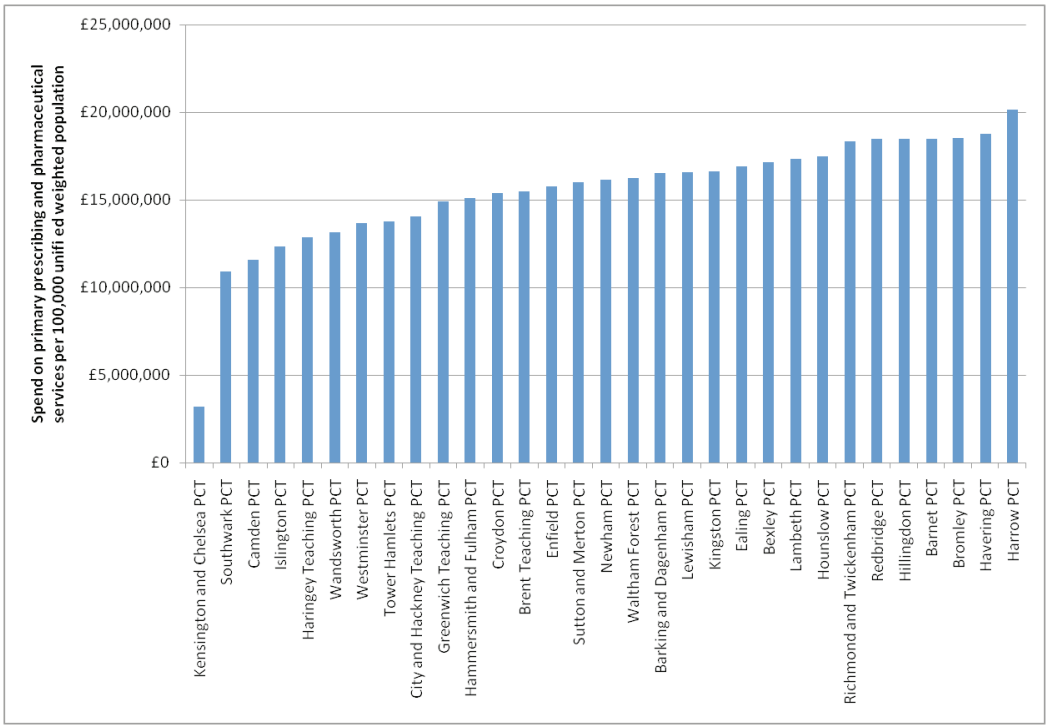
- Variations in prescribing patterns suggest the need for investigation to ensure that prescribing is in line with best practice.
- Several London PCTs are in the highest quintile for prescribing non-insulin anti-diabetic drugs cost per patient on GP diabetes registers. Nationally, there is no correlation between PCT spending on insulin and non-insulin anti-diabetic drugs and the percentage of people with diabetes with controlled blood sugar.
- London spends less on primary prescribing and pharmaceutical services than other regions in England; under-diagnosis of chronic diseases such as COPD could be a contributory factor.
- Studies show that there are inequalities in prescribing by age, sex and ethnicity in London.
- There have been improvements in safe and appropriate prescribing of non-steroidal anti-inflammatory drugs in London.
- GPs must support appropriate medicines management, particularly for older patients who are taking several prescription medications.

Prescribing costs in primary care accounted for 8 per cent of NHS spend in 2011. *The NHS Atlas of Variation in Healthcare* identified variations in prescribing patterns.[84] Anti-diabetic items, including blood-testing items, account for almost 10 per cent of the total spend on prescriptions in primary care in England. For the indicator on non-insulin anti-diabetic drugs cost per patient on GP diabetes registers, several London PCTs were in the highest quintile nationally. The Atlas notes that those PCTs spending most on non-insulin anti-diabetic drugs do not necessarily have the highest proportion of people with diabetes with optimal blood glucose control. It recommends that commissioners and providers should consider whether local prescribing practice is in line with NICE guidance.

Programme budgeting data show that London spends less on primary prescribing and pharmaceutical services per 100,000 unified weighted population than other regions of England, and there is variation within

London (*see* Figure 21). It is not clear what lies behind this relatively low expenditure. Evidence quoted previously suggests that high levels of under-diagnosis of chronic diseases such as COPD in London may be a contributing factor. As prescribing relies on identification of cases of disease, it is a concern that diseases remain undiagnosed and untreated. The reasons for this should be better understood and addressed.

Figure 21: Spend on primary prescribing and pharmaceutical services per 100,000 unified weighted population, London PCTs, 2010/11



Data source: Programme budgeting tools and data http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743

A study in east London showed inequities in prescribing by age, sex and ethnic group for people with coronary heart disease, with fewer drugs being prescribed to women, black/African-Caribbean patients, and older people.[85] Differences in drug prescribing for coronary heart disease have previously been identified by age, sex and ethnic group. A national study found that patient morbidity can explain a large amount of variation in prescribing, both between practices and within practices.[86] Even so, there is evidence of unexplained variations in prescribing patterns. For example, a study of ethnic differences in primary care management of patients with psychosis in an inner London borough found that depot injectable antipsychotics were more likely to be prescribed to black patients than other delivery modes.[87]

Anti-inflammatory drugs are similarly effective, but some are safer than others in some patients. Since 2007/8, London practices have worked to increase the safety of prescribed non-steroidal anti-inflammatory drugs (NSAIDs) by reducing use of diclofenac and cox-2 inhibitors, which are now known to have more side effects than other NSAIDs. This General Practice Outcome Standard indicator measures the percentage of NSAIDs prescribed

that are diclofenac and cox-2 inhibitors. There have been large reductions in London in recent years; the proportion has dropped from 53.2 per cent to 27.4 per cent.

Implications for primary care transformation

As with variations in referrals, variations in prescribing patterns need to be examined to ensure that prescribing is in line with clinical guidelines, is offering value for money, and relates to need. It is also important that GPs consider issues of compliance and ensure that patients who need to take regular medication do so, and that medicines are not wasted because, for example, patients choose to stop taking medication due to side effects. GPs must also support appropriate medicines management, particularly for older patients who are taking several prescription medications. They should also, where appropriate, encourage self-care for minor ailments through establishing partnerships with local pharmacists.

Acute, emergency and urgent care

Key points

- London has the highest accident and emergency (A&E) attendance rates nationally (340 per 1,000 population compared with 290 nationally), and intra-London variations are large (from 251 to 432 between PCTs).
- London's younger, migrant population and the relative ease of access to A&E services in London may be contributing to these patterns. Some evidence suggests that access to GP services is inversely related to the use of A&E services.
- London's 28-day hospital emergency readmission rate is similar to the national average (11.9 per cent compared with 11.6 per cent), but there is significant intra-London variation between PCTs (from 9.3 per cent to 13.8 per cent).
- London PCTs have higher rates of bed days for people over 65, with 7 of the 31 London PCTs being among the 10 PCTs with the highest rates nationally; the rate varied from 2.1 bed days per person to 3.4 between London PCTs.
- Closer co-ordination of care between primary, community, secondary and social care services could reduce the need for emergency readmission and lengths of hospital stays among older people.
- Overall, about 70 per cent of patients nationally are satisfied with out-of-hours GP services compared with 63 per cent in London.

Accessible, timely, high-quality and well-co-ordinated primary and community care can help to reduce the use of emergency care services. In this section, we examine accident and emergency (A&E) attendances, emergency hospital admissions and readmissions, and GP out-of-hours services. We also reflect on the quality of general practice in supporting wider strategies to deal with emergency and urgent care needs.

Accident and emergency attendances

The A&E attendance data for 2009/10* show that:

- A&E attendances in London (340 per 1,000 population) are significantly higher than the national average (290)
- about half of London PCTs (16 out of 31) have a higher rate than the national average
- the highest rates are in Greenwich (402 per 1,000), City and Hackney (415), Haringey (423) and Enfield (432)
- the lowest rates are in Havering (251), Harrow (253) and Richmond and Twickenham (257)
- broadly excluding outliers, there is threefold variation in A&E attendance rates between practices within London.

The changing demographic profile of London poses particular challenges for managing demand for urgent care. A survey of patients at an A&E/walk-in centre at an inner-city London hospital during a one-month period found that, of the 3,262 patients who completed the survey, 45 per cent were overseas-born, representing 87 nationalities, of whom 74 per cent were relatively new migrants to the UK.[88] Australians, New Zealanders, South Africans and the 'Other Migrant' group, comprising mainly Europeans, were less likely to have GP registration and to have made prior contact with GPs.

Another study aimed to explore factors influencing registration of new UK entrants with GPs. Only 32.5 per cent of new entrants were registered.[89] Compared with those from Europe, people from the Americas and Africa were less likely to register with a GP, as were students, long-stay visitors and asylum-seekers. Migrant groups with the lowest proportions registered are likely to be those with the highest health care needs. Recently arriving migrants are a diverse group, of whom refugees and asylum-seekers comprise only a minority. Service reorganisation to ensure improved access to community-based GPs may reduce the use of acute services among new migrants.

Emergency admissions and readmissions

Emergency hospital admission rates in 2009/10 for acute conditions generally managed in primary care – that is, ear, nose and throat infections, kidney/urinary tract infections and heart failure – show that:

- London's rate is lower than the national average (371 and 457 per 100,000 population respectively)

*There are two main sources of A&E and out-of-hours (OOH) services attendance data: the person-specific A&E attendance minimum dataset submitted by A&E Departments to Hospital Episode Statistics (HES), and the Quarterly Monitoring of Accident and Emergency (QMAE) tables of aggregate attendance data submitted by all NHS-funded A&E, OOH and walk-in providers to the Department of Health. Because QMAE data are aggregate, it is not possible to determine who the commissioner is of the attendances, or who initiated the attendance. A&E MDS data contains much more information, but submission of the data by provider trusts has been very incomplete until recently. Data used here are from HES A&E.

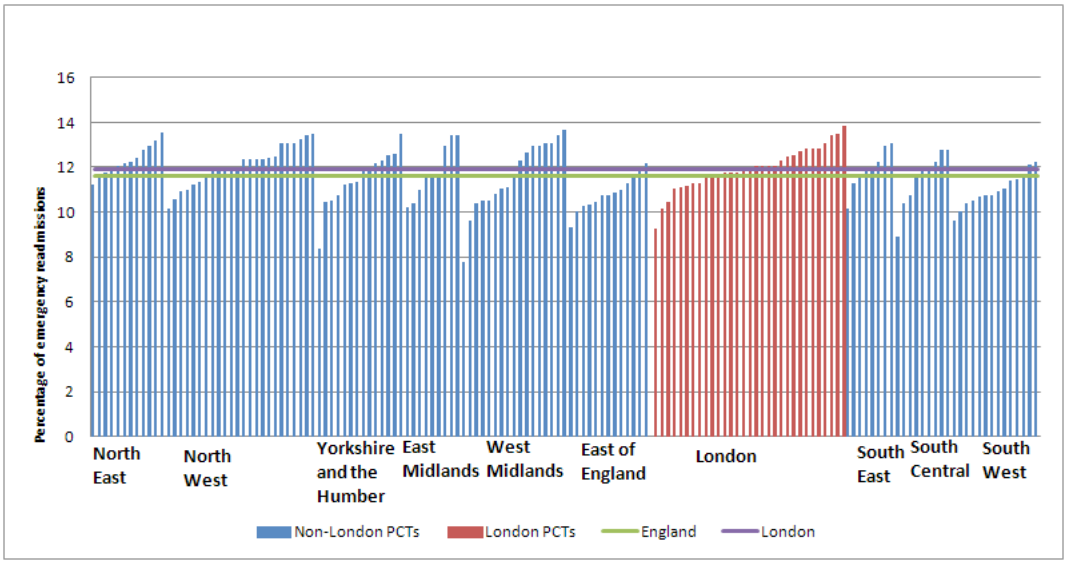
- the lowest rates are clustered in inner north east London (eg, City and Hackney, Tower Hamlets, and Newham) and the highest rates are clustered in north west London (eg, Ealing, Brent and Hillingdon)
- Inner London has a lower rate (338 per 100,000) than Outer London (389).

The percentage of hospital admissions in 2010/11 that were emergencies showed inequalities between ethnic groups, with Asian and black groups having higher than average emergency admission rates, while the Chinese and Mixed groups had lower rates.[90] High emergency admission rates may indicate that some patients are not accessing or receiving the care most suited to managing their conditions.

Emergency readmission within 30 days of discharge from hospital is an indicator in both the NHS Outcomes Framework and in the Commissioning Outcomes Framework (COF) proposed by NICE for assessing CCG performance. This indicator is therefore important for CCGs in their commissioning role, and also for general practice in the context of reducing the risks of readmission by working more closely with community services and social care. Readmissions may be the result of poor treatment in hospital, or poor rehabilitation and support services after discharge from hospital. Although it is difficult to tell how many readmissions are linked to the original treatment, readmissions can be reduced if appropriate local systems are in place. Data on emergency readmission rates within 28 days of discharge from hospital are available for 2009/10 (*see* Figure 22) and show that:

- London's rate (11.9 per cent) is slightly higher than the national average (11.6 per cent)
- there is significant variation within London, ranging from 9.3 per cent in Newham to 13.8 per cent in Barking and Dagenham
- 22 out of 31 London PCTs had higher readmission rates than the national average.

Figure 22: Emergency readmissions to hospital within 28 days of discharge, England PCTs, 2009/10



Data source: The NHS Information Centre Indicator Portal
https://indicators.ic.nhs.uk/download/NCHOD/Data/03N_523ISP4ADP_10_V2_D.xls

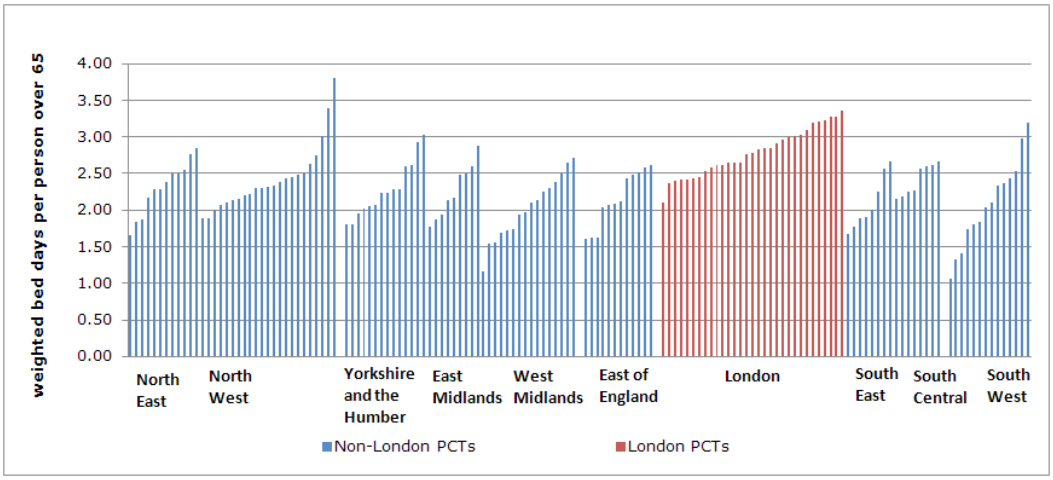
Emergency bed days for people over 65

Older people account for 68 per cent of all emergency bed days in the NHS.[91] London PCTs have higher use of emergency bed days for this age group than the rest of the country (*see* Figure 23)*:

- Seven out of the 31 London PCTs are among the top 10 areas nationally with the highest emergency bed use.
- Within London, emergency bed days varied from 2.1 bed days per person in Harrow to 3.4 bed days in Hounslow.

Although there was no clear link between bed use and access to GP services, PCTs with the highest bed use tended to have excessive lengths of stay for patients for whom hospital was a transition between home and supported living. Areas with lower proportions of older people had higher rates of bed use, which applies to London with its relatively young population. These areas may be less likely to have prioritised the needs of older people and to have developed integrated service models.

Figure 23: Emergency bed days used by over 65s, England PCTs, 2009/10



Data source: Imison *et al*, The King's Fund, 2012.[92]

Out-of-hours services

A detailed survey benchmarking out-of-hours care provided by PCTs shows that case volumes are lower in densely populated areas, and in particular in London compared with other SHAs.[93] This could be due to many factors, including younger populations, availability of alternative emergency services (eg, A&E departments) and an urban environment with easier access. Several London PCTs (eg, Southwark, Lewisham, Lambeth, Wandsworth, and Hounslow) are reported as having the lowest rates of use.

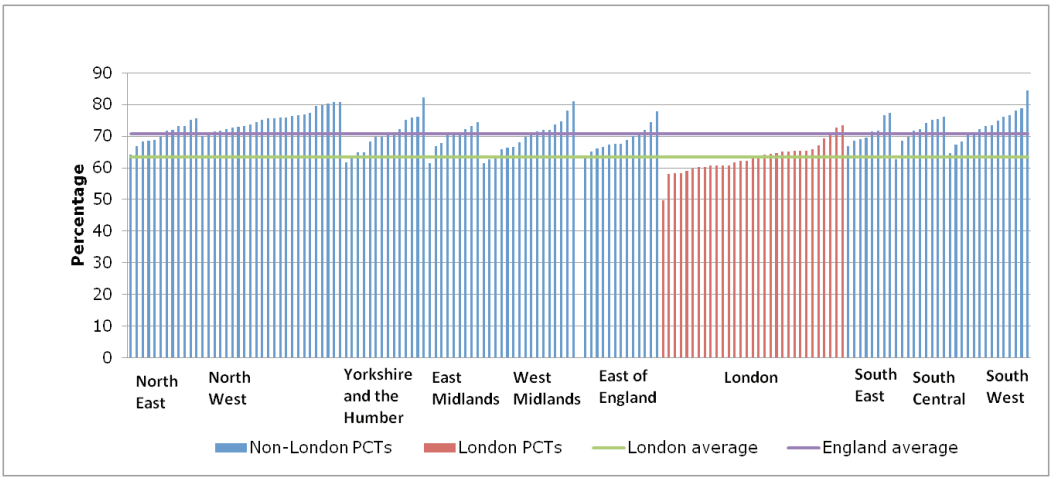
The GP Patient Survey 2012 shows that patients in London are less satisfied with out-of-hours services (*see* Figure 24):

*The rates are needs weighted. The needs weight used was the Hospital and Community Health Services (HCHS) needs index. The HCHS needs index is a component in the resource allocation weighted capitation formula used each year to distribute annual funding to PCTs by the Department of Health.

- 70 per cent found it easy to contact the out-of-hours service by telephone in London compared with 80 per cent in England.
- 54 per cent in London were satisfied with how quickly care was received compared with 63 per cent nationally.
- 63 per cent reported having a good overall experience of the out-of-hours service in London compared with 71 per cent nationally. It varies from 50 per cent in Richmond and Twickenham PCT to 73 per cent in Bexley Care Trust.
- The vast majority of London PCTs performed worse than the national average on all these dimensions.

Overall, these data suggest there is huge room for improvement in the quality of out-of-hours services nationally.

Figure 24: Percentage of patients who described their overall experience of out-of-hours GP services as good, England PCTs, 2012



Data source: GP Patient Survey 2012
www.gp-patient.co.uk/results/

Implications for primary care transformation

There is growing evidence that good access to GP services is inversely related to the use of A&E services.[94] London has higher A&E attendance rates than the rest of the country and lower patient satisfaction with out-of-hours services. London's younger, migrant population and the relative ease of access to A&E services in London may be contributing to these patterns.

Key points

- London has a lower rate of emergency admissions for ambulatory care sensitive conditions than the national average (428 per 100,000 compared with 436 per 100,000 nationally); however, there is fourfold variation between London PCTs (from 223 to 857).
- Rates of emergency hospital admissions in children for chronic conditions such as diabetes, epilepsy and asthma are also lower in London than the England average, although they show a threefold to fivefold variation across London PCTs.
- There is growing evidence that patient-reported good access to general practice is associated with lower emergency admission rates for ambulatory care sensitive conditions.
- Although London's performance on some clinical quality indicators (eg, cholesterol control among patients with coronary heart disease or blood pressure control among stroke patients) is similar to the national average, there are variations of up to 10 per cent within London, with some PCTs covering relatively deprived populations (eg, Tower Hamlets, Newham) outperforming PCTs in more affluent areas. There is also evidence of inequalities based on ethnic groups.
- The National Diabetes Audit found that only 54 per cent of people with diabetes in England received all nine care processes. Among PCTs in London, the range was from 31 per cent to 63 per cent – again, some deprived areas in east London had the highest rates.
- Breast cancer survival rates show no statistically significant differences between London PCTs. For lung cancer, survival rates show a socio-economic gradient, with Westminster and Richmond and Twickenham having higher rates than more deprived parts of London (Hillingdon, Waltham Forest and Redbridge).
- Compared with the England average (29 per cent), London had a higher percentage (35 per cent) of households receiving intensive home care, although there is wide intra-London variation (from 25 per cent to 48 per cent).
- There is potential for exchange and learning across the capital about how to transform services and deliver high-quality care given the unique challenges London faces.

Primary care has a key role to play in preventing illness and premature death through the effective management of people with chronic conditions. As the first and most used point of contact with health care services, general practice is ideally placed to provide the consistent and co-ordinated care that is required.

In this section we look at indicators that reflect opportunities for primary and community care services to work together to enhance care management for these patients, including unplanned hospital admissions for the range of ambulatory care sensitive conditions (ACSCs) and admissions for asthma, diabetes and epilepsy in children. We then focus on four long-term conditions: coronary heart disease (CHD), stroke, cancer and diabetes.

Unplanned hospital admissions for chronic conditions

Ambulatory care sensitive conditions (ACSCs)

ACSCs are widely recognised as being amenable to management in a primary care setting, which may help to reduce emergency hospital admissions. They can be classified as: chronic conditions, where effective care can prevent flare-ups; acute conditions, where early intervention can prevent more serious progression; and preventable conditions, where immunisation and other interventions can prevent illness.[95] Indicators on admissions for acute and chronic ACSCs are included in the NHS Outcomes Framework and in the COF indicators for CCGs proposed by NICE. These indicators are therefore important for general practice in its role as both provider and commissioner.

Relative to elsewhere in the country, London has significantly lower rates of emergency admissions for ACSCs:

- In 2010/11, London's rate was 428.1 per 100,000 population compared with 436.5 in England, with 19 of London's 31 PCTs having a lower rate than the national average.
- However, there was fourfold variation within London (less than in most other SHAs) with, for example, some east London PCTs having significantly lower rates than some west London PCTs, varying from 223 per 100,000 in Greenwich to 857 in Hounslow.

A study of factors associated with potentially avoidable hospital admissions in London found that admission rates for asthma, diabetes, heart failure, hypertension and COPD varied widely across PCTs.[96] There was a significant association between higher admission rates and measures of underlying ill-health and deprivation, but not measures of primary care provision. Provision of specialist chronic disease services in primary care for diabetes and asthma was associated with reduced admission rates. There was no association between prescribing levels and admission rates for any of the conditions examined.

Several studies[97,98,99] and an unpublished report for the NHS Institute for Improvement and Innovation[100] have analysed associations between emergency admissions for 'primary care sensitive conditions' and responses to the GP Patient Survey, specifically the ease of obtaining urgent and advance appointments. They show a fairly consistent protective effect of patient-perceived good access on emergency admission rates. For example, registered and undiagnosed COPD prevalence, smoking prevalence and deprivation were risk factors for admission, while influenza immunisation, patient-reported access to consultations within two days, and primary care staffing were protective.

Asthma, diabetes and epilepsy in children

In terms of managing long-term conditions among children, reducing emergency hospital admissions for asthma, diabetes and epilepsy is included as an indicator in the NHS Outcomes Framework, and in the indicator set proposed by NICE for the COF. Asthma is the most common long-term condition among children, and the UK has among the highest prevalence rates of asthma symptoms among children worldwide. An estimated 1.1 million children are receiving treatment for asthma in the UK and Asthma

UK estimates that 75 per cent of admissions for children with asthma are preventable.[101]

The Royal College of Paediatrics and Child Health[102] estimated that at least 22,947 children aged 0–17 years in England have diabetes. The report highlights the need for PCTs and local authorities to be aware of the need to provide proper support for children in school to manage their condition.

Epilepsy is a common serious neurological disorder affecting 48,000 children under the age of 18.[103] An assessment of current provision for people with epilepsy found that key clinical priorities for providing an effective epilepsy service (as set out in NICE guidelines) were unlikely to be available in many PCTs.[104]

Emergency hospital admissions for asthma, diabetes and epilepsy in under 19-year-olds in London (237 per 100,000 for asthma, 50 per 100,000 for diabetes and 69 per 100,000 for epilepsy in 2008/9) were lower than the England averages (244, 63 and 77 respectively).[105] The PCT-level figures show large intra-London variations:

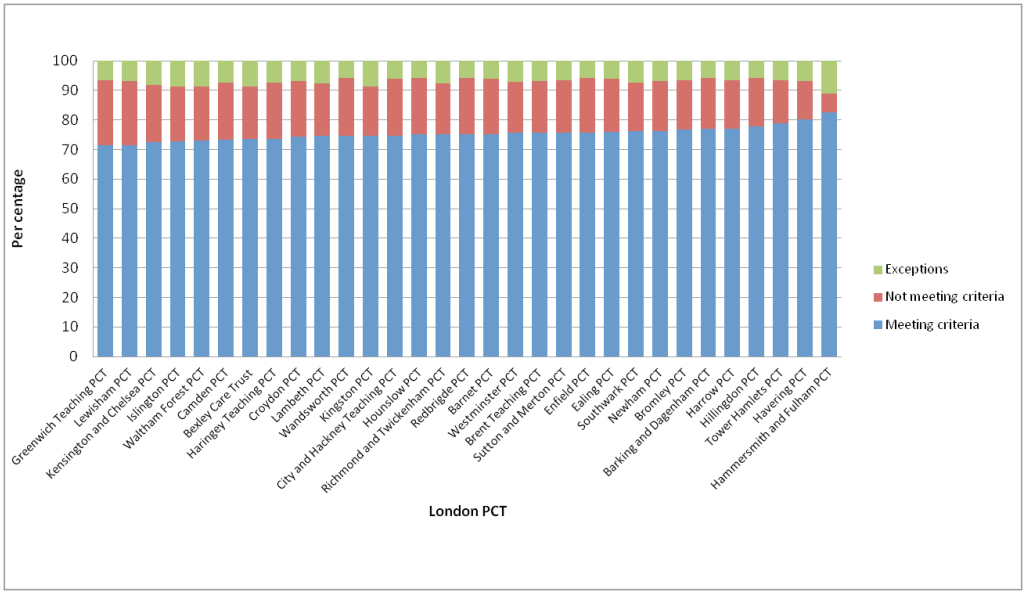
- Asthma: ranged from 107 per 100,000 in Bexley to 433 in Ealing – a fourfold variation, although 19 of London's 31 PCTs had lower rates than the national average.
- Diabetes: ranged from 25 per 100,000 in Westminster to 90 in Hillingdon – more than threefold variation, although 23 of London's 31 PCTs had lower rates than the national average.
- Epilepsy: ranged from 22 per 100,000 in Kensington and Chelsea to 107 in Tower Hamlets – a nearly fivefold variation, although 18 of London's 31 PCTs had lower rates than the national average.

Coronary heart disease (CHD)

Cholesterol control in coronary heart disease (CHD) patients in 2010/11 was somewhat lower in London (80.6 per cent) relative to the national average (82.1 per cent). Variation on this QOF indicator within London PCTs ranged from 76 per cent to 86 per cent, with some PCTs in deprived areas (eg, Tower Hamlets and Newham) performing comparatively better than some PCTs in more affluent areas (eg, Kensington and Chelsea) (*see* Figure 25). London's exception reporting rate (6.9 per cent) is well below the national average (8.7 per cent), but varies significantly from 5.7 per cent in Redbridge, Barking and Dagenham, Enfield, and Hounslow, to more than 8 per cent in more affluent areas such as Kensington and Chelsea and Kingston, to the highest rate of 11 per cent in Hammersmith & Fulham. There is no correlation between achievement rates and exception reporting.

A study examining the association between quality of cardiovascular care and CHD outcomes in 1,531 general practices in London found that, overall, practices with higher QOF scores for CHD had better CHD outcomes in terms of fewer CHD admissions for practices serving deprived populations.[106] There was no association between CHD QOF scores and CHD admissions for practices serving affluent populations, but they observed a similar deprivation-dependent gradient between quality achievement and CHD deaths. The authors concluded that the association between high-quality primary care and improved health outcomes is strongest in deprived areas,

Figure 25: Percentage of patients with CHD whose last measured total cholesterol is 5mmol/1 or less in past 15 months, London PCTs, 2010/11



Data source: QOF 2010/11

suggesting that high-quality primary care may play an important role in reducing health inequalities.

A study of ethnic inequalities based on case records from GP practices in Lambeth of patients with diabetes, coronary heart disease, stroke, hypertension, and chronic kidney disease found that blood pressure monitoring was similar across ethnic groups and as good for black patients as for white.[107] However, marked ethnic inequalities in blood pressure control were found, with black patients significantly less likely to achieve QOF blood pressure control targets than their white counterparts. This may have important implications for cardiovascular risk management in black patients.

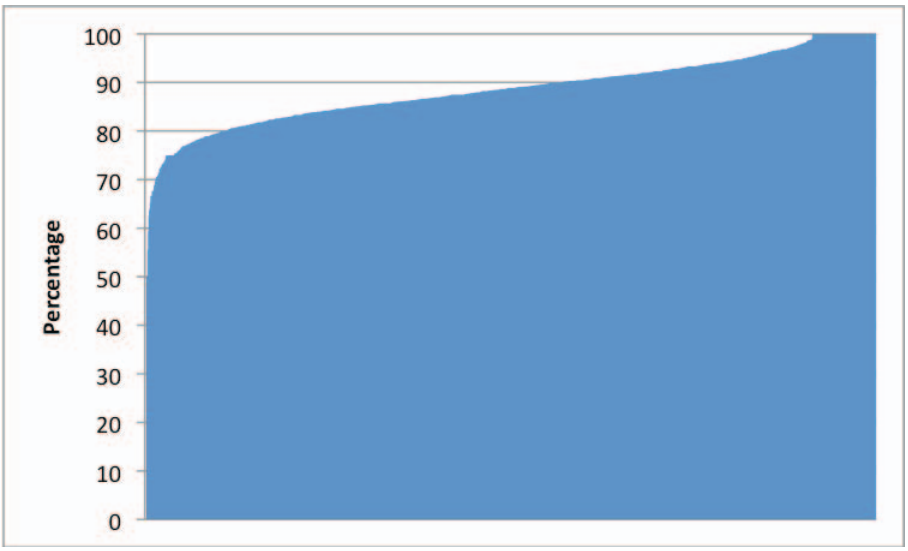
Stroke

Blood pressure control among stroke patients in London (88 per cent) is only marginally lower than the national average (88.6 per cent); however, intra-London variations range from 84.7 per cent to 92.6 per cent between PCTs. As with the QOF CHD cholesterol control indicator, some PCTs in relatively deprived areas of east London (Tower Hamlets and Newham) perform comparatively better than some PCTs in more affluent areas (eg, Bromley and Westminster). There are significant variations between London practices (*see* Figure 26).

Diabetes

General practice plays a key role in the management of diabetes and reducing the risks of secondary complications. The quality of diabetes care has improved significantly in recent years through better recording and ongoing management. QOF data for 2010/11 show that achievement levels nationally were above 90 per cent for almost all of the process measures

Figure 26: Percentage of patients with a history of TIA or stroke whose blood pressure is 150/90 or less in past 15 months, London practices, 2010/11



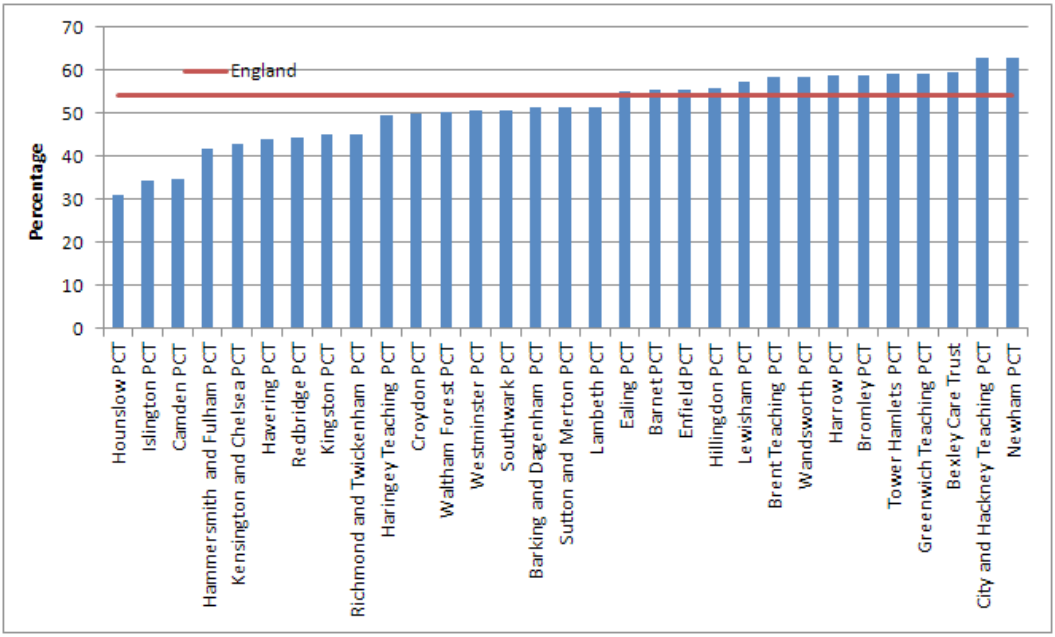
Data source: QOF 2010/11

relating to diabetes. However, QOF measures practice performance on each indicator individually, and not the totality of care received by an individual patient with a particular condition.

The National Diabetes Audit report of 2010/11 covered 83 per cent of practices in England and 88 per cent of the 2.5 million people with diagnosed diabetes reported in QOF 2010/11.[108] All patients with diabetes aged 12 years and over should receive all of the nine care processes recommended by NICE (the core annual review 'bundle'), many of which are included in the QOF. However, the audit found that 54.3 per cent of patients in England received all nine care processes (an increase of 2.9 per cent since 2009/10). The variation between PCTs nationally ranged from 16 per cent to 71 per cent. Performance on this quality marker varied twofold across London PCTs, from 31 per cent to 63 per cent (*see* Figure 27). Some areas of high deprivation (eg, Newham, Tower Hamlets, City and Hackney in east London) had the highest rates.

The National Diabetes Audit also found significant variation in the individual checks. Some, like blood pressure, are done almost invariably while others, like urine microalbumin checks or digital eye photography, are notably less frequent and more variable. Failure to complete all nine care processes and lack of timely care increases the risk of secondary complications and impacts negatively on early treatment to prevent worsening. The report recommended that general practices should review their organisation and recording of annual reviews for people with diabetes to improve the proportion who receive all nine annual checks. This quality marker is also included in the set of indicators for CCGs proposed by NICE for inclusion in the COF from April 2013. The report's recommendations for practices also included improved glucose control and cardiovascular risk reduction in people with diabetes, and that patients with exceptionally high risk should be identified, and plans for addressing their risk drawn up in conjunction with the patient and co-ordinated between primary and secondary care. GPs

Figure 27: Percentage of patients with diabetes receiving all nine care processes recommended by NICE, London PCTs, 2010/11



Data source: National Diabetes Audit Report 2010/11[108]

in England will be able to access their own results via a tool provided by the National Diabetes Information Service from the autumn of 2012.

About 6,000 diabetes-related lower limb amputations occur in England annually, 80 per cent of which are considered avoidable. Variations in timely preventive care contribute to the tenfold variation in amputation rates, ranging from 2 to 22 per 10,000 patients across PCTs,[109] highlighted in Diabetes UK's awareness raising campaign, *Putting Feet First*.

On one QOF measure – retinal screening – London's achievement rate in 2010/11 was slightly below (89.3 per cent) the national average (91.6 per cent), and shows significant intra-London variation (from 80.9 per cent in Newham to 94.3 per cent in Sutton and Merton). The exception rate for London (6.3 per cent) is lower than that for England (7.2 per cent), but also shows significant variation, from less than 5 per cent to more than 30 per cent.

A study of patients with diabetes registered in 23 practices in north west London found that patients excluded from QOF scores may be less likely to achieve treatment goals for HbA1c, blood pressure and cholesterol, and disproportionately come from disadvantaged groups and those with co-morbidities.[110]

A study of ethnic differences in the management and outcome of diabetes in practices in three north west London PCTs found that a smaller proportion of South Asian patients (4.7 per cent) compared with white patients (7.1 per cent) received insulin, although the proportion with a satisfactory HbA1c was smaller (25.6 per cent compared with 37.9 per cent).[111]

A 10-year study of ethnic disparities in diabetes management in 26 practices in north west London found that black patients were less likely to achieve target blood pressure levels than white patients; South Asian patients had better lipid target control and were more likely to receive oral hypoglycaemic

agents, but less likely to receive insulin than white patients.[112] Although ethnic disparities in diabetes management persist in this study population, they are starting to be addressed, and all ethnic groups have benefited from recent quality initiatives in the UK.

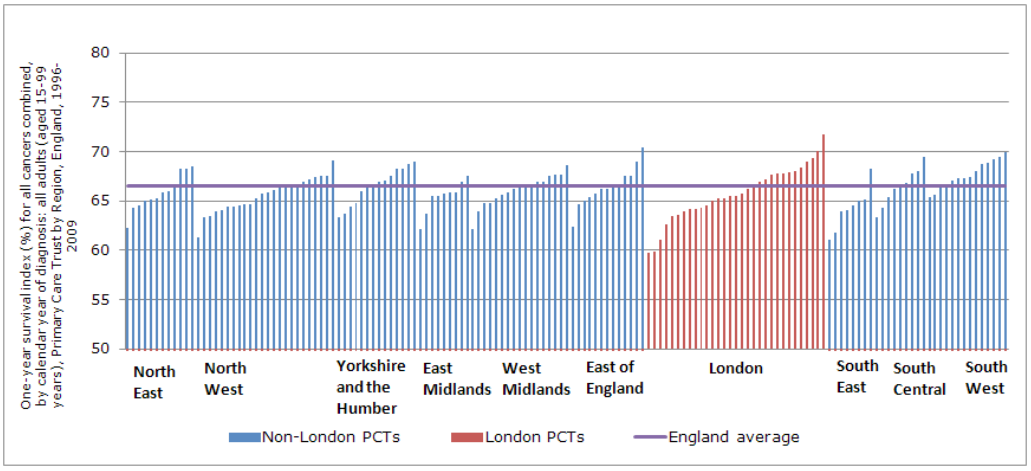
A study of diabetes care in a cohort of ethnically diverse patients in south west London found that the introduction of pay for performance was associated with reductions in blood pressure that were greater than those predicted by the underlying trend in the white, black and South Asian patient groups.[113] Reductions in HbA1c levels were greater than those predicted by the underlying trend for white patients but not for black or South Asian patients. The authors concluded that the introduction of a pay-for-performance incentive in UK primary care was associated with improvements in intermediate outcomes of diabetes care for all ethnic groups. However, the magnitude of improvement appeared to differ between ethnic groups, thus potentially widening existing disparities in care.

Cancer

The UK has worse cancer survival rates than several OECD countries, attributable in the main to later diagnosis and/or differences in treatment, particularly in older patients.[114] Cancer survival rates for lung, breast and colorectal cancer are included in the NHS Outcomes Framework.

The ONS has published estimates of cancer survival at one year after diagnosis for all cancers combined for PCTs in England, for patients diagnosed during 2009 and followed up to end of 2010 (*see* Figure 28).[115] The survival index is adjusted for differences in the profile of cancer patients by age, sex and type of cancer. Wide geographic variations are seen in London, with some PCTs having the highest one-year survival rates nationally and some the lowest rates nationally. Survival rates were lowest in east London PCTs (Barking and Dagenham, Newham, Tower Hamlets, Waltham Forest, City and Hackney, and Haringey) and highest in more affluent areas (Kensington and Chelsea, Richmond and Twickenham).

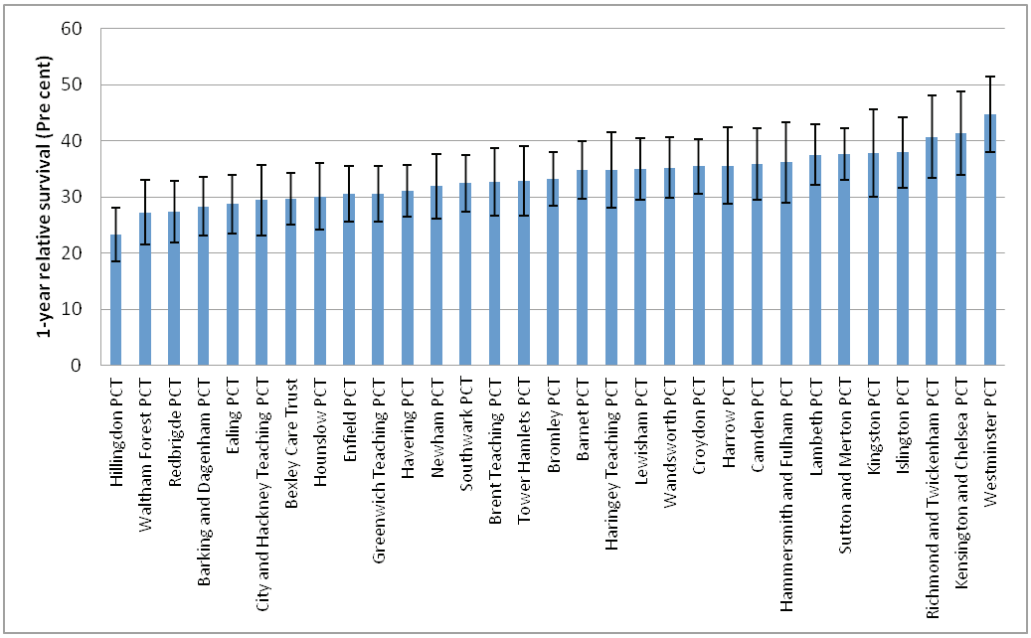
Figure 28: One-year survival for all cancers diagnosed in 2009, England PCTs



Data source: Statistical bulletin: Index of Cancer Survival for Primary Care Trusts in England: Patients diagnosed 1996–2009 and followed up to 2010[115]

One-year relative survival rates for breast and lung cancers diagnosed between 2007 and 2009 are produced by the National Cancer Intelligence Network (NCIN) (NB: relative survival rates compare survival in people with cancer with survival rates in those without cancer). Relative survival rates for breast cancer show no statistically significant differences between PCTs. For lung cancer, the rates show a socio-economic gradient, with Westminster and Richmond and Twickenham having higher rates than more deprived parts of London (Hillingdon, Waltham Forest and Redbridge) (*see* Figure 29).

Figure 29: One-year relative survival for lung cancer, London PCTs, 2007–9



Data source: National Cancer Intelligence Network
www.ncin.org.uk/cancer_information_tools/profiles/pctprofiles.aspx

Care of frail older people

The NHS Outcomes Framework aims to increase the proportion of frail older people who receive support to live at home. Promoting independence and supporting people in their own homes can prevent or postpone a person needing more intensive care packages or residential care, and enable them to go home following hospital treatment. Most people prefer care in their own homes and it comes closest to enabling people to live a normal, independent life. Often, the cost of home care is also less than that of residential care. Figure 30 shows the number of households receiving intensive home help/care as a percentage of all adults and older people in residential and nursing care and households receiving intensive home help/care in 2007/8. It shows that:

- compared with the England average (29 per cent), London had a higher percentage of households receiving intensive home care (35 per cent). Most London local authorities (24 out of 33) had a higher rate than the national average

- the rate varied between 25 per cent (City of London, Harrow and Hillingdon) and 48 per cent (Tower Hamlets) between London councils with responsibility for social services.

Figure 30: Number of households receiving intensive home help/ care as a percentage of all adults and older people in residential and nursing care and households receiving intensive home help/ care, England local authorities, 2007/8

Data source: London Health Observatory
www.lho.org.uk/download.aspx?urlid=9039&urlt=1

Data on people aged 65 or over receiving help at home show that:

- London as a whole was similar to the England average (95 per 1,000)
- the rate varied almost threefold (61–172 in London)
- east and south London councils had lower rates than more affluent areas like Richmond Upon Thames, Kensington and Chelsea, Croydon, and Westminster.

The proportion of a practice's patients that are in nursing homes in London was similar to that elsewhere, ranging from 0 to 5 per cent in London, with the vast majority of practices having 0 or 1 per cent.

The implementation of a local enhanced services (LES) for care homes in one London borough reduced hospital referrals, improved continuity of care for care home residents, and enhanced the monitoring of residents for health problems and prescribing systems.[116] The success of these processes appears to rest on the establishment of positive working relationships between GPs and care home professionals.

Implications for primary care transformation

London is doing better than the national average on unplanned hospitalisation for conditions that can effectively be managed in primary care. Intra-London variations show that inner London has lower rates of emergency admissions for chronic acute conditions. These two indicators show a promising picture in London.

The rise in the proportion of the population over 85 years old requires general practice to be integrated with community services and social care to prevent unnecessary and costly hospitalisations or admissions to care homes for frail older people. London has a higher proportion of households receiving intensive care from local authorities, and a similar proportion of older people helped to live at home, compared to the national average. However, for both indicators, the intra-London variation was large.

Mental health and dementia

Key points

- London has a lower suicide rate than the national average.
- The prevalence of mental health problems varies twofold (from 10 per cent to 20 per cent) between the most and least deprived parts of the capital; use of secondary care community mental health services varies fourfold and admission rates for psychotic disorders vary eightfold.
- The admission rate for mental health problems among London's black population is 2.6 times higher than the national average.
- In 2009, a third of GPs in London did not feel they had sufficient training to diagnose and manage dementia. Services are struggling to meet the needs of black and minority ethnic Londoners with dementia.
- Although the London and England averages are similar, there is a 10 per cent variation between London PCTs in the proportion of patients with dementia whose care has been reviewed in the previous 15 months.
- General practice in London is not doing as well as it could in promoting the physical health of those with severe mental health problems. The percentage of patients with psychosis who had a review in the preceding 15 months and were offered preventive advice (91.4 per cent), and the follow-up of patients who did not attend for a review (91.4 per cent), was the lowest of all SHAs (national averages of 92.6 per cent and 94.6 per cent respectively). However, exception reporting rates are lower in London than the England average.
- General practice must play an important role in the diagnosis and treatment of mental health problems, including for patients with long-term conditions, and in promoting the physical health of people with serious mental illness. Educational support for GPs is needed to ensure they are equipped to diagnose and effectively manage people who have dementia and support their families and carers.

London has a significantly lower suicide rate than the England average.[117] However, 24 in every 1,000 working age Londoners in 2009 were on incapacity benefit for mental health problems, 10 per cent higher than in 2000. Between 16 per cent and 18 per cent of adults experience a common mental health problem in a given week, and prevalence of mental health problems varies twofold between the most deprived parts of the capital (20 per cent) and the least deprived areas (10 per cent). The use of secondary care community mental health services varies fourfold across London and the admission rate for psychotic disorders varies eightfold. The admission rate for all mental health problems among London's black population is 2.6 times higher than the national average.

Dementia presents unique challenges for London. London spends an estimated £1 billion on health and social care for people with dementia (2009/10). Commissioning Support for London (CSL) has noted that older people with dementia occupy 20 per cent of acute hospital beds across England, when in fact around 70 per cent of these may be medically fit to be discharged.[118]

A report by the Institute for Public Policy Research (IPPR) on dementia care in London concluded that there is a 'serious deficit in GPs' awareness of dementia, which can result in a failure to diagnose and signpost, in turn risking crisis intervention at a later stage and increased costs in the longer term'.[119] Services for people over 80 with dementia are weak compared with services for people with early onset dementia, and they are struggling to meet the needs of older black and minority ethnic Londoners who have dementia. Just 31 per cent of the capital's GPs believe they have received sufficient basic and post-qualification training to diagnose and manage dementia.[120]

The lack of early diagnosis results in poor-quality care and places a burden on acute services further down the line. Data (2010/11) for the QOF indicator on the proportion of patients diagnosed with dementia whose care has been reviewed in the previous 15 months show that, while the mean for London practices (79.9 per cent) is similar to that for all practices in England (79.2 per cent), there is significant intra-London variation (ranging from 74.5 per cent to 85.8 per cent between PCTs). Overall, performance on this indicator is well below the 90+ per cent achievement scores seen for many other QOF indicators.

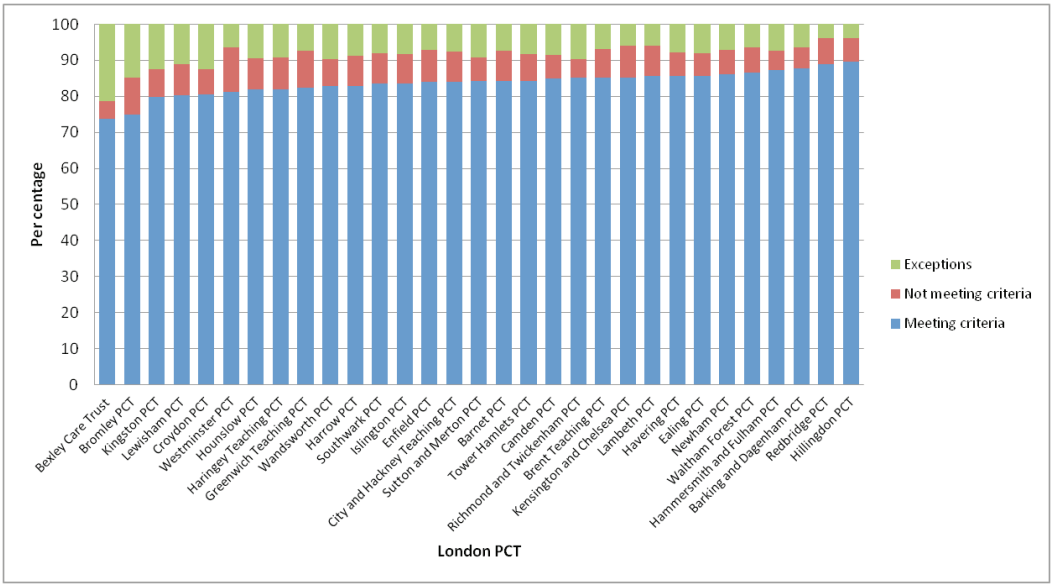
There is overwhelming evidence that people with serious mental illness have a significantly shorter life expectancy than those without such illness. Improving the physical health of such patients is therefore important for reducing inequalities in health outcomes and the associated costs of mental illness. The NHS Outcomes Framework includes an indicator on reducing premature death among people with serious mental illness. Primary care can play a significant role in this, through the provision of health promotion and preventive services. QOF 2011/12 includes six indicators related to the physical health of people with serious mental illness, covering checks for blood pressure, blood sugar, cholesterol, smoking, alcohol, and cervical screening. NICE has proposed an indicator for COF based on people with severe mental illness who have received a list of physical checks.

Meanwhile, QOF 2010/11 includes two indicators as follows:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have had a review in the preceding 15 months in which the patient has been offered health promotion and prevention advice. London's performance (91.4 per cent) was the lowest of all SHAs (range 91.4 per cent to 93.8 per cent), comparing poorly with the average for England (92.6 per cent). There was significant intra-London variation (*see* Figure 31). However, although the exception reporting rate for this indicator showed significant variation across London practices, the overall mean exception rate for London (8.8 per cent) was significantly lower than the average for England (13.8 per cent).

- The percentage of such patients who do not attend for their annual review and who are followed up within 14 days of non-attendance. London's performance on this indicator (91.4 per cent) was also lower than the national average (94.6 per cent), and lowest of all SHAs (range 91.4 per cent to 97.7 per cent). Again, there was significant variation between London PCTs, from 77 per cent to 100 per cent. The overall mean exception rate for London practices (7.2 per cent) was lower than the average for England (7.8 per cent).

Figure 31: Percentage of patients with serious mental illness with advice review recorded in the preceding 15 months, 2010/11



Data source: QOF 2010/11

Implications for primary care transformation

The government has set out its ambition to put mental health on a par with physical health. There is evidence that general practice in London is not doing as well as it could in promoting the physical health of people with severe mental health problems.

General practice also plays an important role in the diagnosis and treatment of mental health in people with long-term conditions. A report by The King's Fund on long-term conditions and mental health[121] estimated the costs of untreated mental health problems in people with long-term physical health conditions. Care could be improved by better integrating mental health support with primary care and chronic disease management programmes.

The rising prevalence of dementia will put a particular strain on health services in London in future. There is a need for educational support for GPs to ensure that they are equipped to diagnose and effectively manage people who have dementia and support their families and carers. But supporting better diagnosis of dementia will require a multifaceted approach, including access to new diagnostic tests, multi-professional service models, and training and better information for patients and families to recognise the early signs.

End-of-life care

Key points

- London PCTs have relatively low rates for the proportion of all deaths that occur in the usual place of residence.
- Many London PCTs have among the highest rates of deaths that occur in hospital among children aged 0–17 years with life-limiting conditions.
- There is a need for stronger community support services for palliative care in London and more information for GPs about services that are available locally.

Of the nearly 0.5 million deaths annually in England, 40 per cent occur in the usual place of residence (defined as own home or residential care or nursing home), often with the support of health and social care services to enable people to die at home. *The NHS Atlas of Variation in Healthcare* shows that London PCTs have relatively low rates for the proportion of all deaths that occur in the usual place of residence.[122] Preliminary findings of research by the Nuffield Trust show that patients from black and minority ethnic groups are more likely to die in hospital than white patients.[123]

Life-limiting conditions are those for which there is no cure and from which children or young people will die prematurely. Most children with life-limiting conditions and their families express a preference for dying at home. Community support is important for enabling such preferences to be realised. The proportion of all deaths that occur in hospital among children aged 0–17 years with life-limiting conditions varies almost twofold nationally, from 56 per cent to 93 per cent between PCTs. Many London PCTs have among the highest rates for this indicator in the NHS Atlas of Variation in Health Care. Both these indicators suggest the need for stronger community support services for palliative care in London.

A study of London-based GPs' involvement in and attitudes to palliative care found that: 65 per cent were providing palliative care to patients on their list; 72 per cent agreed that palliative care was a central part of their role; and 27 per cent wanted to hand care over to specialists.[124] Many were unaware of out-of-hours district nursing and specialist palliative care services. Larger practice size, more years' experience as a GP, receipt of palliative care education, and current provision of palliative care were associated with agreement that palliative care was central to a GP's role. A minority of GPs in London would rather have no involvement in palliative care. Knowledge of current services for palliative care is generally poor among GPs. The findings highlight potential gaps in services, particularly in small practices. Specialists will need to consider these factors in working with GPs to develop primary palliative care and to enable greater access to specialist palliative care.

Implications for primary care transformation

The fact that people in London are less likely to die at home than people living elsewhere in the country – despite this being most people's preference – suggests the need for stronger community support services for palliative care in London. Encouragingly, the majority of GPs in London believe they have an important role to play in palliative care, but they need more information about available services to be effective in this role.

Summary

There are a number of areas where the quality of care in London is comparatively good. For example, there are lower rates of emergency admission for ambulatory care sensitive conditions, and London meets the required waiting times for urgent referrals for cancer and waits from diagnosis to treatment. Furthermore, on several of the clinical indicators we examined, socio-economically deprived parts of London with ethnically diverse populations – for example, east London – perform comparatively well relative to more affluent areas.

However, the magnitude of geographical variation seen within London on most indicators suggests that there is much more to do to ensure that all Londoners experience high-quality care that is appropriate to their needs. It also points to the potential for exchange and learning across the capital about how to transform services and deliver the best quality of care possible given the unique challenges London faces.

The NHS reforms place a clear responsibility on primary care and general practice to address health inequalities. A review of the impact of the QOF on health inequalities concluded that, overall, differences in performance between practices in deprived and non-deprived areas are narrowing.[125] However, inequalities in primary care persist. Studies of ethnic differences in the quality of primary care also show there are important inequalities in care and outcomes for different ethnic groups. In order to tackle inequalities it is important that ethnicity coding in general practice is complete. This is especially significant in the context of primary care in London, given that black and minority ethnic groups constitute 30 per cent of London's population.

While socio-economic inequalities and the mobility and diversity of London's population present significant challenges for general practice, it is clear that some areas such as inner north east London are addressing these and demonstrating that it is possible, through a more systematic and co-ordinated approach, to improve the quality of care.

5 Patient experience

Patient experience of care is a key dimension of quality alongside patient safety and clinical effectiveness. The previous section focused on the clinical quality of care. In this section we look at how patients experience different aspects of care in general practices in London.

After a general overview of patient experience, we highlight specific aspects, including:

- access to care
- continuity of care
- patient engagement and involvement.

Overall patient experience

Key points

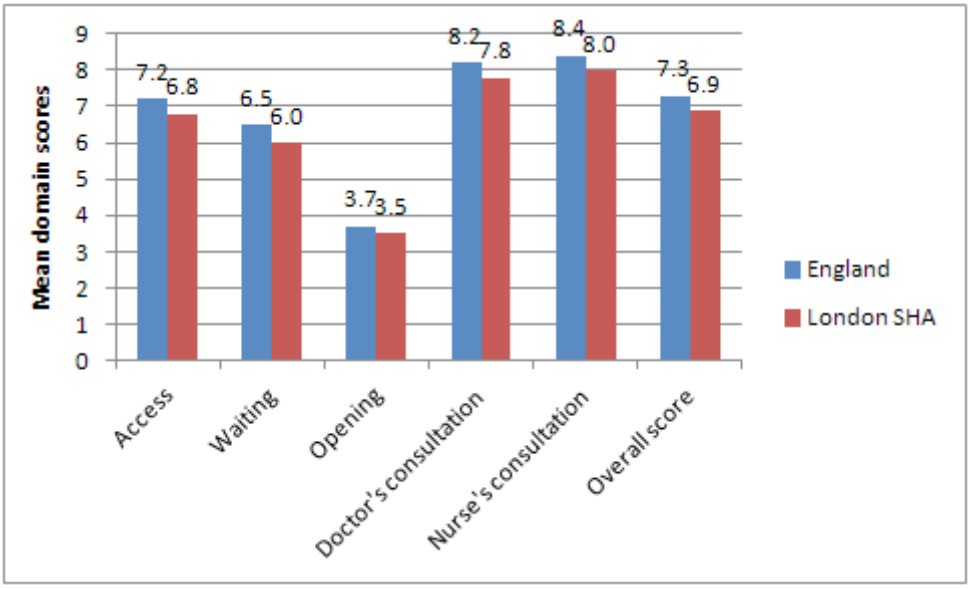
- Londoners consistently rate their overall experience of care at their GP practice less highly than respondents elsewhere, although overall satisfaction levels remain high (80 per cent).
- There is a 'London effect' apparent in all other surveys of users of NHS services, which may reflect the impact of factors other than the quality of care. However, significant intra-London variations in patient experience remain a concern.
- The large variations in patient experience between London practices suggest that practices have much to learn from each other.
- People from black and minority ethnic groups often report a less favourable experience than white respondents across a range of NHS services.

The Picker Institute Europe was commissioned by the Department of Health to derive a set of composite markers to summarise the different aspects of the 2010/11 GP Patient Survey data, and an overall score to represent patient experience. The Institute's data show that patients in London report a less positive experience of using their GP services than the national average across all domains of patient experience (*see* Figure 32). For both London and England overall, patient feedback is most negative in relation to practice opening times.

However, it is important to note that, although patients in London generally respond more negatively to the GP Patient Survey than patients elsewhere, overall, patient satisfaction with the care they receive at their GP surgery is high (80 per cent).

Across all surveys of users of NHS services (inpatients, outpatients, A&E users, etc), respondents in London are less positive about their experience of care than respondents elsewhere in England. These differences may be due to the actual quality of care received or the result of a 'London effect' in terms of how people in the capital respond to such surveys. However, what is

Figure 32: Scores for domains of patient experience, England and London, 2010/11



Data source: Picker Institute Europe

pertinent from a quality improvement perspective is the significant variation in patient experience that is apparent **within** London.*

Analysis of the GP Patient Survey data found that patients from minority ethnic groups evaluate their care more negatively than white patients, even after adjusting for potential confounding factors.[126] The differences could reflect issues such as communication and language, different interpretations of the questionnaire items, differences in beliefs about health, illness and medical care, and previous experiences and expectations. Other research shows that people from black and minority ethnic groups often report a less favourable experience than white respondents across a range of NHS services.[127,128,129,130]

Access

There are many issues involved in determining whether patients feel they have good or poor access to general practice and other primary care services. Research for The King's Fund in 2010, for example, listed 23 possible measures of quality related to access issues.[131] Within these, some themes emerge as important domains of quality, including: access to GP surgeries; speed of access (timeliness), especially to out-of-hours services; and choice (the ability to see a preferred doctor). It is these aspects that we examine here.

An Ipsos MORI survey of more than 7,000 Londoners in 2006 revealed that, despite reductions already achieved, patients prioritise further improvement

*It is important to note that from 2011/12, the GP Patient Survey (GPPS) data are weighted to take account of not just age and sex, but also additional factors including region, deprivation, crime levels, ethnicity, marital status, household over-crowding, household tenure and employment status. Such weighting will improve the accuracy of the results.

in waiting times for operations, appointments, and in A&E departments. The survey found that Londoners gave their GP services a lower net satisfaction rating than people nationally.[132] A 'listening event' conducted by the Department of Health as part of the *Your Health, Your Care, Your Say* consultation reported that people found it difficult to book GP appointments in advance; they could seldom speak to GPs directly by phone and tended to get reactive rather than proactive care. Londoners reported using A&E departments for urgent care because of dissatisfaction with the availability of GP services outside normal working hours.[133]

The GP Patient Survey provides valuable feedback on patients' direct experience of using the services of their surgery. The results from three questions in the 2011/12 GP Patient Survey (relating to satisfaction with opening hours, ease of getting through on the phone, and being able to get an appointment) were aggregated and used to assess patients' satisfaction with accessing primary care. The data show that Londoners are less satisfied with access to primary care (83 per cent) compared with the national average (86 per cent); only five PCTs in London scored higher than the national average. The scores within London varied from 75 per cent in Redbridge to 88 per cent in Kensington and Chelsea.

Of all respondents in London, 78 per cent said they were satisfied with their practice opening hours compared with 81 per cent in England overall. Only 4 of the 31 London PCTs had more positive responses than the national average. The variation within London ranged from 74 per cent in Camden to 83 per cent in Barking and Dagenham.

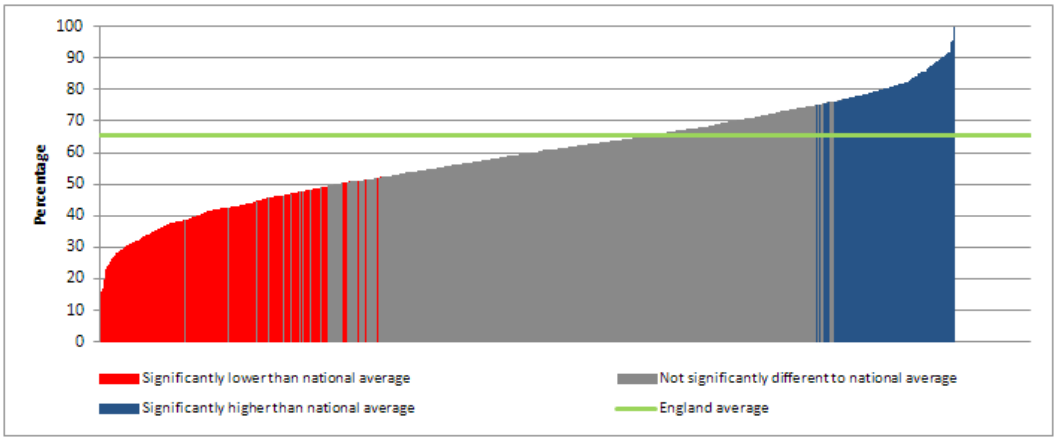
People who are younger, of Asian ethnicity, working full-time, or with long commuting times to work, report the lowest levels of satisfaction and experience of access.[134] Respondents in London are the least satisfied and generally report worse experience in terms of access compared with other regions in England.

Continuity of care

Continuity of care – being able to see the doctor or primary care professional of your choice over time – is highly valued by patients and can bring specific benefits to patients with long-term illnesses where familiarity with a patient's condition and good personal relationships can support better outcomes.[135] However, The King's Fund's independent inquiry into the quality of care in general practice in England noted that it has become harder for GP practices to offer continuity of care; a survey of GP principals recognised that this was probably the highest future priority in improving the quality of the services they provide.[136]

The 2011/12 GP Patient Survey shows that London compares unfavourably with the national average in this respect, with 56 per cent of patients reporting the ability to see their preferred GP always or most of the time compared with 65 per cent nationally. Although for many London practices the results did not reach statistical significance, the large variation between the high and low performers was significant (*see* Figure 33).

Figure 33: Patients who report seeing their preferred GP always or most of the time, London practices, 2011/12



Data source: GP Patient Survey 2011/12
www.gp-patient.co.uk/results/

Patient engagement and involvement

Key points

- Satisfaction levels remain high across most London practices but there are large variations within London. Londoners are somewhat less satisfied with the quality of consultations with their GPs compared with the England average (84 per cent and 88 per cent respectively).
- Similar patterns are apparent for patient feedback about the quality of consultations with practice nurses.
- London has lower proportions of patients reporting that they have an agreed care plan to manage their condition than elsewhere in the country.
- All London PCTs (54 per cent average) were below the national average (64 per cent) on the proportion of patients with a long-term health condition who felt supported by local services to manage their condition. There were also significant variations across practices.
- However, there was relatively little difference between London and the England average in the proportion of people with long-term conditions who felt confident about managing their own health (91 per cent and 93 per cent respectively).

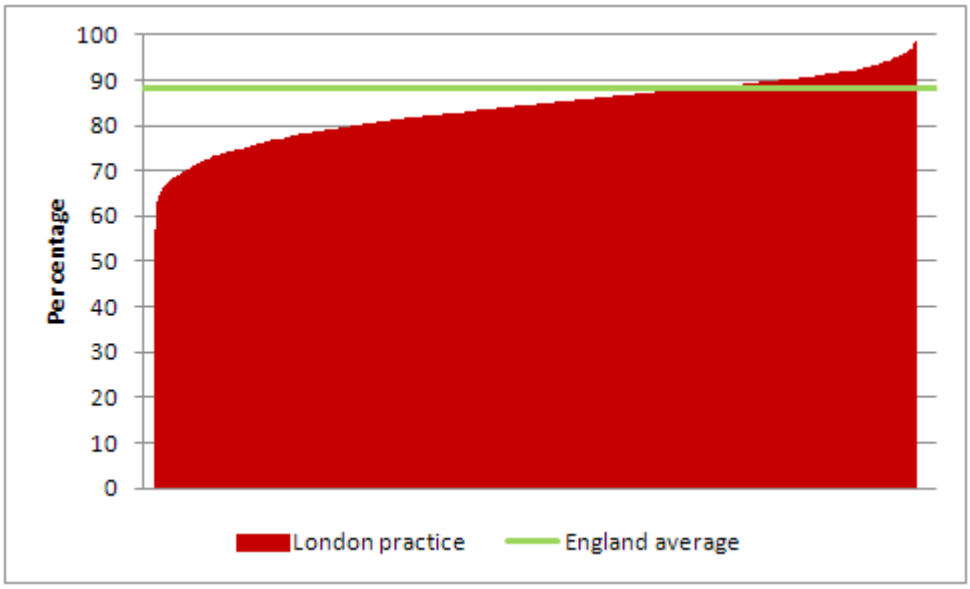
A study in south London found that GPs' perceptions of their patients' desire to be involved in decisions about medicines are often inaccurate.[137] Doctors underestimate patients' preferred level of involvement, and are more likely to do so when patients have not been consulted about their condition before.

The 2011/12 GP Patient Survey includes six questions that reflect on the quality of patients' consultations with GPs and practice nurses: getting enough time; being listened to; having tests and treatments explained; being involved in decisions about care; being treated with care and concern; and having confidence and trust in the GP/nurse. The responses to these questions were aggregated to derive a measure of the quality of the

consultation with the GP/practice nurse. The results for London practices (*see* Figure 34) show that:

- 84 per cent of Londoners were satisfied with the quality of the consultation with their GP, compared with the national average of 88 per cent, but there were large intra-London variations between practices
- similar patterns were apparent for nurse consultations: 87 per cent of Londoners were satisfied with the quality of the consultation with their practice nurses, compared with 91 per cent in England; again, large intra-London variations were apparent.

Figure 34: Patient satisfaction with the quality of consultation with the GP, London practices, 2011/12



Data source: General Practice Outcome Standards www.gppracticeoutcomes.london.nhs.uk/

People with long-term chronic conditions benefit from involvement in planning their own care, and agreeing a care plan can be a useful way to facilitate this. This is especially important for those who require care inputs from multiple agencies, often at infrequent or unpredictable times. Two-thirds of respondents in England to the GP Patient Survey (January to March 2011) reported having an agreed care plan to manage their condition, of whom 96 per cent reported an improvement in their care. This varies between 77 per cent and 86 per cent across the country, with London PCTs having a lower proportion of people with chronic conditions reporting that they have an agreed care plan to manage their condition than elsewhere in the country.[138]

Of all respondents to the 2011/12 GP Patient Survey with a long-standing health condition, only 54 per cent of patients in London felt they had received enough support from local services in the past six months to help them manage their condition, compared with 64 per cent of patients nationally. All London PCTs were below the national average and there were significant variations across practices. This could reflect variation in access to and

availability of support services and/or a lack of awareness of these services among GPs. Having said that, there was relatively little difference between London and the rest of England in the numbers of people who felt confident about managing their own health (91 per cent and 93 per cent respectively).

Summary

The evidence presented here suggests that more could be done to improve the experience of care in general practice in London. Variations across London are evident on all dimensions of patient experience.

While people's preferences in terms of access to care vary, it is clear that patients in London find it more difficult to access care than patients in other parts of the country. Access is not only about convenience; barriers to access may result in people delaying presentation of symptoms for serious conditions, with consequences for outcomes.

Continuity of care is also important, particularly for patients with chronic conditions. Londoners find it more difficult than patients in other parts of the country to see their preferred GP. There is also large variation between practices within London on these dimensions of patient experience, which suggests that practices have much to learn from each other. It is vital that practices that are enabling their patients to get timely and convenient access to care as well as a degree of relationship continuity (if not with an individual GP then at least with a care team) share their experiences with practices that are struggling to do so.

6 The future of general practice in London

General practice in London already faces enormous challenges: a rapidly growing, young, mobile and highly diverse population with extremes in socio-economic status. These trends are set to continue as the population of London continues to grow and becomes ever more diverse. While the population in London is generally younger than other parts of the country, London is not immune from the challenges of rising multi-morbidity and dementia. These demographic changes – along with the tighter financial context, changes in resource allocation, and cuts in local authority budgets and social services – mean there is a risk that the quality of care will deteriorate and inequalities widen if general practice in London does not adapt quickly to address these challenges.

We acknowledge the considerable challenges faced by London primary care staff in their day-to-day work and the significant improvements in quality of care provided by general practice to Londoners over the past decade. However, the pace and scale of these improvements needs to accelerate if general practice is to rise to the challenges of the future. General practice in London is characterised by smaller practices than elsewhere, often working out of older, cramped facilities. The GP workforce is older in London than elsewhere in England, with over a quarter of GPs aged over 60 years in some areas. The ratio of practice staff to GPs is lower than in the rest of the country. If general practice in London is to deliver high-quality care to all Londoners, changes need to be made. Clinical commissioning groups (CCGs) and GPs across the capital must take the lead to drive this change in order to improve the health and wellbeing of Londoners, which will include working more effectively with other parts of the health and social care system to do 'more with less'.

This report, like others that have gone before, has highlighted the huge variations that persist in both the availability and quality of care experienced by patients across London. The improvements and innovations seen in some general practices need to be spread more rapidly, and commissioners of primary care will need to have robust systems in place to tackle unacceptable standards of care.

In this section we set out some ideas about how general practice in London needs to change and some of the practical things that will support a new model of general practice. This will require changes to the workforce and intelligent use of data, information systems and IT to support change and improvement. It will also require primary care to think differently about the facilities and estates it owns, tapping into the wider assets available in local communities. It is not the intention to provide specific solutions to the problems faced or strategies to deal with them, or to make any specific judgements on how incremental or radical the process must be, as this will be the subject of future work being led by London's Primary Care Transformation Team.

How does general practice in London need to change?

In 2011, The King's Fund published the results of its investigation into the quality of care in general practice, and set out a number of ways in which

general practice needed to adapt to meet current and future challenges. In the context of general practice in London, we return to these core themes here:

- changing the skill-mix
- sharing care with hospital and community services
- partnership with patients
- meeting the health needs of the wider population.

Changing the skill-mix

The growing range and complexity of health needs that are seen and can be managed in the community means that GPs must be supported by a wider range of health (and social) care professionals. GPs need to work with physician assistants, health visitors, district nurses, social workers, physiotherapists, and counsellors. Across London, GP practices are smaller on average than in the rest of England, with well over half having only one or two GPs, and they have fewer practice staff. While small practices can and do provide high-quality care, it is more difficult for them to afford or accommodate a wider range of staff and services on site. By working in federations or formal networks of practices, it is easier for practices to invest in shared services, which can then be accessed by a wider group of patients.

The ability of primary care professionals to effectively co-ordinate care for patients during the course of their treatment and through the management of their long-term illness is an essential feature of good primary care. However, there is growing evidence that care is often poorly co-ordinated, particularly for people with multiple chronic conditions. As Mercer *et al* (2012) concluded, in the context of Glasgow, the work of generalists needs to be supported by a wider care team that can promote continuity and co-ordination of care to provide a more personal approach for people with co-morbidity.[139] This appears to be especially important in deprived areas and areas with ethnically diverse populations, providing lessons for certain parts of London.

While there is good evidence that practice nurses can effectively support patients with (single) chronic conditions to achieve good outcomes, patients with multi-morbidity and complex health needs are likely to require more time with experienced GPs.[140] There are examples from both the UK and abroad where changes in scheduling and use of email and telephone has freed up senior doctors' time, allowing them to have longer consultations with patients with complex needs. This is likely to be time well spent, if the agreed care plan then enables others in the wider care team, the patient and their carers to manage things more effectively without repeat visits to the GP.

It is also vital that experienced GPs are available to see and diagnose people who present with undifferentiated symptoms. New career paths and ways of working within and between practices are needed to ensure that newly qualified GPs are supported in their decision-making. Peer review of referrals and other internal processes can be used as developmental and learning opportunities. Innovations in skill-mix, professional roles and ways of working need to be evaluated to ensure that they are cost-effective.

The increasing complexity of care, rapid changes in medical technologies, and exponential growth in evidence potentially mean that generalists will need better access to diagnostic tests and more input from specialists. General practice needs to access specialist advice either from GP colleagues with specialist interests or directly from consultants. Quick and easy access to such advice can reduce the need for referral and ensure that GPs are supported wherever possible to see and treat. Communication technologies need to be used to enable this.

Sharing care with hospital and community services

A study of morbidity in Scottish general practice found that 42 per cent of all patients had one or more morbidities, 23 per cent had multi-morbidities (ie, two or more disorders), and that the prevalence of mental health disorders increased as the number of physical morbidities increased.[141] The impact of multi-morbidity is profound, leading to a markedly poorer quality of life, poorer clinical outcomes and longer hospital stays; and this is the most costly group of patients the NHS has to care for.[142]

The Department of Health estimates that the number of people with multiple long-term conditions is set to rise to 2.9 million in 2018 from 1.9 million in 2008. The additional cost to the NHS and social care is likely to be £5 billion in 2018.[143] Although the prevalence of multi-morbidity increases with age, the absolute number of people with multi-morbidity is higher at ages under 65 years.[144] Mental health disorders are more prevalent in people with increasing numbers of physical disorders and the onset of multi-morbidity occurs 10–15 years earlier in people from the most deprived areas. These epidemiological trends highlight the increasing inadequacy of single-disease approaches to the management of people with long-term conditions.

It is no longer enough to perform well on QOF indicators; an annual check of patients with a chronic disease is inadequate, especially when it takes no account of **all** dimensions of care for a patient with a specific condition, or of co-morbidities. Care needs to be more frequent and intensive for higher-risk patients and more reliably delivered so that patients receive all elements of recommended care.

For people with multi-morbidity, frail older people and those at the end of life, general practice has a pivotal role to play in co-ordinating care across care providers and settings, and helping patients, users and their carers to navigate the health and social care system. The Mandate for the NHS Commissioning Board stresses the importance of integrated care for these patients, and measures are being developed for inclusion in the NHS Outcomes Framework in future.

More formal partnerships with community service providers could be developed to ensure more proactive care for people to prevent admission and ensure timely discharge back home. It may also be desirable to develop new forms of integrated care partnerships to draw in, as appropriate, home-based services, community providers, social care staff, the voluntary sector, and local hospitals to collaborative agreements that help integrate care around the needs of patients. Developments in information technology are increasingly permitting secure sharing of patients' medical records between practices, with secondary care colleagues, and in some places with social

care, in order to facilitate seamless management of patients across different settings.

Change will also require more sophisticated decision support and feedback than is currently available in practices. Risk stratification of patients, together with a case-load approach where a named GP takes responsibility for a group of patients, could facilitate GPs to act more effectively as co-ordinators. GPs need to be given as near to real-time data as possible on a patient's status so they can ensure that gaps in care (such as unfilled prescriptions) are addressed, any deterioration in the patient is responded to in a timely way, and, where possible, that the patient is stabilised and able to stay at home. The identification of a named GP for residential and nursing homes would also provide similar support to care home staff to prevent emergency admissions to hospital for residents. Joint commissioning between CCGs and local authorities could also improve the care provided to nursing home residents.

The subspecialisation in acute hospitals means that the generalist perspective is often lost and patients feel that no one is in charge of their care.[145] GPs could also play a more active role in co-ordinating care and work with hospital-based generalists to ensure that all of the patient's needs are recognised and met.

Currently there are a range of integration activities going on across London, with the emergence of a number of integrated care hubs.[146] Some have been in operation for many years. For example, virtual wards providing nurse-led case management within the community have been running in Croydon and Wandsworth since 2004 and 2008 respectively.[147] Brent has benefited from an integrated and primary care-based diabetes service since 2004,[148] while Newham has been providing home-based telehealth services to people with a range of long-term conditions since 2008.[149] More recently, the North West London Integrated Care Pilot has established a service to support better care planning and care co-ordination for older people and those with diabetes,[150] while community teams in Lambeth and Southwark are developing proactive care services for older people in their community.[151]

While it is too early to expect positive population health outcomes – such as reduced emergency hospital admission rates – from these pilots, they illustrate how things might change in future. Ideally, general practice, working closely with its partners, should take on accountability for the quality of care and treatment of its patients regardless of where in the system they are receiving care and treatment.

Partnership with patients

Although overall satisfaction levels with general practice in London are high, there is clear evidence from patient surveys to suggest that Londoners rate their relationships with GPs and experience of general practice lower than people in other parts of England do. Moreover, there is significant variation within London, and many patients want greater patient engagement and involvement in their care.

Evidence suggests that more time is required for professionals to work with patients, especially in multi-ethnic settings, to develop trust and to build in shared decision-making that supports people to self-care. Indeed, improving continuity of care within general practice has been argued to be more

important in determining outcomes than establishing more intricate systems of integrated care delivery.[152]

In London, fewer patients with long-term health conditions feel supported by local services to manage their condition, suggesting the need for general practice to work with others to increase the availability of self-management support for patients with long-term conditions. Clinicians need to actively engage in shared decision-making, and support patients and their carers to self-care and self-manage (supported where appropriate by self-monitoring devices and telehealth). Structured support for carers is also important. Primary care should be the gateway to education and support for patients and carers.

It is important that practices in London improve access for patients. This does not simply mean longer opening hours and, with it, longer working hours for GPs. Nor is it simply about convenience (though this is important to patients). Delayed access and presentation is a clinical issue and can result in worse outcomes. Patients who need urgent care need to be confident that they will be responded to promptly, whether in or out of office hours. A fundamental redesign of urgent primary care across the capital is needed, which looks at the relationship between general practice, out-of-hours providers, A&E departments, and community-based crisis teams and social services.

Meeting the health needs of the wider population

The evidence summarised in this report shows that there are real and persistent inequalities in health outcomes across London, with an unequal relationship in the availability of primary care services relative to local need. This is a longstanding problem for London that has never adequately been addressed. Any new expansion of facilities and staff needs to be matched to local needs and areas of under-supply.

There are specific issues faced in dealing with transient, ethnically diverse and otherwise hard-to-reach populations, and services must be developed that better meet the needs of these groups. There has been little success in drawing GPs 'beyond their surgery door'.[153] Generally speaking, the current model of care focuses attention on secondary prevention and high-risk individuals, potentially missing the significant opportunities for health promotion and primary prevention.[154,155]

The development of health and wellbeing boards provides an opportunity for GPs and their CCGs in London, jointly with local authorities, to engage more proactively in this agenda and seek new and innovative ways to prevent ill-health and tackle long-term and persistent inequalities. This is likely to require the development of new integrated care partnerships that seek to make specific joint commitments to improving the health of local communities.

Realising this transformation will require major changes in the organisation and delivery of primary care. In the final section, we reflect on some of the things that need to be put in place to enable this transformation.

The foundations for the future of general practice

Effective networks of practices

Evidence tells us that Londoners, as with patients in other parts of England, value the continuity of relationships and local access that comes with small practices. There are some positive things about small-scale businesses. They are often more personal, conveniently located, and part of the local community. But small businesses today are harnessing the potential of new technologies to reach more people, work virtually, involve the consumers in co-design and co-production, derive the benefits of scale by networking with other like-minded businesses, and develop social capital within the local community. General practice needs to do the same.

Effective networks of practices can enable practices to retain their identity and knowledge of the population they serve while also enabling them to deliver the new models of care they would find difficult to provide on their own. These networks would also provide opportunities to spread learning between practices for peer review and professional development, create a stronger basis from which to develop partnerships with others beyond general practice, and provide scale to invest in information technology and data analysis to support different ways of working.

The solution is not to 'industrialise' general practice or to introduce larger and more homogenised provision, but for smaller practices to work together to improve care. Group practices, networks, federations and, more recently, super-partnerships have all developed in recent years. There does not appear to be a single organisational model to be applied, but the principle is of shared accountability for patient care rooted in and around primary care practices that act as the hub around which the wider system operates, and these are important features in achieving better outcomes for people in need of care co-ordination.[156,157,158,159,160,161]

A strong and vibrant network of high-quality general practices should lie at the heart of any transformation agenda for primary care in London.

Remodelling the primary care estate

Despite the lack of recent audit data, there remains a widespread perception that the primary care estate in London, especially in general practice, is not fit for purpose. Given the future demands that will be placed on primary care, it is becoming harder for general practices to deliver high-quality care from premises that are not fit for purpose and from small buildings. There has been some investment in recent years in polyclinics and GP-led health centres. But a more strategic approach is needed to maximise utilisation of the buildings and land owned by the NHS, the wider public sector and other community-based organisations, as well as looking at alternative locations for general practices while ensuring that they remain embedded within local communities.

Better and smarter use of information and IT

Using data to drive quality improvement is not yet routinely embedded as a way of working in primary care. GPs and other primary care professionals remain unaware of many of the variations in quality that exist – some of

which are outlined in this report – and few are encouraged to explore the reasons for variation and to act on these insights. Data and information tools must be used by commissioners and providers to identify and prioritise areas for quality improvement and inform local action to reduce inequalities in care. To do this effectively, they will need to become adept at using the data sets available for general practice, along with bespoke data extracted from GP computer systems, to benchmark practices, including comparisons with external peers where possible. This will help to identify good practice and tackle poor performance. The NHS has a wealth of data that can be used by CCGs and primary care providers in London to better understand variations in general practice and the underlying causes, and to drive improvements in the equity, quality, cost-effectiveness and outcomes of services. General practice must own this information-driven quality improvement agenda. The King's Fund has published a twin set of slides as an educational resource for CCGs on using measurement for improving outcomes.[162]

Ethnicity coding in general practice must improve in order to ensure regular and timely monitoring of this important dimension of inequality. General practices in a number of areas of London, including Lambeth, Wandsworth, Tower Hamlets, and Hammersmith & Fulham, have achieved very high levels of ethnicity coding in patient records, and this should become the norm.

Variations in the quality of health care and outcomes can have many causes – some warranted, others not. Variations can arise, for example, from the demographics, lifestyles and disease burden of the local population, the configuration and 'whole system working' of local health and social care services, variations in clinical practice, the quality of care, patient preferences, etc. Practices and CCGs will need to understand the reasons for local variations in order to take appropriate action. This is best done locally, by identifying the underlying causes through further disaggregation of data and the use of 'grey' local information.

Quality is complex and multidimensional and no single set of indicators is likely to capture all dimensions of quality. Aspects of quality of care such as relational continuity, co-ordination and compassion are not easily measured. There is a wealth of data held within general practice, and more needs to be done to harness this; more diverse and creative approaches to assess and improve quality in general practice are also needed. Audit at practice level can play an important role; peer observation, patient feedback and focus groups can all generate insights into the quality of care.

Primary care and CCGs in London must develop an open culture in which comparative and timely performance data are shared transparently and in which the ability to challenge is balanced with the need for support. Training and support will be required to equip people with the necessary skills to use data proactively to improve quality. General practice must share information and data on progress at a local level with patients, the public, and professional peers, as the General Practice Outcome Standards tool is starting to do. Access to timely and relevant information about the quality of care is the key priority for the transformation of primary care in London.

Exploiting the potential of IT to support patient care – for example, through linkage of patient records across primary and secondary care, and sharing of records across care providers – should be a priority. Enabling patients to access their GP records, which the government has committed to delivering

by 2015, will support self-care and management, especially for those with chronic conditions.

Training and development of the workforce

The future of primary care in London will require new and different professional roles and staff to work differently. Investment in training and development needs to benefit both new and existing staff, to ensure that GPs, nurses and other community-based staff gain the experience necessary to deal with greater complexity confidently, and to work together effectively in teams. Some staff who are currently based in hospitals may need to be re-trained to equip them to work with and in the community.

There is also a need to foster strong clinical leadership in order to develop the clear vision and shared values through which effective collaboration and teamworking can flourish. The age profile of GPs in London suggests that there will be a significant loss of experience in the next few years and it is important that younger GPs are prepared for these leadership roles.

Staff will also need protected time if they are to focus on quality improvements, audit, reflecting on their practice together in teams, and engaging more with patients and others in the wider primary care and health and social care system to redesign care, and to reach out to other organisations to work together to improve the health of the population through more proactive prevention.

A commitment to change

What struck us in undertaking this review of general practice in London was that the key issues and recommendations for changes to primary care that were raised in previous reports remain much the same today. The transformation agenda for primary care and general practice is, therefore, unlikely to bear fruit unless there is simultaneous change in the way care is delivered in other settings. As The King's Fund has recently argued, and which appears to be especially true in the case of London, the health and social care system has failed to keep pace with the needs and demands of local people; incremental changes are unlikely to be enough and a bolder approach is needed to drive innovation in the delivery of new models of primary care.[163] A strategic view is required that avoids short-term fixes designed to preserve existing services in favour of long-term investment to transform the way care and services are provided. This requires strong leadership and a collective commitment to change over time.

These changes will require leadership from within providers of primary care services in London and also from commissioners. CCGs will need to work closely with those in the NHS Commissioning Board who are responsible for contracting with general practice to ensure that improvements are made, and that where there are longstanding problems with the quality of care, these are tackled. As commissioners of care with responsibilities for populations, GPs will also need to work closely with local authorities, the voluntary sector and the private sector to ensure that longstanding health inequalities are tackled. These are not easy transitions to make, and those leading practice organisations, networks and CCGs in the future will need to be bold and challenge the status quo if they are to deliver a new vision for the future of general practice.

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