Primary Care Networks in North Central London – Islington GP Federation case study March 2019

Sana Burney, Primary Care Network Operational Lead

The demand on access to local health services is increasing as more people are living longer, often with multiple long term conditions. To meet these needs, practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in primary care networks (PCNs) within their local area.

PCNs build on the core of current primary care services and seek to enable greater provision of proactive, personalised, co-ordinated and more integrated health and social care. This is described as a shift from reactively providing appointments to proactively caring for the people and communities they serve.

The NHS Long term plan and the Next Steps to the Strategic Commissioning Framework describes a chance for practices, to work together through PCNs, and to support each other while providing improved services to patients. One example of best practice in North Central London is Islington GP Federation.

In 2015, general practices in Islington were working in silos, the majority of them confronted with the challenges of growing demand, a struggling workforce and unwarranted variations in care. The opportunity for a borough wide extended access GP service (I:HUB) provided the driver for Islington practices to come together with the shared purpose of delivering improved access to GPs for the patients of Islington. This led to the formation of the Islington GP Federation (IGPF); a collaboration between Islington practices, and the subsequent delivery of other commissioned services such as Community Gynaecology and ENT.

The North Central London (NCL) Sustainability and Transformation Plan (STP) proceeded to develop Care closer to Home Integrated Networks (CHINs) to meet the need for a more cohesive and integrated health and care system and to encourage further collaboration toward improving health outcomes, patient experience and system efficiency.

Meanwhile, Islington CCG commissioned regular “integrated care network” MDTs where multiple provider organisations met to discuss patients with increased or complex needs, such as frequent attenders or discharges after a long period in hospital. All of the above changes were instrumental in developing closer working relationships between practices and providing opportunities to share good clinical practice.

The three years the federation spent in building relationships, communication channels and trust with practices placed us in an excellent position to facilitate this new way of working. The infrastructure we have developed such as; shared access to clinical databases, information governance policies, capability around multi-provider contracts and human resources, has further enhanced our ability to work collaboratively.

This successful collaboration shaped the current general practice at scale infrastructure in Islington. By March 2018 we had established, 8 Primary Care Networks each looking after patient populations of 30-50k, grouped into 3 localities (aka CHINs) of approximately 90k patients each – North, Central and South. Each locality has a GP clinical lead and each network has a non-clinical ambassador acting as a conduit between the constituent practices and the federation.

Each network has been further enhanced by the recruitment of 8 practice-based pharmacists. These pharmacists are new to the primary care workforce and focus on the delivery of face to face long term condition care and medicines optimisation at network level. They are on the Health Education England training pathway and each is supported by a GP clinical supervisor.

Meanwhile, at locality level we now have 3 mental health nurses providing physical health assessments for patients with Severe Mental Illness (SMI). Patients are invited to an hour long mental and physical health review with an experienced dual qualified mental health nurse, seconded from the local mental health trust and trained in physical health screening. Patients who are unwilling to attend the practice are offered the option of being reviewed at home, which has led to engagement of patients who were traditionally hard to reach.

Another example of locality level working is a group of 9 practices in the north of the borough who have been working collaboratively with the acute hospital, consultant geriatricians and voluntary sector providers to provide a proactive case finding and intervention service for those living with moderate frailty. This has included the creation and validation of a frailty register and a multi-agency team consisting of a physiotherapist, pharmacist, community matron and care navigator to support the local GP in caring for patients by completing a complex geriatric and falls assessment, medication/pharmacist review and streamlining pathways between key services

The Federation's shared database and enhanced data analytics have provided the key building blocks which have enabled our Quality Improvement Support Team (QIST) to deliver these projects. Working with and in local general practices, these teams have provided hands on support to improve patient care and share best practice relating, for example; hypertension, atrial fibrillation and diabetes.

There have been challenges including persuading patients to travel to other local practices for consultations therefore, sufficient resource needs to be allocated to communications and engagement ensuring the message about new models of care reaches communities. Sourcing appropriately skilled staff who are able to engage with patients in different ways is not easy but can definitely improve outcomes for hard to reach groups. Project delays due to commissioning timetables and associated budget constraints make evaluation difficult where the project has not run its full course.

Complex clinical judgements and prescribing decisions for example; AF and Frailty etc. require reliable input from speciality colleagues to allow safe management in the community. A consideration is whether projects keep this expertise separate and refer on (like Frailty) or keep it core to the offered service (as in AF).

We have also sought to support practice resilience across the borough. Our Super Admin project, for example; has implemented streamlined document management processes which have moved work from clinicians to administration staff and thereby allowed GPs to spend greater time on direct patient care.

The recently published NHS Long Term Plan and GP contract provide financial levers to enable transformation of primary care and is very timely at this stage of the Federation's

development. For the past 3 years, we have been listening to the views of our GPs and working together to tackle some of the most fundamental questions about '*how'* we work, and particularly how we work together and integrate with other healthcare providers. The Federation is ensuring that general practice is at the heart of this exercise to shape what the future health and social care system looks like locally, and make this work for the patients and the practices.

Who to contact for more information

Sana Burney
E-mail: sana.burney@nhs.net