



Access to extended GP services and primary care in Brent

A Scrutiny Task Group Report

September 2015

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GLOSSARY OF TERMS

A&E	Accident & Emergency
BCF	Better Care Fund
CCG	Clinical Commissioning Group
GP	General Practitioner
HSCC	Health and Social Care Coordinators
HSCIC	Health and Social Care Information Centre
GP Access Hub	GP practice offering evening and weekend appointments for patients registered with other practices in the area, providing access to primary care out of normal GP practice opening times.
LAS	London Ambulance Service
LLMC	Londonwide Local Medical Committees <i>An overarching organisation providing strategic leadership, support, administrative, secretarial, communications and educational services to 27 of London's 32 LMCs.</i>
LMC	Local Medical Committee <i>A borough-based elected representative statutory body.</i>
LNWHT	London North West Healthcare NHS Trust
MDG	Multi Disciplinary Group
NHSE	NHS England
NWL	North West London
SaHF	Shaping a Healthier Future
STARRS	Short-term Assessment, Rehabilitation and Reablement Service

CHAIR'S FOREWORD



The Scrutiny task group was established to review the implementation of the primary care element of Brent Clinical Commissioning Group's transformation programme and examine access to primary care services in the London Borough of Brent.

The task group was concerned with the capacity in Brent and the ability of local services to meet demand and ensure fair and equitable access to primary care services.

Brent's population is rising and we recognise the significant pressures on general practice as well as the central role it plays in the local healthcare system. The growing demand for primary care is impacted by an ageing population, an increase in long-term conditions and changing patient expectations. To address concerns with access to services we need ongoing investment in general practice and innovative ways of meeting demand for primary care. We also need to continue to promote health and wellbeing and encourage our local residents to support themselves wherever possible.

Our ambition is for Brent to be a borough in which people live well, with access to high quality healthcare when they need it. Recent initiatives have been established to increase capacity and deliver improved access to primary care, including the development of GP Access Hubs across the borough. The task group supports the development of extended primary care services where these offer local residents improved access and a choice of services to best meet their needs but we feel that access still remains a concern in Brent. The report outlines key recommendations from the task group findings and we urge the Council, Brent Clinical Commissioning Group, NHS England and partner organisations to implement the recommendations of the task group in full.

I would like to thank everyone who participated in our work, including patient group representatives, officers, local commissioners and service providers. In particular I wish to thank local GPs, Health and Social Care Co-ordinators and Multi Disciplinary Groups for taking the time to meet with the task group. Thanks also to staff from the Urgent Care Centre at the Central Middlesex Hospital and representatives from Brent Clinical Commissioning Group, Central London Clinical Commissioning Group, NHS England, the Londonwide Local Medical Committees, Local Medical Committee, London Ambulance Service, Brent Patient Participation Groups and Healthwatch Brent for their participation in this review. I would also like to acknowledge the contribution from officers in Brent Council's Policy Team and Research and Intelligence Team in supporting the work of the task group and helping prepare this report.

A final thank you to my task group colleagues for their time and valuable contributions to this review – Cllr Agha, Cllr Conneely, Cllr Daly, Cllr Hector and Cllr Mitchell-Murray.

Cllr Reg Colwill

Chair, Access to Extended GP Services and Primary Care in Brent

EXECUTIVE SUMMARY

Good access to primary care services across the London Borough of Brent is central in ensuring local residents receive the right care, in the right setting, at the right time. Demand for primary care is growing and population projections for Brent suggest an ongoing increase in resident numbers, placing increasing pressure on GP services already under strain. The projections also show changes in the age profile of residents with an increase in the number of older residents resulting in additional challenges for both health and social care services.

The purpose of the task group was to review access to extended GP services and primary care in Brent. The review was concerned with the capacity in Brent, out of hours care and the delivery of out-of-hospital services to provide enhanced and extended care to meet the needs of local residents as acute hospital care is reduced as proposed by Shaping a Healthier Future (SaHF). The work of the task group included identifying areas that are working well, as well as any barriers, weaknesses or risks associated with the transformation of primary care in Brent.

Key areas of focus were agreed during the work of the task group and are outlined within the report. For each key area, the task group has reviewed the views of participants and evidence gathered in drawing conclusions and making recommendations. These key areas include:

- Demand for primary care;
- Access to primary care in Brent;
- Delivering the out-of-hospital strategy;
- Developing an integrated care approach;
- Investing in the primary care workforce;
- Responsive urgent and emergency care; and
- Focusing on health and wellbeing.

Evidence presented to the task group highlighted the pressure that GP services are under in meeting increasing demand for services. These pressures will not go away with other factors impacting on healthcare services both now and in the future. As mentioned above, a growing population and the projected increase in the number of older people provide additional challenges, as well as the deprivation level in the borough and high population churn. Brent has a high number of migrant patient registrations with GP practices. The total number of registered patients at GP practices also appear to be growing faster than the resident population.

Brent Clinical Commissioning Group are carrying out a programme to transform how primary care is delivered in Brent, focusing on delivering more health care in the community and improving access to GP services. This has included the development of a new hub model to deliver extended GP services in Brent. The model is offering additional capacity in the evenings and at weekends but, with take up below target levels, it needs to be assessed to measure the extent to which it is meeting the needs of all residents. Addressing increasing demand will require ongoing work to look at flexible ways in which people can access primary care, including GP opening hours, e-prescriptions, Skype and FaceTime consultations, as well as out-of-hours and extended access. The task group believes the ability to deliver primary care services that meet the needs of local people, improve patient experience and reduce dependency on urgent and emergency care requires involvement of residents in the design of new solutions.

RECOMMENDATIONS

In light of the findings of this review, the task group make the following recommendations. The task group recognises that these recommendations will need to be implemented in partnership across agencies and with the support of patients and the public.

Recommendations are categorised under the following key areas.

Access to primary care in Brent

1. NHS England, Brent CCG and local GP networks carry out a review of current GP opening hours across the borough and consider additional ways of accessing GP services, including the roll-out of Skype and FaceTime consultations, telephone consultation and email consultations where appropriate and within Information Governance principles. Online appointment bookings and e-prescription ordering have been enabled in all Brent GP practices and patients should be encouraged to take up these services.
2. NHS England and Brent CCG produce an action plan including opportunities for sharing of good practice across networks in improving patient experience when making appointments and contacting the surgery by phone, with a view of improving patient satisfaction rates in the next GP patient survey.
3. Brent CCG and NHS England clarify the out of hours element of the GP contract for people in Brent and publicise out of hours services across the borough given the lack of information and awareness by local residents highlighted in the most recent GP patient survey.
4. Brent CCG develops a written protocol between GP practices and GP Access Hubs for the receipt of hub attendance reports to ensure continuity of care and minimise the risk of fragmentation of primary care health services.
5. Brent CCG carries out a detailed review of GP Access Hubs following the initial six months and first full year of operation against the new service specification, providing a detailed evaluation on the level of take up, impact on patient satisfaction regarding access and impact on A&E and UCC attendances.
6. That the review, outlined in recommendation five, includes public engagement to assess the extent to which the model reaches and benefits all residents in any part of the borough, including vulnerable groups, and to determine public support for the model.

Delivering the out-of-hospital strategy

7. Brent CCG carries out a rolling programme of evaluation of the impact of the out-of-hospital strategy against individual contractual arrangements for services.
8. Brent CCG outlines its plans to commission any additional community services to support primary care to meet the needs of Brent residents in the community following its support for changes to hospital care.

Developing an integrated care approach

9. Brent CCG in partnership with Brent Council's Adult Social Care Department review the job description of care coordinators, including the breadth, key requirements and core competencies of the role currently being piloted to ensure these can be fulfilled.

Supporting the primary care workforce

10. Brent CCG in partnership with LNWHT Community Services investigate the extent of the gap in recruitment and retention of district nursing in Brent and consider the need for a programme to support district nursing, focused on ensuring an effective, motivated, independent and responsive service is in place.

Responsive urgent and emergency care

11. Healthwatch Brent to work with providers to develop a clear communication strategy for ensuring the public are aware of and informed of the Urgent Care Centres available to the residents of Brent, as well as the services provided at Central Middlesex Hospital.
12. Care UK and London North West Healthcare NHS Trust review access to the Urgent Care Centre at Central Middlesex Hospital, including the introduction of clearer road and access signs for the Urgent Care Centre and a review of the cost of parking at the centre.

Focusing on health and wellbeing

13. Brent Council, Brent CCG and Healthwatch Brent develop a communication strategy with targeted activities across the borough, including establishing links with schools, workplaces and local faith groups, in promoting the right access to services, raising awareness of the range of services available and promoting self care. This should include using a range of communication methods across our diverse communities.
14. Brent Council's Public Health Department continues work with NHS England and Brent CCG to improve the take up of preventative services, including health checks.

We recognise the work required in implementing these recommendations in full. It is hoped that these can be delivered through active collaboration with Council colleagues and support from the Brent Health and Wellbeing Board.

1. INTRODUCTION

The Scrutiny Task Group was established to review the implementation of the primary care element of the the transformation programme and examine access to primary care services in light of Shaping a Healthier Future (SaHF). The review was concerned with the capacity in the London Borough of Brent, access to out of hours care and the delivery of out-of-hospital services to provide enhanced and extended care to meet the needs of local residents as acute hospital care is reduced as proposed by SaHF. The work of the task group included identifying areas that are working well, as well as any barriers, weaknesses or risks associated with the transformation of primary care.

Brent Clinical Commisisoning Group (CCG) and London North West Healthcare NHS Trust are changing the way healthcare is provided in Brent. These plans are reflected in the CCG's draft five year strategic plan (2014) and is a direct response to the proposals contained within the SaHF document for North West London.

There are three major transformational programmes:

- Shaping a Healthier Future – the ‘reconfiguration’ of hospital services, including a reduction in the number of available hospital beds;
- Primary Care Transformation – focusing on the provision of health care in the community and more primary care services, including initiatives to deliver better access to GP services; and
- Whole Systems Integrated Care – joining together health and social care to provide more integrated health services to patients.

The plans set out major changes for the way in which healthcare is delivered, reducing dependance on acute hospital services and reinvesting in primary and community care. The three programmes have many interdependencies. The intention is for hospitals to concentrate on providing specialist services. Other services will be provided in a community setting, which will require the expansion of capacity in primary care, and a greater link between health and social care to ensure patients receive a more integrated and coordinated service, meeting both health and social needs and preventing more acute interventions.

The North West London draft five year strategic plan outlines that the scale of change required in primary care to achieve quality, patient experience and financial objectives is significant. To ensure that the changes to hospital services are implemented successfully, there is an increased need for effective and accessible primary care to deliver out of hospital care, deliver improved access and meet rising patient expectations. This includes new models for primary care, including access to extended GP services through locality networks and where appropriate across all Brent practices by networks working jointly.

2. TASK GROUP MEMBERSHIP

The task group included six elected members:

Councillor Reg Colwill (Chair)
Councillor Amer Agha
Councillor Rita Conneely
Councillor Mary Daly
Councillor Claudia Hector
Councillor Wilhelmina Mitchell Murray

3. METHODOLOGY

The aim of the Scrutiny task group was to assess the progress of primary care transformation in Brent, including investment in Brent GP networks and primary care services, in order for this to address the reduction in the acute services as proposed by SaHF.

The review focused on the following key questions:

1. What are the needs of Brent residents, including vulnerable groups, in relation to accessing GP care?
2. Is there sufficient capacity within the Brent GP network to provide enhanced extended primary care to meet the objectives set out within the SaHF proposals?
3. Are there any barriers, weaknesses or risks associated with the transformation of primary care?
4. What actions are required to ensure effective primary care services are available in Brent?
5. What actions are needed to ensure fair and equitable access to GP services is available to all Brent residents?

In carrying out the review the task group invited a range of partners to contribute through face-to-face meetings and discussion groups. A range of visits and observations were also carried out.

Information, advice and views were gathered from a number of people and sources, including:

- Reviewing a range of documents relating to the national, regional and local picture on primary care;
- Gathering information on the Brent CCG primary care transformation programme;
- Reviewing health needs, demographic data and statistical information;
- Meetings with key officers from Brent CCG, Brent Council, NHS England, London Ambulance Service, Londonwide Local Medical Committees and the Local Medical Committee;
- Meetings with GPs;
- Seeking the views of patient groups, including Patient Participation Groups and Healthwatch Brent;
- Attending Multi-Disciplinary Group (MDG) meetings;

-
- Carrying out a range of visits, including visiting a GP Access Centre, Brent Urgent Care Centre and observing a Health and Social Care Coordinator Action Learning Set;
 - Gathering information on examples of best practice in neighbouring boroughs, including a visit to a GP practice in Westminster.

A full list of participants can be found in section seven of this report.

During the review, the task group had the opportunity to speak with a range of partners who shared their opinions and experiences of services. The task group recognises that people have different experiences of primary care and, through the analysis of information gathered, has tried to present a balanced view of the opinions given.

4. BACKGROUND AND POLICY CONTEXT

4.1 The local picture

Brent is an outer borough in North West London. It has a long history of ethnic and cultural diversity, which has created a place that is truly unique and valued by those who live and work in the borough. Brent has a young, dynamic and growing population.

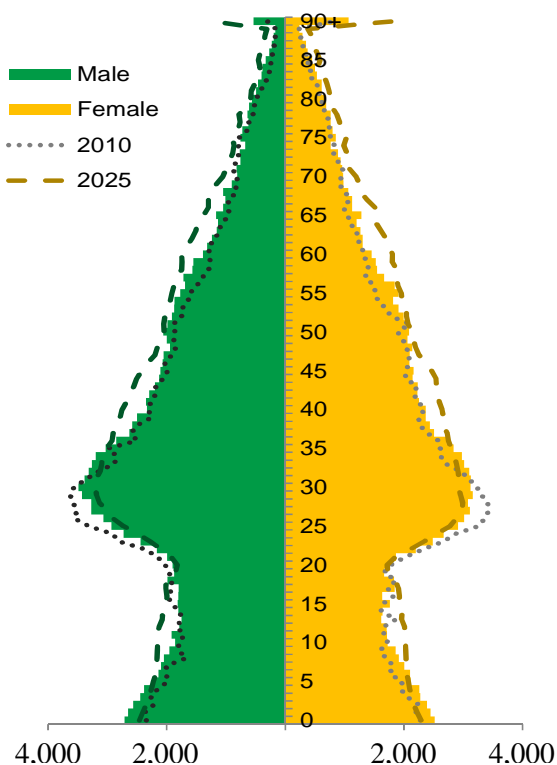
Brent's population

Brent's population increased by 1.7% from 311,215 in 2011 to 320,190 in 2013¹. Population projections for Brent show a continued increase, with the population rising by 10,456 over the next five years, from 320,781 in 2015 reaching 331,237 in 2020, an increase of 3.3%¹.

➤ Age

Brent has a large proportion of people aged under ten and between 25 and 35 years of age. Currently the under tens make up 14.1% of the population; this is projected to decrease to 12.8% in 2025. Those aged between 25 and 34 make up 19.7% of the population; this is also expected to decrease over the next ten years to 17.5%. The older population has increased since 2010 and is projected to increase further. The number of people aged 65 and over has increased from 32,593 in 2010 to 36,045 in 2015. This cohort is projected to increase by 9,081 to 45,127 in 2025, a percentage increase of 25.2%. Looking more closely at the older population, those aged between 85 and 89 are projected to increase by 48.5% from 2,905 in 2015 to 4,313 in 2025 and those aged 90 and over, by 90.3%, from 1,607 to 3,057.¹

Figure 1: Population by age and gender 2015¹

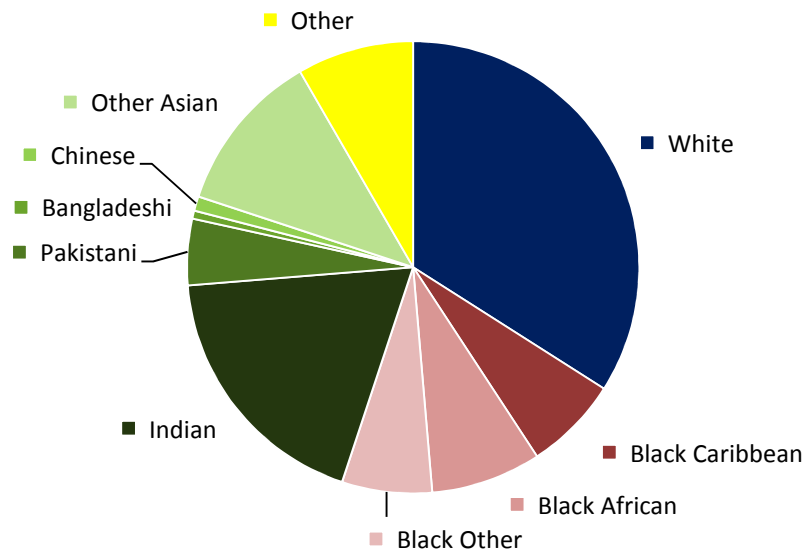


¹ GLA SHLAA based population projections 2013 rnd

➤ **Ethnicity**

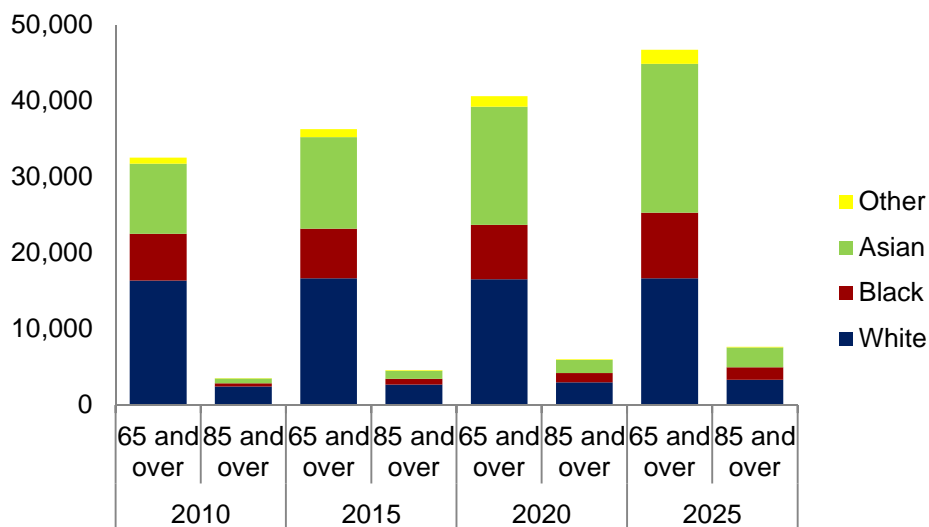
Brent is an ethnically diverse borough. In Brent, the black, Asian and minority ethnic (BAME) groups make up 65.0% of the population, compared to 41.8% in London¹. About one third (37.0%) of the population are Asian; 34.0% white and 21.1% black¹.

Figure 2: Ethnicity profile 2015¹



Currently the population aged 65 and over is predominantly white (45.9%). Although the numbers of white people aged 65 and over remains at around 16,000, the proportion is projected to decline to 35.7% in 2025¹. The numbers and proportion of Asian people aged 65 and over will increase from 33.1% in 2015 to 41.8% in 2025¹. The population aged 85 and over has a bigger change, with the number of white people increasing, but the proportion of white people decreasing from 59.2% of the population in 2015 to 43.2% in 2025. Conversely, the proportion of Asian and black people will increase from 22.4% and 16.6% to 33.8% and 21.7% respectively¹.

Figure 3: Change in ethnicity of people aged 65 and over and 85 and over from 2010 to 2025¹



➤ Migration

Brent has the highest number and population share of non-UK born residents out of all the London Boroughs, 55% of residents were born outside of the UK and 26% of residents have arrived in the borough since 2000².

Brent residents who left the borough moved to the East of England and South East, as well as Harrow. More residents came to Brent from Camden and Kensington and Chelsea than migrate there. Results from the Resident's Attitude Survey (September – November 2014) revealed that 30% moved to Brent because the housing was affordable and 25% because friends and relatives were already here.

➤ Length of residence in the UK

In Brent, 44.9% of residents were born in the UK, compared to 63.3% of London residents. Over a quarter (25.7%) of Brent's residents have been resident in the UK for less than ten years.³

Table 1: Length of residence in the UK of Brent residents³

Length of residence in the UK	Brent		London	
	n	%	n	%
Born in the UK	139,788	44.9	5,175,677	63.3
Less than 2 years	19,332	6.2	368,529	4.5
2 years or more but less than 5 years	26,822	8.6	458,019	5.6
5 years or more but less than 10 years	33,997	10.9	620,600	7.6
10 years or more	91,276	29.3	1,551,116	19.0

➤ Languages

There are 149 languages spoken in Brent, 63% speak English as their main language, 8% Gujarati, 3% Polish, 3% Arabic, 2% Tamil, 2% Portuguese, 2% Somali, 2% Romanian, 2% Urdu and 13% other. In one in five households nobody speaks English as their main language and in Alperton one in 40 households cannot speak English³.

➤ Deprivation

Brent is ranked amongst the top 15% most-deprived areas of the country⁴. This deprivation is characterised by high levels of long-term unemployment and low average incomes. Children and young people are particularly affected with a third of children in Brent living in low income households and a fifth in single-adult households. The proportion of young people living in acute deprivation is rising. In 2013, Brent had the fourteenth highest rate of child poverty (after housing costs) in the UK, tenth highest in London⁵. In 2014, 30% of Brent households had an annual income of £20,000 or less.⁶

² www.ONS.gov.uk Population - migration

³ 2011 Census

⁴ Indices of Multiple Deprivation (IMD) 2010

⁵ End child poverty 2013: <http://www.endchildpoverty.org.uk/why-end-child-poverty/poverty-in-your-area>

⁶ CACI 2014

In Brent there are 218,100 working age people. Of these, 159,800, (73.3%) are economically active. Since 2004 the working age population has increased by 37,000 to 218,100. The rate of economically active people in Brent is lower than the rate for London (76.7%) and for the UK (77.4%).⁷

What is the impact for healthcare in Brent?

In order to provide an analysis of the demand and level of need for primary care services in Brent, it is important to gain an understanding of the landscape in which services operate. There are key challenges that will impact on healthcare services both now and in the future, including a growing population, the deprivation level in the borough, the number of children and young people living in low income households, a projected increase in the number of older people and high population churn.

A more detailed analysis of the health profile of the borough is outlined in section 5.1. However, it is important to highlight the impact of these key challenges including an increased demand on local primary care services as a result of a growing population.

Population projections indicate that the number of older people in Brent is increasing. Figures outlined above show that between 2011 and 2013, the largest increase was in people aged 85 and over. This places increased pressure on both health and social care services.

Transformational programmes to improve healthcare in Brent

Brent CCG and North West London plan to 'transform' the way health care is provided in Brent. There are three major transformational programmes being carried out in Brent. These include SaHF, Primary Care Transformation and Whole Systems Integrated Care.

The SaHF Programme, officially launched in 2012, set out a vision for the future of how services are delivered across North West London. The programme was established to address inconsistencies and variations with current systems, as well as meeting changing demands of the local population. The programme envisages a shift from hospital and secondary care to primary and community care.

In 2012 NHS NWL CCGs outlined their commitment to changing healthcare in the NHS NWL Case for Change (February 2012). The transformation of care across the eight NWL boroughs (Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster) included the reconfiguration of services with an emphasis on investing in primary care services and providing more services in the community. This involves changing the way services are provided across hospitals, GP practices and other community care sites, focusing on integrated care delivered through a partnership between health and social care, and more investment in GP services and other local healthcare. Self management is also viewed as playing a central role in the transformation of services. A focus of the service redesign is on people taking care of themselves and accessing treatment in the community and managing their own conditions.

⁷ Brent Diversity Profile – Labour Market. Work patterns in Brent 2015

Table 2: Transformation programmes

Programme	Details	Proposed outcome	What does this mean for Brent?
Shaping a Healthier Future	The reconfiguration of hospital services	Centralised services to support specialist and improved outcomes. More health services available out of hospital, in settings closer to patients' homes seven days a week	Changes for Northwick Park Hospital and Central Middlesex Hospital, including the reduction of acute beds
Primary Care Transformation	Making it easier to see a GP and making more treatments available in a community setting	Patients have access to General Practice services at times, locations, via channels that suit them seven days a week	More services delivered on a network basis New IT capability to offer electronic prescriptions, electronic bookings and online consultations GP Access Hubs offering appointments evenings and weekends
Whole Systems Integrated Care	Joining together health and social care to provide more integrated health services to patients	Patients with complex needs receive high quality multi-disciplinary care close to home, with a named GP acting as a care-coordinator	A care plan for people with a long-term condition, with support from Health and Social Care Coordinators

In a report to the Overview and Scrutiny Committee in August 2014, Brent CCG outlined their ambition to increase the effectiveness and capacity of primary care in the borough. The CCG stated that this will provide all patients with:

Coordinated care – ‘providing patient-centred, coordinated care and GP-patient continuity’

Accessible care – ‘providing a responsive, timely and accessible service that responds to different patient preferences and access needs’

Proactive care – ‘supporting the health and wellness of the population and keeping people healthy’

Convenient care – ‘provided at a range of centres, including some local GP centres and community settings’⁸

The report also highlighted constraints on practices, including a lack of staff and space, placing an emphasis on moving towards delivering primary care in networks to maximise potential for delivering extended services.

⁸ Brent CCG’s Transformational Programme for Health Services in Brent. Report to the Overview and Scrutiny Committee (August 2014).

It is acknowledged that operational models for delivering out-of-hospital strategies will differ between CCGs but the delivery of out-of-hospital care should be based on a set of agreed principles, outlined in the NWL CCG draft five year strategic plan:

Urgent

- Patients with urgent care needs provided with a timed appointment within four hours;
- Patients with non-urgent needs offered the choice of an appointment within 24 hours, or at their own practice within 48 hours;
- Telephone advice and triage available 24 hours a day, 7 days a week through the NHS 111 service.

Continuity

- All individuals who would benefit from a care plan will have one;
- Everyone who has a care plan will have a named 'care co-ordinator';
- GPs will work in multi-disciplinary networks;
- Longer GP appointments for those who need them.

Convenience

- Access to General Practice 8am to 8pm (Monday to Friday) and 6 hours per day during the weekend;
- Access to GP consultation in a time and manner convenient to the patient;
- Online appointment booking and e-prescriptions available at all practices;
- Patients given online access to their own records;
- Online self-management advice, support and service signposting.

In April 2014, 20 GP pilots were announced nationally; this included all eight CCGs in North West London who were awarded £5 million from the Prime Minister's Challenge Fund to support schemes to make it easier for patients to see their GP. The aim of this funding was to provide capacity for networks to focus on planning and IT capability, and to support practices working together in order to provide extended opening hours, weekend opening and better use of technology. Brent received a total of £958,000, allocated to the four networks of Harness, Kilburn, Kingsbury & Willesden and Wembley for their development.

Continued support for the GP networks is outlined within Brent CCG commissioning intentions 2015 – 2016; this includes support in developing enhanced services in primary care and continuing to develop out-of-hospital services. The continued provision of extended opening hours is also outlined in the commissioning intentions.

Potential impact for residents

It is important to understand the impact of these changes on the local population. Local residents will also need to be informed of how changes to services may affect them. Between 2012 and 2014 consultation and evaluation was carried out on proposals. This included a strategic review of the equalities impacts of proposals under SaHF, commissioned by NHS North West London in 2012.

The equalities impact assessment was carried out at a strategic level and was based on the population across North West London. The findings of the review carried out by Mott MacDonald (2012) highlighted that clinical evidence showed a proportionally higher rate of demand for some or all services under review among children (under 16), young people (16

to 25), older people (65 and over), disabled people, particularly those with learning disabilities and mental health conditions, and gender reassignment⁹.

Through the evaluation of the overall impact of SaHF proposals potential negative impacts were identified. These included loss of hospital familiarity and meeting the specific needs of equality groups, the period of transition which could create some confusion amongst the population, patient – clinician relationships and longer journey times to access emergency care.

As a result of the proposed changes to acute provision, the review highlighted that the impact of longer journeys is more likely to affect people with disabilities and older people for who travel can be more challenging. The assessment identified that women are also more likely to travel by bus, foot, community transport or taxi than men. BAME residents are also more at risk in terms of longer journey times as they are less likely to live in a household with a car. Deprived communities are less likely to have their own private transport. However, the review identified that this is more likely to impact visitors than patients, with patient journeys more likely to take place by ambulance. Mitigation and opportunities to address the potential negative impacts were outlined in the review.

If objectives set out in SaHF are realised a number of potential positive impacts were identified, including improved health outcomes for complex and acute patients and care delivered closer to home and within the community.

4.2 The national picture

The NHS Five Year Forward View was published in October 2014 setting out a vision for the future of the NHS. The Five Year Forward View outlines the need for new partnerships between health, local communities, local authorities and employers in delivering outcomes. It also acknowledges the importance of prevention and public health in avoiding illness. This includes action on obesity, smoking, alcohol and other major health risks. Patient control, integration of health and social care and a role for voluntary organisations and local communities also feature in the plan.

The NHS set out in its vision future models of care continuing to move away from traditional boundaries between services – primary care, community services and hospitals – with services integrated around the patient and an increased emphasis on strengthening and expanding primary care and out-of-hospital care. A key focus is stabilising general practice with a range of initiatives as outlined below in the new deal for primary care from the NHS England Five Year Forward Plan (2014):

A new deal for primary care (NHSE, 2014)

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care.

Steps we will take include:

- Stabilise core funding for general practice nationally over the next two years while an

⁹ NHS North West London (2012). Equalities Impacts – Strategic Review. Shaping a Healthier Future.

independent review is undertaken of how resources are fairly made available to primary care in different areas.

- Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.
- Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.
- Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.
- Expand funding to upgrade primary care infrastructure and scope of services.
- Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.

A paper published by the King's Fund (2015), in response to the NHS five year forward view, outlined the changes required in developing new health policy and supporting local leaders in implementing the new care models and transformational changes outlined in the plan. It recognises the importance of systems leadership and the requirement for organisations to work together in local systems of care and take forward initiatives. This includes implementing new forms of commissioning and contracting.

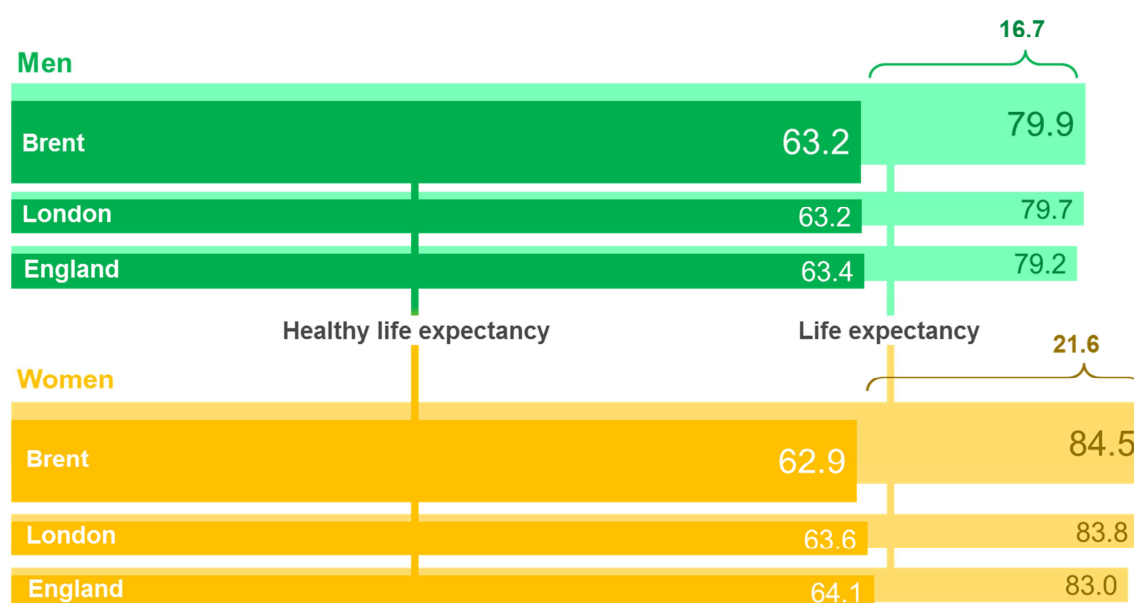
5. KEY FINDINGS

5.1 Demand for primary care

Local Health profile

There is a growing demand for primary care due to an ageing population, long-term health conditions and changing expectations. In Brent life expectancy is increasing steadily; for women born between 2010 and 2012 life expectancy is higher (84.5) than London (83.8) and England and Wales (83.0). Men born between 2010 and 2012 have similar life expectancy (79.9) to London (79.7) and England and Wales (79.2). Although life expectancy is long in Brent, healthy life expectancy is similar to the average for London (63.2 for men and 63.6 for women) and England (63.4 for men and 64.1 for women) for both men (63.2) and women (62.9), meaning that women in Brent are likely to live longer in bad health.¹⁰ However, within the borough, there is inequality in health with a life expectancy gap for men of 9.2 years, ranging from 74.2 years in Stonebridge to 83.4 years in parts of Preston¹¹. Women have a longer life expectancy than men, ranging from 80.6 years to 90.5 years, a gap of 9.9 years¹¹.

Figure 4: Life expectancy and healthy life expectancy, 2010-2012¹⁰



The main causes of premature mortality¹² in Brent include cancer (724 deaths of people aged under 75 between 2011 and 2013) and heart disease and stroke (521 deaths of people aged under 75 between 2011 and 2013)¹³. Brent has a high rate of people dying prematurely from heart disease or stroke (93.5 per 100,000 population) and ranks 110th out of 150 local authorities.¹⁴ The rate of premature death from heart disease or stroke is 80.1 per 100,000 population in London and 78.2 per 100,000 population in England. Although

¹⁰ Brent JSNA

¹¹ ONS: life expectancy at birth 2008 to 2012

¹² Dying before the age of 75

¹³ Public Health outcomes framework

¹⁴ <http://healthierlives.phe.org.uk/topic/mortality/area-details#are/E09000005/par/E92000001/ati/102/pat/>

cancer has caused more premature mortality, Brent has a good record for cancer and ranks 20th out of 150 local authorities.¹⁴

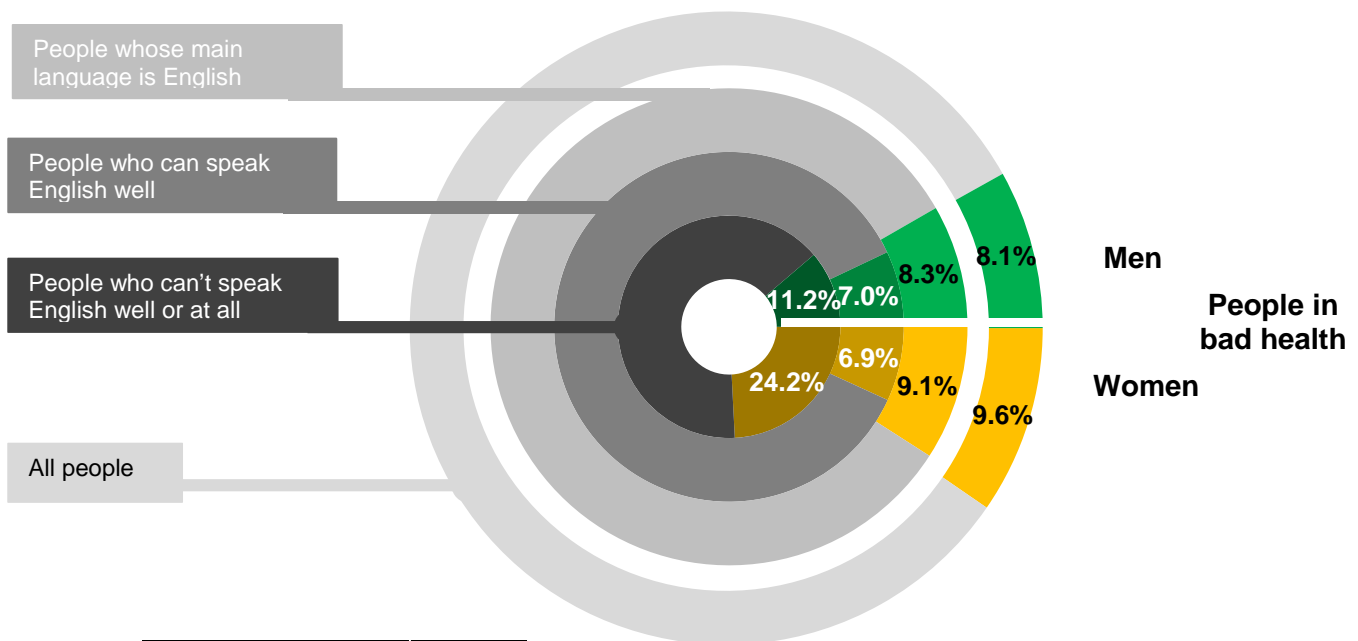
For self reported health in Brent, 82.9% reported their health as good or very good¹⁵. At ward level, Kilburn had the highest number of residents who assessed their health as “very good” (8,448 residents), while Kenton had the lowest number of residents (5,502 residents) in “very good” health. Harlesden had the highest number of residents with both “good” health (5,815 residents) and those reporting “very bad” health (313 residents).¹⁶ In Brent, 85.6% of people felt their day-to-day activities were not limited at all by a long term health problem or disability. This is similar to the London average of 85.8% and slightly better than the England average of 82.4%.¹⁵

In 2012/13, 3.4% of adult patients registered with NHS Brent CCG were on a GP register for depression, this is lower than the national average of 5.8%. Take up of talking therapies is lower in Brent (53%) compared to England (60%) in relation to the number of referrals who enter treatment. Estimates show that 19.5% of Brent residents surveyed consider themselves to have high levels of daily anxiety compared to the England average of 21%.¹⁶ In Brent, 2,369 people aged 65 and over are currently predicted to have dementia. This is estimated to increase to 3,857 by 2030.¹⁶

In 2012/13 there were over 23,000 people in Brent recorded as having a diagnosis of diabetes on GP registers. This equates to 8% of the GP registered population, which is above the England average of 6%.¹⁶

There has been a dip in births in Brent and the under five population is expected to remain fairly static over the next five years. Children in Brent have worse than average levels of childhood obesity. This will impact on future health needs within the borough if these children stay in Brent. The most common cause for planned admission to hospital is dental extraction. In 2011/12, 46% of five year olds had one or more decay filled or missing teeth. Immunisations rates are below 95%.¹⁶

Figure 5: Health by proficiency in English¹⁵



¹⁵ 2011 Census
¹⁶ Brent JSNA

In Brent there are additional challenges. Although 20% of households do not have English as their main language, only 8% of people are unable to speak English well or at all. People that are unable to speak English well or at all are more likely to be in bad health, with 35.4% in bad health (24.2% of which are women) compared to the average of 17.7%.¹⁵ This presents additional challenges for ensuring individuals can access the care and support they require.

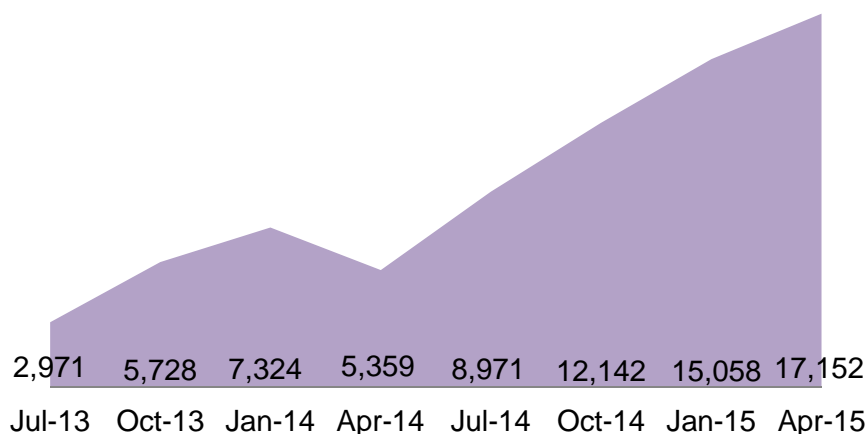
Registered patients

In 2012 there were 69 GP practices in Brent and 339,381 registered patients. In April 2015 there were 67 GP practices in Brent, with 365,165 registered patients.¹⁷ The number of registered patients across the 67 practices has risen since 2012 and is continuing to rise. Between April 2014 and April 2015, the number of registered patients increased by 11,793 from 353,372 to 365,165, which on average is nearly 3,000 patients per quarter.¹⁷

Figure 6 shows the overall increase in patients between July 2013 and April 2015. It is important to note that a patient doesn't have to live in Brent to register with a Brent GP.

Population projections for Brent, outlined in section four, suggest an ongoing increase in resident numbers, which will place increasing pressure on GP services, already under strain. In addition to the projected increase in resident numbers, projections show changes in the age profile of residents with an increase in the number of older residents placing additional pressures on both health and social care services.

Figure 6: New patients registered since April 2013¹⁷



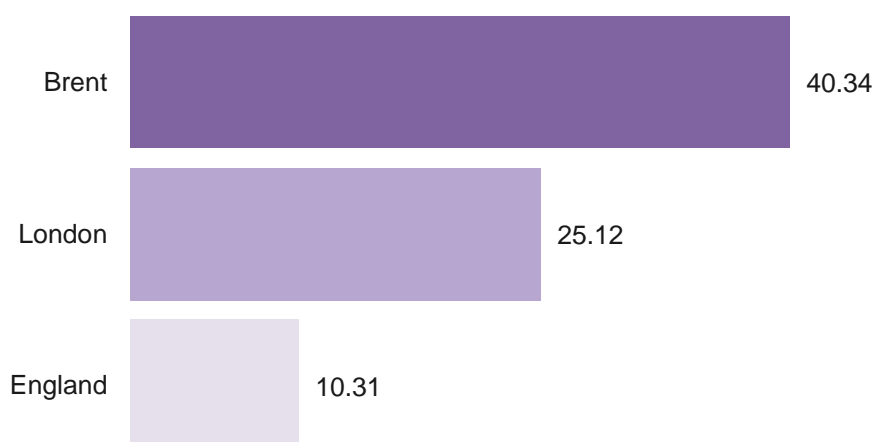
Migrant patient GP registrations

Brent has a high number of migrant patient registrations with GP practices. The estimated migrant patient GP registration rate for Brent is around 40.3 per thousand population, compared to 25.1 for London and 10.3 for England. The figures are slightly lower (35.8) when the total patient estimates are used instead of population estimates, although the trend

¹⁷ HSCIC – Number of Patients Registered at a GP Practice

is similar.¹⁸ The smaller proportion of migrant registrations is due to a higher number of registered patients in the borough, compared to the population estimate.

Figure 7: New migrant patient GP registrations per thousand population¹⁸



Of the 374 local authorities for which the migrant patient registration rate is available, Brent had the sixth highest. Rates range from 0.9 per thousand (Caerphilly) to 57.4 per thousand (Cambridge).

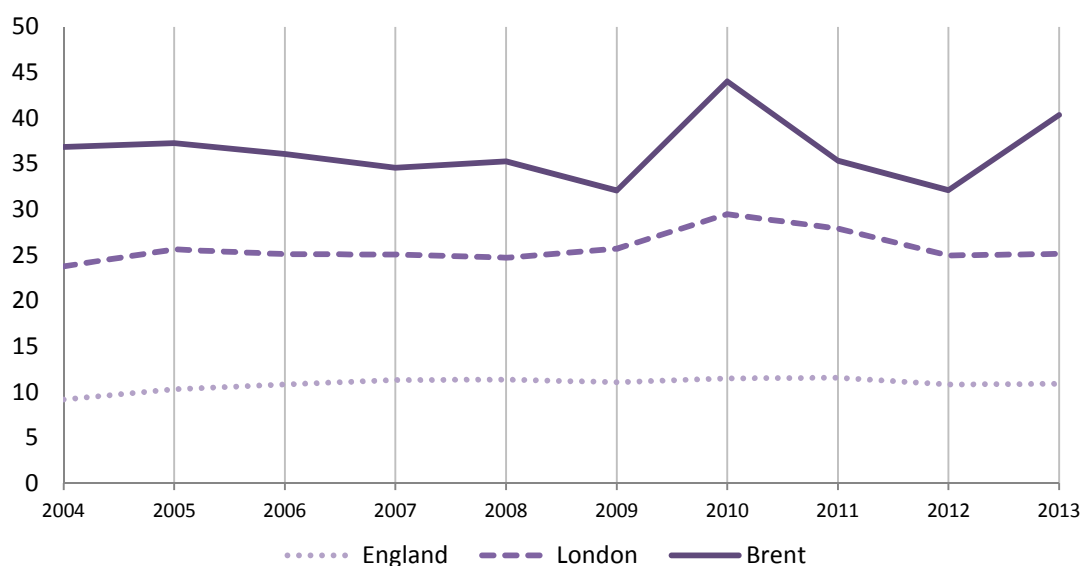
Table 3: Top ten migrant patient GP registrations (2013)¹⁸

	Local Authority	Migrant GP registrations per thousand resident population
1	Cambridge	57.4
2	Oxford	52.3
3	Newham	48.4
4	Tower Hamlets	42.8
5	Westminster	41.1
6	Brent	40.3
7	Kensington and Chelsea	35.9
8	Camden	35.8
9	Hammersmith and Fulham	35.2
10	Haringey	35.2

Examining migrant GP registration rates over a ten year period, 2004 to 2013, shows Brent's rates have remained at a high rate compared to London and England, although mostly following the same trajectory as London, peaking at a rate of 44 per thousand population¹⁸ (as illustrated in Figure 8).

¹⁸ ONS international migration
<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Local+Area+Migration+Indicators#tab-data-tables>

Figure 8: New migrant GP registrations 2004-2013¹⁸



Patient growth analysis

The two previous sections illustrate the growth in patient population. Looking at this in more detail and comparing patient growth with the local resident population growth, we are able to identify whether there are any unexpected changes in patient groups. In January 2015 there were 363,071 patients registered in Brent while the projected population for mid-year 2015 was 325,226.¹⁹ In the period from January 2014 to January 2015 the patient registrations increased by 2.2% while in the comparison period (June 2014 to June 2015) the population of the London Borough of Brent increased by 1.1%.¹⁹

It is important to note, the area of residence of the registered practice population and ward boundaries do not correlate. However, as a guide to the changes in each, it is possible to compare the median and quartile ranges of the GP practices in Brent CCG with the wards of Brent. One practice had a decrease in patient population of 12.4%. During the same period another practice had an increase in patient population of 41.4%. These are the extremes in population change, for example the second greatest increase was 19.7%. The average (median) population growth for practices (January 2014 to January 2015) was 1.6%. This compares to an average (median) population growth for wards of 0.6%. The population growth of the middle 50% of practices varied between a decrease of 0.9% and an increase of 5.1%, this compares to an increase in the middle 50% of wards from 0.4% to 1.1%.¹⁹ A full breakdown of patient growth rates by practice is detailed in appendix 1.

Both practices and wards are experiencing a range of growths in the registered patient population and in some cases shrinkages but despite the practices showing some more extreme movements the changes would appear to be largely in step. A comparison by gender, shows that there is no significant difference in the increase of the female population but indicated that the male population is increasing faster than the borough's wards, with an

¹⁹ Comparing the number of patients registered to Brent CCG GP surgeries on January 1st 2014 and January 1st 2015 with the mid-year population projections for Brent for 2014 and 2015 from the GLA (using the Ward SHLAA capped AHS short term 2014 Round projections).

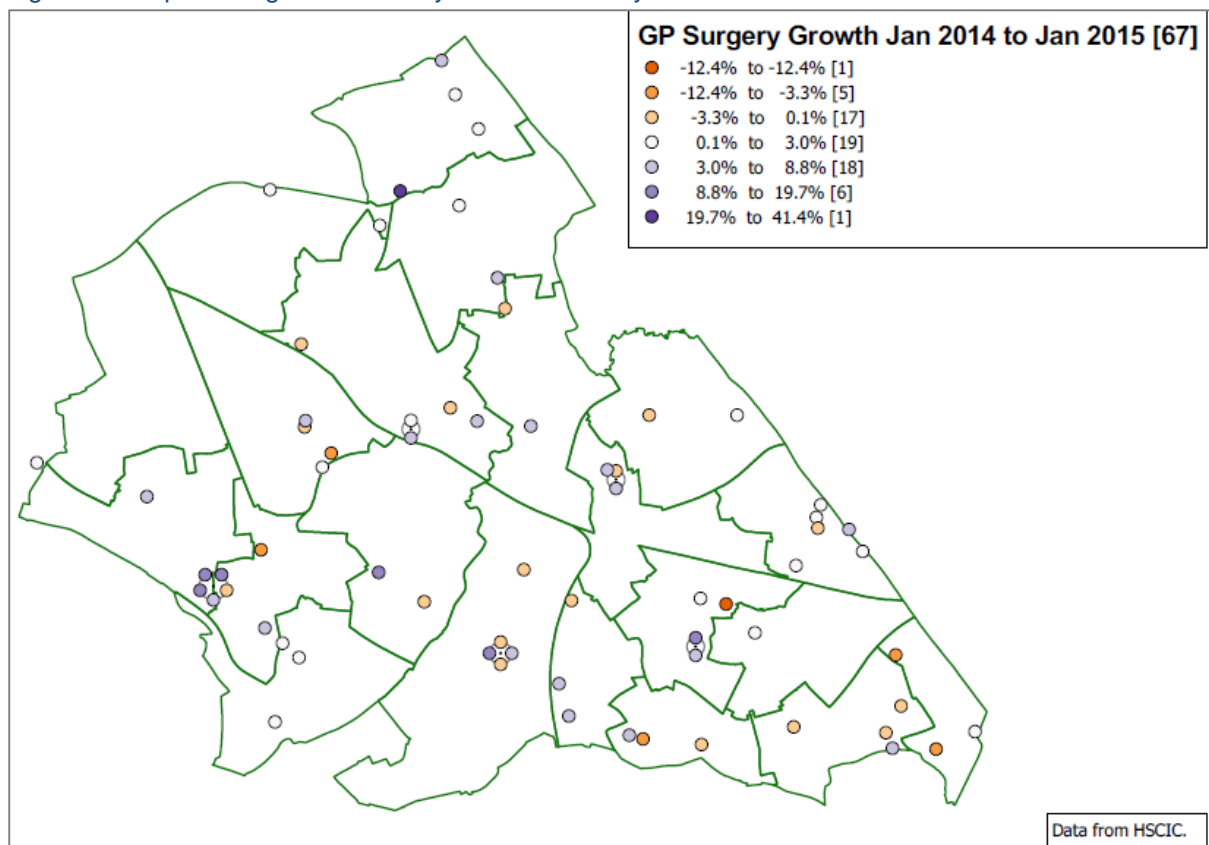
average (median) population growth of 2.9% compared to the ward population growth of 0.8%. More specifically, this is men between the ages of 20 and 54.¹⁹¹⁸

Table 4: Population growth in Brent CCG practice and Brent wards¹⁹

Total population	Brent CCG practices	Brent wards
Minimum	-12.4	-0.4
1 st quartile	-0.9	0.4
Median (average)	1.6	0.6
3 rd quartile	5.1	1.1
Maximum	41.4	5.9

The patient registers of Brent GP practices appear to be growing faster than the population projections. The task group recognise that continuing regeneration across the borough and surrounding areas could impact this further. Looking at the GP practice growth across Brent there is a fairly even spread of growth in the centre of the borough. This is not true for the whole borough, as all practices in Alperton and Queensbury had an increase in registered patients between January 2014 and January 2015. During the same period, the majority of practices within the wards of Kilburn, Queens Park and Kensal Green had a decrease in registered patients as illustrated in figure 9. In terms of pressure, while there are particular wards with a higher rate of growth in patient numbers, an analysis of capacity at individual practice level would be required to determine whether a practice is able to manage this increase in demand.

Figure 9: GP practice growth January 2014 to January 2015²⁰



²⁰ HSCIC

5.2 Access to primary care in Brent

Commissioning arrangements

NHS England commissions all primary care, including medical, pharmacy and optometry, dental and secondary care dental services. Most medical practices operate as independent contractors in a partnership model but the contract also allows for Foundation Trusts and limited companies to be providers (i.e. walk-in centres). GPs generally have responsibility for running their business and managing their premises in addition to providing medical care for their registered population. NHS England funds core GP services based on the number and type of patients on the practice registered list via a national contract. Other payments to practices include additional services, Quality Outcome Framework (reward and incentive programme), enhanced services and funding for premises (e.g. rent reimbursement, rates, capital grants). Enhanced services are primary medical services provided by GPs, over and above the core services to patients, to address the populations healthcare needs.

GP practices are contracted to provide care for patients between 8am and 6.30pm Monday to Friday. Many practices also provide additional services, including extended opening. Brent CCG currently commissions extended primary care outside of core hours through a hub model. Brent CCG is also responsible for commissioning a range of community based services including NHS walk-in centres, Urgent Care Centres, Community Ophthalmology Services, Brent Short Term Assessment Rehabilitation and Reablement Service (STARRS), Brent Integrated Diabetes Services (BIDS), Sickle Cell, CAMHS, health services for Looked After Children, primary care dementia nurses, and community nurses.

The above services are only part of the range of services commissioned by the CCG. Brent CCG also commissions services from GPs and networks to support the Out of Hospital Strategy. This includes cardiology (ECG and 24 hour BP monitoring), insulin initiation, phlebotomy, End of Life, IAPT and cancer injection administration.

Access to general practice and patient experience

There are 67 GP practices in Brent, with practice list sizes ranging from 1,672 patients to 14,518²¹ (a full list of practices sizes is attached in appendix 2). Figure 10 shows the location of practices in the borough and population density. In some cases there is more than one GP practice in the same building. There appears to be a good geographical spread of practices across the borough with the exception of Northwick Park, Kenton and north Preston. However, patients may choose to access practices located outside of the borough.

National figures show that the average number of appointments per patient in general practice rose from 3.9 to 5.5 between 1995 and 2008²². As at 30 September 2014, there were 1,784 registered patients per full time equivalent GP (based on 200.2 FTE) in Brent, which means that the GPs across Brent are delivering approximately 1.9 million consultations a year based on an average of 5.5 appointments per patient per annum. This places huge pressures on practices but will also vary across practices, as illustrated by the number of patients per GP varying considerably in the borough, from 410.8 to 6,256.5.²³ Looking at the number of patients per GP in neighbouring boroughs, Brent is the fourth highest of the eight North West London CCGs (as outlined in Table 5).

²¹ HSCIC – Number of Patients Registered at a GP Practice (April 2015)

²² HSCIC (2008). Trends in Consultation Rates in General Practice 1995 to 2008

Figure 10: Map of GP practices and population density

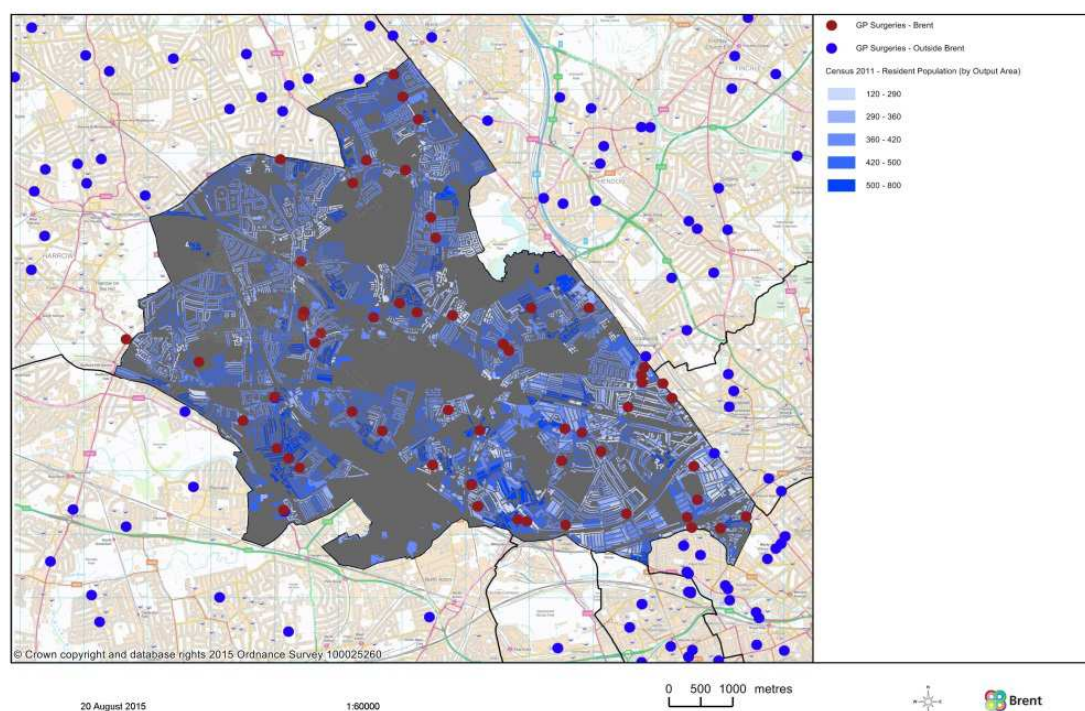


Table 5: GP FTE and patient numbers 30 September 2014²³

CCG	Total Patients	Total GPs (FTE)	Patients per GP	Total number of practices	Population (2011 Census)
NHS BRENT CCG	357,173	200.20	1,784.08	67	311,215
NHS HARROW CCG	252,174	145.64	1,731.51	36	239,056
NHS EALING CCG	413,640	211.11	1,959.35	80	338,449
NHS HOUNSLOW CCG	291,038	142.40	2,043.88	53	253,957
NHS HAMMERSMITH AND FULHAM CCG	201,766	125.25	1,610.96	31	182,493
NHS HILLINGDON CCG	295,072	159.10	1,854.59	48	273,936
NHS CENTRAL LONDON (WESTMINSTER) CCG	199,409	117.48	1,697.43	40	219,396
NHS WEST LONDON (K&C) CCG	234,882	149.05	1,575.83	53	158,649

Brent CCG has lower patient satisfaction results compared to the national average with regards to accessing primary care. Brent ranks 191st out of 211 CCGs with respect to patient satisfaction on opening hours and, for overall satisfaction, Brent ranks 204th out of 211.²⁴

²³ HSCIC General and Personal Medical Services, England – 2004-2014 as at 30 September 2014

²⁴ Brent CCG – Service Specification for Primary Care Access Hubs

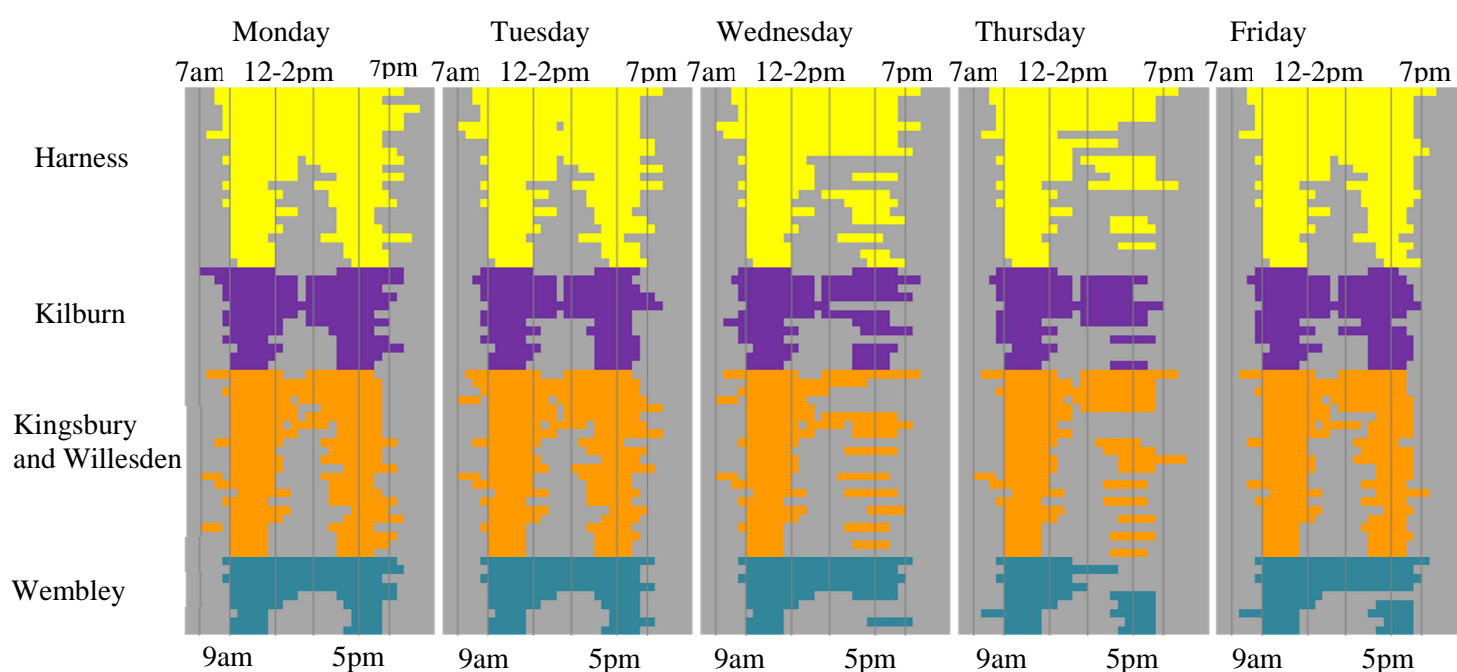
An analysis of the 2013/14 GP patient survey shows that 71.0% of patients would recommend their practice, compared to the national average of 78.7%. Four practices report a significantly better recommendation rate than the average for England, while three have a significantly lower rate. These three practices report a rate below 50%. Statistically, the remaining 60 practices are similar to the England average.²⁵

Table 6: GP patient survey 2013/14 ²⁵

Measure	Brent CCG Average	England Average
Would recommend practice	71.0%	78.7%
Satisfied with phone access	70.4%	75.5%
Satisfied with opening times	73.2%	76.9%
Saw / spoke to nurse or GP same or next day	47.4%	50.7%
Good overall experience of making appointment	68.6%	74.6%
Know how to contact an out of hours GP service	44.2%	55.8%

Satisfaction with phone access is also lower than the national average (70.4% in Brent compared to the England average of 75.5%). Out of the 67 practices in Brent, 17 report a significantly better rate of satisfaction with phone access than the average for England, while eight have a significantly lower rate; five of these report a rate lower than 50%. Telephone access was also raised in the feedback received from participants. During the task groups visits, access by telephone was raised as an issue for practices and a need to invest resources was identified.

Figure 11: Surgery opening times in Brent²⁶



²⁵ <https://gp-patient.co.uk/surveys-and-reports#july-2015>

In Brent, 73.2% of patients are satisfied with opening hours, compared to 76.9% in England. Six practices report a significantly better rate of satisfaction than the average for England, while three are significantly lower (two of which report a rate below 50%).²⁵ Figure 11 shows the surgery opening hours of practices across GP networks in Brent. Practices may be open for longer but the chart shows when GP appointments are available.

All practices offer morning appointments Monday to Friday, with the majority of practices offering afternoon appointments. There are a number of practices which do not offer appointments between 12pm and 2pm. It is acknowledged that some surgeries are sole practitioners and other activities may also take place during these times, for example home visits. Access to appointments outside normal working hours vary across practices. Out of the 67 Brent GP practices, 37 open after 6pm, including 15 that open until after 7pm, and 37 practices open at 8.30am or before. Of these, six open at 7am at least one day a week and ten at 8am.²⁶ Concerns with GP premises were also highlighted through the review and the constraint these may be placing on delivering services.

Results from the 2013/14 patient survey showed that less than 50% of respondents saw or spoke with a nurse or GP the same or next day in Brent, compared to 51% in England. In Brent, 10 practices report a significantly higher proportion of patients able to see or speak to a nurse or GP the same or next day compared to the average for England, while seven are significantly lower. In Brent, 42 practices have a rate below 50% (just under two thirds of Brent GP practices). The majority of respondents (68.6%) reported a good overall experience of making an appointment, compared to 74.6% for England, with ten practices reporting a significantly higher proportion of patients with a good experience of making an appointment than the England average, while four have a significantly lower proportion (two of which have a proportion smaller than 50%). The poorest result related to knowledge of how to contact an out of hours GP service (an average response of 44.2% in Brent), with 54 out of 67 practices having a proportion below 50%.²⁵ This raises concerns regarding how out of hours services are publicised across the borough and any additional information the public may require. The task group feel this is an area which needs urgently addressing.

Waiting times for GP appointments in Brent vary. Based on data from patient survey results, 43.0% of patients wait more than 15 minutes to see a GP, higher than the England average of 27.1%. In terms of perception, 50.6% of Brent patients who expressed a view considered they had to wait too long (*a bit* or *a lot*), compared to an England average of 34.5%.²⁵

It is acknowledged that good access to GP services will mean different things to different people. The service people receive when contacting their local surgery and the ability to make timely appointments will be key to overall levels of satisfaction. In March 2015 Healthwatch Brent commissioned a piece of research into GP services in Brent. The research looked at the process for booking appointments and waiting times. Of those surveyed 31 out of 85 respondents (36.5%) received an appointment on the same day. Of the 31 patients who saw their GP on the same day, 15 said it was easy, while six said that it was not easy.²⁷ The majority of people interviewed make appointments to see their GP by telephone. Patients also go directly to their surgery to make an appointment or wait in a queue. Online booking is being tried by more people but has not always been successful. The research highlighted that the current systems for emergency booking, which rely on early morning contact, may disadvantage certain groups, such as those on particular types of medicine and those who rely on carers. It was also suggested that queuing and online booking disadvantaged older people and those with poor access to IT.

²⁶ NHS Choices: GP opening times, downloaded August 2015

²⁷ Healthwatch Brent

Figure 12: Waiting time at surgery²⁸

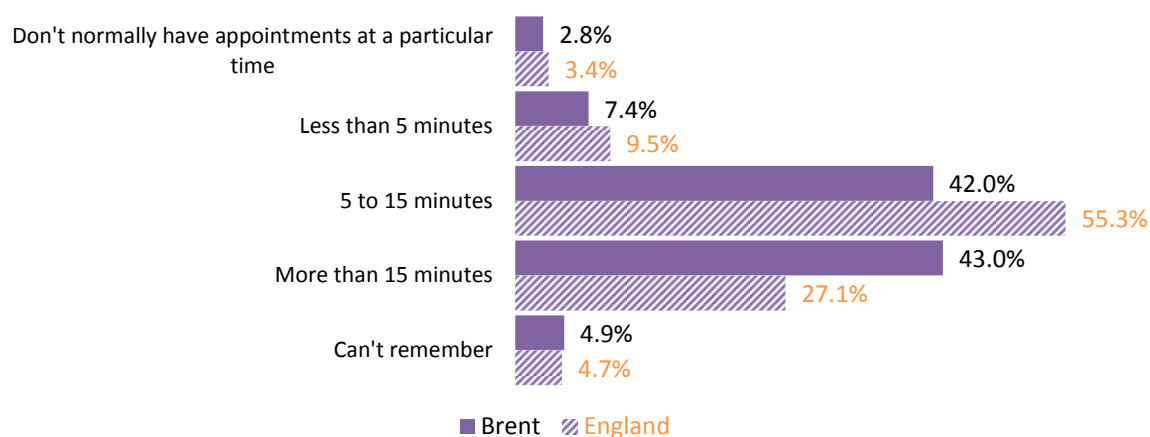
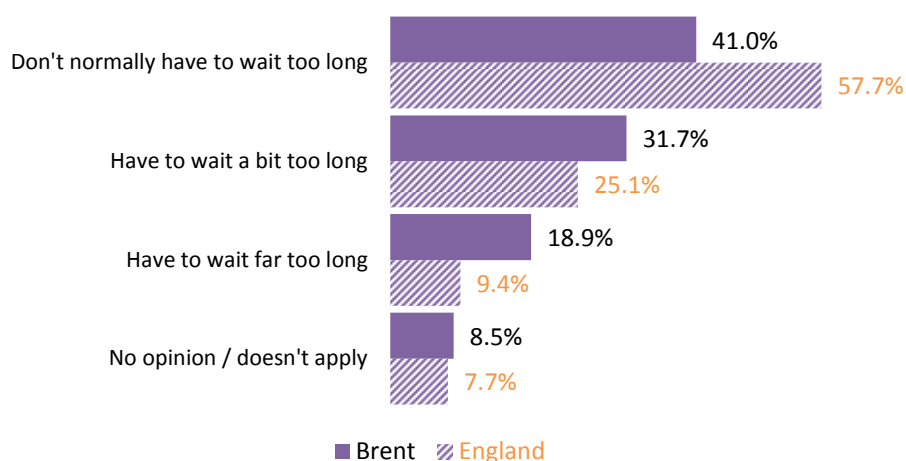


Figure 13: Impression of waiting time at surgery²⁸



The research found that most patients felt that the overall service they receive from their GP practice is good or okay. The response to individual GPs is good, with 94.2% of respondents rating their relationship with their GP as good or okay. The survey also found patients to be loyal to their surgeries, with recognition and appreciation for the good work that is being done.

Ensuring that local people can continue to receive an improved level of service from primary care provision is outlined in Brent CCG commissioning intentions. This includes enabling practices to develop improvement plans to address their performance needs and improve the overall patient experience. Local plans to introduce extended hours in primary care aim to improve access and increase patient satisfaction rates.

²⁸ This is based on aggregated, weighted, data collected from Jul-Sept 2014 and Jan-Mar 2015 by NHS England. Number of respondents giving each answer as a percentage of the number of people who responded to the question

Key Learning and Insight

The task group found that access to GP services continues to be a key concern for Brent residents. There is significant pressure on GPs with capacity stretched, a result of a growing population and increasing demand for primary care. GP services need to find ways to expand or change to meet ongoing demand, including other means of communication.

Residents' experience of access to GP services appears to vary. A number of contributing factors were highlighted, including the variance in the GP to patient ratio and a range of opening times for practices across the borough. Many practices have limited opening hours between 7am and 7pm. There are particular gaps during 12pm and 2pm and on Wednesday and Thursday afternoons. This highlights the need for an urgent review of GP opening hours across primary care centres. It is also acknowledged that GP premises may be placing additional constraints on services.

Patient satisfaction rates in Brent are below the national average, with areas that need addressing including patient experience of making appointments and phone access to surgeries. Awareness of out of hours GP services is also a key concern.

Recommendation 1

NHS England, Brent CCG and local GP networks carry out a review of current GP opening hours across the borough and consider additional ways of accessing GP services, including the roll-out of Skype and FaceTime consultations, telephone consultation and email consultations where appropriate and within Information Governance principles. Online appointment bookings and e-prescription ordering have been enabled in all Brent GP practices and patients should be encouraged to take up these services.

Recommendation 2

The patient survey shows varying levels of patient satisfaction across practices. NHS England and Brent CCG produce an action plan including opportunities for sharing of good practice across networks in improving patient experience when making appointments and contacting the surgery by phone, with a view of improving patient satisfaction rates in the next GP patient survey.

Recommendation 3

Brent CCG and NHS England clarify the out of hours element of the GP contract for people in Brent and publicise out of hours services across the borough given the lack of information and awareness by local residents highlighted in the most recent GP patient survey.

Extended GP services

The development of GP access hubs was seen as a way of freeing up capacity, managing demand differently and providing access to out of hours care through the delivery of seven day care provision. It is dependent on practices working together in networks in order to provide extended access to GP appointments.

A hub is a GP practice that offers evening and weekend appointments for patients registered with other practices in the area, providing access to primary care out of normal GP practice opening times. The pilot scheme of GP access hubs provided a hub in each clinical network across Brent CCG at the following locations (a full list of hubs can be found in appendix 3):

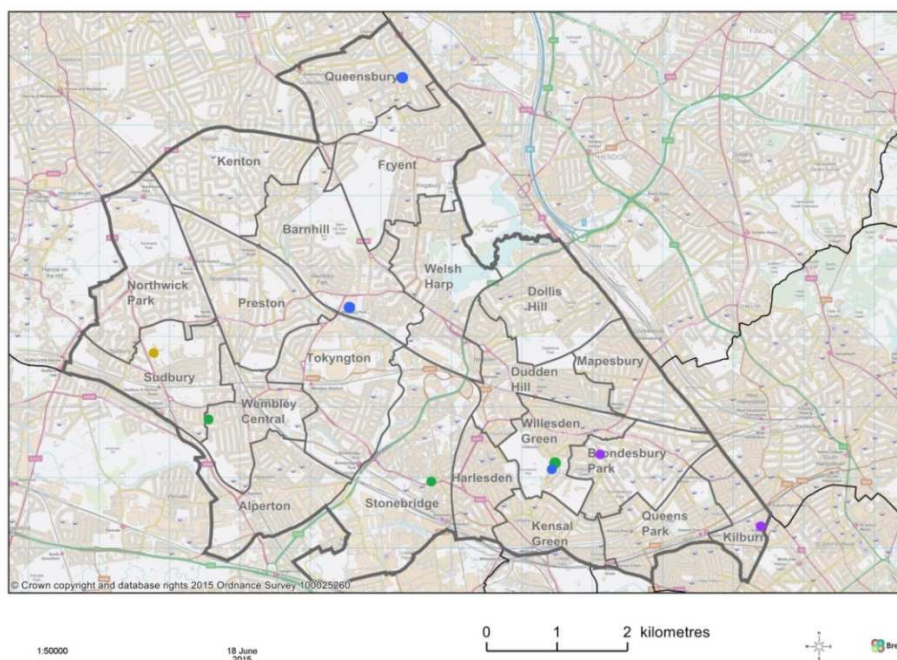
- Harness Locality: Harness Harlesden Practice and Wembley Centre for Health and Care

- Kilburn Locality: Kilburn Park Medical Centre and Staverton Surgery
- Kingsbury Locality: Chalkhill Family Practice
- Willesden Locality: Willesden Centre for Health and Care
- Wembley Locality: Integrated Health CIC and Sudbury Primary Care Centre

An evaluation of the pilots was undertaken in January 2014 and the Applied Research Unit at Brent CCG analysed 900 patient satisfaction questionnaires. Patient feedback from the pilots was positive with patients reporting that they like being able to see a GP or a nurse in the evenings and at weekends. Patients also said that they would recommend the service to family and friends. Over 75% of users stated that they would go to A&E or the Urgent Care Centre if the service was not available to them²⁹. An analysis of the demographic data showed that most users are aged between 20 and 50 (65%), with the largest number aged 30 to 39 (27%). The majority of users were female (64%) and about 55% of users were unmarried.²⁹ Figures provided by Brent CCG show that the highest usage in the pilot sites was between 3pm and 6pm. The areas for improvement highlighted during the evaluation of pilots in January 2014, including poor levels of utilisation, a need to increase publicity and marketing, and establish patient pathways to refer patients from other services such as A&E, UCC, LAS and 111, are being addressed by Brent CCG.

Following a review of the pilots, the CCG carried out a procurement exercise for a longer-term service in 2014, with the implementation of a three year contract from April 2015. GP hubs and access to extended opening hours are outlined in Brent CCG's commissioning priorities for 2015/16 and the model has been rolled out to additional sites. The location of GP hub sites is detailed in figure 14. This was based on a revised service specification, which details both national and local defined outcomes for the service. The main changes include removing week day afternoon appointments at hubs due to NHS England requirements that the service should not overlap core GP hours and changes to weekend appointments (revised hours of 9am to 3pm on Saturday and Sundays and to include bank holidays).

Figure 14: Map of GP access hubs



²⁹ Brent CCG – Hub Access Service Review of Pilot Sites (September – December 2013)

The sessions on a Saturday afternoon have been reduced as appointments were not being taken up in the pilot arrangements. However, the changes in operating hours have removed some of the additional capacity as the availability of the afternoon appointments, offered as part of the initial pilots, could alleviate some of the pressure on practices in providing additional appointments during week days. This will not be offered going forward as GP practices are funded to provide core hours.

The total investment in extended GP hubs is £1.9 million, funded by Brent CCG.³⁰ In March 2015, the hubs had delivered an additional 70,000 GP and nurse appointments in primary care³⁰. Utilisation figures for pilot sites outlined in the Hub Access Service Review (September – December 2013) showed a total GP utilisation of 42% and utilisation of nurse appointments at 25%.²⁹ As part of the new service specification, providers are required to complete and return monthly utilisation reports and the specification sets out key performance indicators including a reduction in A&E and Urgent Care Centre attendances. The target is for 85% capacity utilisation, 90% of patients seen within waiting times of no more than 20 minutes and delivering 90% patient satisfaction.

Under the new arrangements, there are 1,234 GP and nurse appointments offered per week. Figures provided for April 2015, showed utilisation of 59.9% for GP appointments and 32.1% for nurse appointments across all sites. As outlined in the figures in Table 7, the utilisation in April 2015 varied across localities from 83.3% of appointments booked in Harness to 38.6% in Wembley. This is an improvement on the pilot scheme and the overall percentage of GP appointments booked had increased further in June 2015 to 67.7% across all sites. A total of 7,064 patients were seen by a GP at a hub between April and June 2015 (from 8,036 appointments booked). Utilisation of nurse appointments also increased between April 2015 (32.1%) and June 2015 (43.3%). However, figures are still significantly below the target of 85% utilisation, which raises some questions about the best use of the nursing role. There are also a number of do not shows, averaging 12.8% for GP and nurse appointments across all sites in April 2015, 10.2% in May 2015 and 11.3% in June 2015.³⁰

Table 7: GP access hubs utilisation April – June 2015³⁰

Network	Apr-15			May-15			Jun-15		
	GP appts offered	No. booked appts	Percentage of booked appts	GP appts offered	No. booked appts	Percentage of booked appts	GP appts offered	No. booked appts	Percentage of booked appts
Harness Kingsbury & Willesden	1,110	925	83.3%	1,272	1,026	80.7%	1,206	990	82.1%
Kilburn	1,351	750	55.5%	1,375	849	61.7%	1,451	1,051	72.4%
Wembley	1,012	550	54.3%	1,130	586	51.9%	931	593	63.7%
TOTAL	684	264	38.6%	726	197	27.1%	681	255	37.4%
TOTAL	4,157	2,489	59.9%	4,503	2,658	59.0%	4,269	2,889	67.7%

During November and December 2014, Healthwatch Brent carried out a survey asking residents about GP hubs. This was carried out via a questionnaire sent to members and contacts. A total of 41 responses were received. This is a relatively small sample of residents and some respondents lived in the London Borough of Harrow (information on the registered practice was not collected). The results of the questionnaire showed that the majority of respondents did not know what a GP hub appointment was and 15% of people surveyed had used a hub appointment, highlighting a possible problem with communication about the model. The results showed that almost everyone had a positive view of their GP practice, and most people were prepared to wait for an appointment. In response to the

³⁰ Brent CCG

general experience of their own practice, the majority of respondents felt making a GP appointment is OK, quite good, good or very good. A copy of the report can be found in appendix 4.

A key area of concern for the task group was that access to additional appointments, without having to wait, may come at the cost of continuity. Continuity of care allows an individual to build up a relationship with their GP. There was also concern about access to patient records and the process for following up on patients seen at a hub site. There are agreed procedures in place to manage this. Patient records are sent via secure email from the registered practice to the hub where the appointment will be held. This is sent either the day before or on the day of the appointment. The hub updates the patient record and sends it back to the registered GP practice to ensure any issues or concerns are followed up. A summary report of the hub attendance is received by the registered practice the next working day. Performance indicators have been built into the contract to monitor this process. The task group feel there is an additional need for the patient to receive their hub attendance report so they understand any required follow up. This will also help promote patient engagement and support ownership of their individual care. An agreed written procedure for receiving and acting on recommendations from the hub visit would support this.

The relationship between GP practices and the GP access hub model is unclear. Performance monitoring indicates that the full capacity of the service is not currently being utilised. Improving the utilisation of extended GP services would require increased publicity across the borough, including clarity over the purpose and range of services offered in the hubs, particularly in relation to nursing. Given the importance of self care in the SaHF model, details of health promotion built into the model would be of benefit. With an emphasis on meeting targets and delivering services seven days a week, contracts are based on seven day access but, feedback received indicates that some patients do not want to visit a GP at the weekend, as weekend appointments are not being filled. There is also further information required in analysing any equality impacts of the model of extended primary care.

Key Learning and Insight

Over 70,000 additional appointments have been offered to date through the GP access hub model. Data shows a recent increase in the take up of GP access hub appointments but utilisation still remains below the target level for the service.

It appears that awareness of the roll out of GP access hubs and access to the hubs has been varied across the borough, which is having an impact on utilisation of the service. There is still some confusion over the range of services offered in hubs and how local residents access them in fully utilising resources.

The evaluation of the pilot phase indicated that the majority of people using the service were young women, which raises further questions as to whether the range of services on offer are meeting the needs of users. Additional appointments are not being offered at times that suit patient preferences as these fall within the GP core hours (the highest usage in the pilot was between 3pm and 6pm) and may not alleviate pressures on GP practices, UCCs and A&E.

Recommendation 4

Brent CCG develops a written protocol between GP practices and GP Access Hubs for the receipt of hub attendance reports to ensure continuity of care and minimise the risk of fragmentation of primary care health services.

Recommendation 5

Brent CCG carries out a detailed review of GP Access Hubs following the initial six months and first full year of operation against the new service specification, providing a detailed evaluation on the level of take up, impact on patient satisfaction regarding access and impact on A&E and UCC attendances.

Recommendation 6

That the review, outlined in recommendation five, includes public engagement to assess the extent to which the model reaches and benefits all residents in any part of the borough, including vulnerable groups, and to determine public support for the model.

5.3 Delivering the out-of-hospital strategy

The development plans for Brent's out-of-hospital services were outlined in March 2012 and endorsed by the Brent CCG Governing Body in May 2012. The strategy sets out five main areas of action, including:

- Easy access to high quality, responsive primary care making out-of-hospital care first point of call for people;
- Clear and planned care pathways;
- Rapid response to urgent needs – if a patient has an urgent need, a clinical response will be provided within four hours;
- Social care and health providers working together;
- Patients spending an appropriate time in hospital, supported by early discharge.

Initiatives to deliver the actions set out in the out-of-hospital strategy are being rolled out.

The Brent Short Term Assessment Rehabilitation and Reablement Service (STARRS) is reported to be delivering year on year improvements in preventing hospital admissions and was set to exceed its 2014/15 target to prevent 2,300 admissions.³¹

Services aimed at delivering more outpatient services in the community and develop community health care facilities are in the early stages. This includes Community Ophthalmology Service (implemented October 2014), Brent Integrated Diabetes Service (launched October 2014) and Sickle Cell Service (commenced March 2015).

If, as outlined in the transformation plans, hospitals focus on the provision of specialist services, other services need to be fully established in a community setting. Despite the investment in out-of-hospital services there appears to be little progress, with many services still in the early phases of implementation. Without robust data available, it is too early to evaluate the impact at this stage.

Key Learning and Insight

The task group acknowledge the success and impact of STARRS in preventing hospital admissions. However, the roll out of other areas outlined in the out-of-hospital strategy have been delayed, with a number of services starting in late 2014. It is too early to measure the impact of these services in evaluating the investment of both time and resources in commissioning out-of-hospital community based services and the benefits these are

³¹ Brent CCG - figures provided in March 2015 showed 2,796 preventions

delivering for local residents.

Recommendation 7

Brent CCG carries out a rolling programme of evaluation of the impact of the out-of-hospital strategy against individual contractual arrangements for services.

Recommendation 8

Brent CCG outlines its plans to commission any additional community services to support primary care to meet the needs of Brent residents in the community following its support for changes to hospital care.

5.4 Developing an integrated care approach

Integrated Care Programme

The Integrated Care Programme (ICP) was introduced in 2012 to improve care for people with long term conditions such as diabetes, coronary heart disease, respiratory problems and those over the age of 75. The ICP is focused on delivering person-centred integrated health and social care across the boroughs of Brent, Ealing, Harrow and Hillingdon. The ICP works with a range of partner organisations and stakeholders, including acute trusts, mental health trusts, local authorities, community services and primary care, as well as voluntary sector organisations.

As part of the programme, multi-disciplinary groups meet in each locality on a monthly basis to discuss patients referred to them. The aim of the multi-disciplinary approach is to care for patients within the community wherever possible and avoid unnecessary hospital admissions. The multi-disciplinary groups observed were well attended and provided a good opportunity for discussion and support.

The current NHSE guidance recommends that GPs carry out a care plan for the top 2% most vulnerable patients identified using an appropriate risk stratification tool. This equates to approximately 7,200 people based on the current population in Brent. Integrated care is predominantly aimed at people with long-term conditions. Figures provided by Brent CCG in July 2015 estimated that there are around 57,528 people in Brent living with a long-term condition³², out of a total GP registered population of 363,071³³. However, not all of these people are likely to need a care plan as many of them will be stable and not at high risk of admission. A joint decision between the patient and their GP as to whether they feel they would benefit would form part of the process. Figures provided by Brent CCG in March 2015 show that in excess of 8,500 care plans had been completed, 142 multi-disciplinary group meetings held with 477 patients discussed. The number of care plans completed since the start of the ICP in 2012 had increased to 11,000 in July 2015, with just under 6,000 having been carried out in 2014/15.³²³²

A quality review audit of the care planning process was carried out in January 2015. The purpose of the audit was to review the quality of care plans, to improve learning through sharing good practice and to improve quality of plans. Brent CCG evaluated the ICP through 600 patient surveys; these provided positive feedback on the programme. The findings show that the care plan has enabled 72% of people surveyed to be more confident to manage their health, and 75% of patients with a care plan said their family or carer was

³² Brent CCG

³³ HSCIC

involved in decisions about their health as much as they wanted them to be. Figures provided by the CCG in March 2015, showed that the outcomes delivered through the ICP had also included a reduction of 398 non-elective (emergency) admissions.³²

Health and Social Care Coordinators

The HSCC role has been introduced as part of a 12 month pilot programme funded by Brent CCG through the ICP. The team are currently being supported through a bespoke training programme. There are economic drivers for this model, including a reduction in A&E attendance and a reduction in hospital admissions, as well as outcomes of improved patient experience.

Appointments were made in 2014. HSCCs act as the first point of contact for patients in relation to their care and provide support for the delivery of care plans, signposting patients to services and resources within the community where appropriate. The task group had the opportunity to attend an Action Learning Set and discuss case studies. The individual case studies highlighted good outcomes in terms of delivering interventions to reduce dependency on GP services and avoid unnecessary hospital admissions.

HSCCs are viewed as playing a key role at the heart of multi-disciplinary groups, acting as the first point of contact for vulnerable people in relation to their care. There are currently 13 HSCCs representing 180 practices across three boroughs. There are five HSCCs in Brent, covering 67 practices across the borough. The HSCCs support joint working across agencies, working with both the local authority and voluntary sector to identify those who might not have been identified via a GP route. They also receive referrals from Adult Social Care. The HSCCs provide support as part of the hospital discharge process and work alongside STARRS, making referrals to and picking up cases from STARRS as appropriate.

During the observation of the HSCC Action Learning Set, the task group were presented with several case studies from HSCC Teams across the three boroughs. There appeared to be common circumstances for the individuals supported by the HSCCs and similar information provided in terms of interventions detailed in the case studies. Support was offered to patients who were frequent users of A&E and had high numbers of GP calls. The HSCCs deliver a range of interventions coordinated through the care plan, including regular contact with the patient, family and carer. The HSCCs are also able to raise cases with GPs and at practice meetings, organise home and hospital visits and facilitate multi-disciplinary meetings where necessary. There appear to be good outcomes delivered through these interventions including securing temporary step-down care for patients, and finding workable solutions in avoiding dependence on GP services (for example, support from carers within the home, links with befriending services and access to pharmacies). They were also able to share good outcomes, including an overall reduction in hospital admissions contributing to a reduction in non-elective (emergency) admissions. The work of the HSCCs relies on information sharing and good local knowledge in facilitating access to the right support within the community. They also have a role in sharing information with patients and introducing use of other agencies where appropriate. Some challenges were raised, in terms of information sharing, including system flow issues from hospital to GP practice.

Case studies provided by the HSCCs highlighted some good outcomes in individual cases presented to the task group. The task group identified areas for consideration in reviewing the pilot and planning future arrangements for the role. The team are currently being supported through a bespoke training programme but it is unclear how they will be supported going forward or how future arrangements will be funded. Details of the reach of the role were also unclear and there appear to be differing viewpoints as to the key focus (clinical or support services). There is also further clarity required regarding the level of responsibility

and breadth of the role, in identifying any potential areas of overlap with other roles and services. An added complication raised through discussions is that there is no single agency employer bringing together one joint management framework.

Key Learning and Insight

The task group acknowledge the positive outcomes of a multi-disciplinary approach and the opportunity for professionals to meet through multi-disciplinary forums in sharing resources, knowledge, skills and expertise.

There is a clear need for a coordinated role across health, social care and the voluntary sector. This role should have at its core ensuring that the patients' needs are paramount. It is felt that with the coordinators are currently constrained by the number of patients they have to see. The core competencies, level of responsibility and breadth of this role need to be reviewed in considering future arrangements. It is also evident that this role can only function effectively if the services are available to meet the needs of the vulnerable patients in the community.

Recommendation 9

Brent CCG in partnership with Brent Council's Adult Social Care Department review the job description of care coordinators, including the breadth, key requirements and core competencies of the role currently being piloted to ensure these can be fulfilled.

Recommendation 10

Brent CCG outlines its plans to commission any additional community services to support primary care to meet the needs of Brent residents in the community following its support for changes to hospital care.

5.5 Investing in the primary care workforce

General Practitioners

A national shortfall in GPs has received much attention. In 2013, the Royal College of General Practitioners (RCGP) released information indicating that a lack of funding could lead to a shortfall of 16,000 GPs in England by 2021.³⁴ A survey of 458 GPs carried out by Pulse in April 2015, found that 9% of Full Time Equivalent (FTE) GP positions are currently unfilled, compared with a 6% vacancy rate in 2014.³⁵ More recently, the RCGP said the pressure of more consultations, complex cases and increased bureaucracy was causing fatigue and burnout.³⁴ Figures for GP vacancies in Brent were requested as part of the review but were not available at the time of writing.

In September 2014 there were 254 GPs working in Brent both full and part-time equivalent (200.2 FTE)³⁶. In 2012 and 2013 there were 208 FTE GPs in Brent, showing a reduction of 7.8FTE.³⁶ The headcounts and FTEs for other types of practice staff are shown in table 8.

³⁴ Royal College of General Practitioners

³⁵ http://www.pulsetoday.co.uk/your-practice/practice-topics/employment/gp-vacancy-rate-at-highest-ever-with-50-rise-in-empty-posts/20009835.article#.VberH_7bKJA

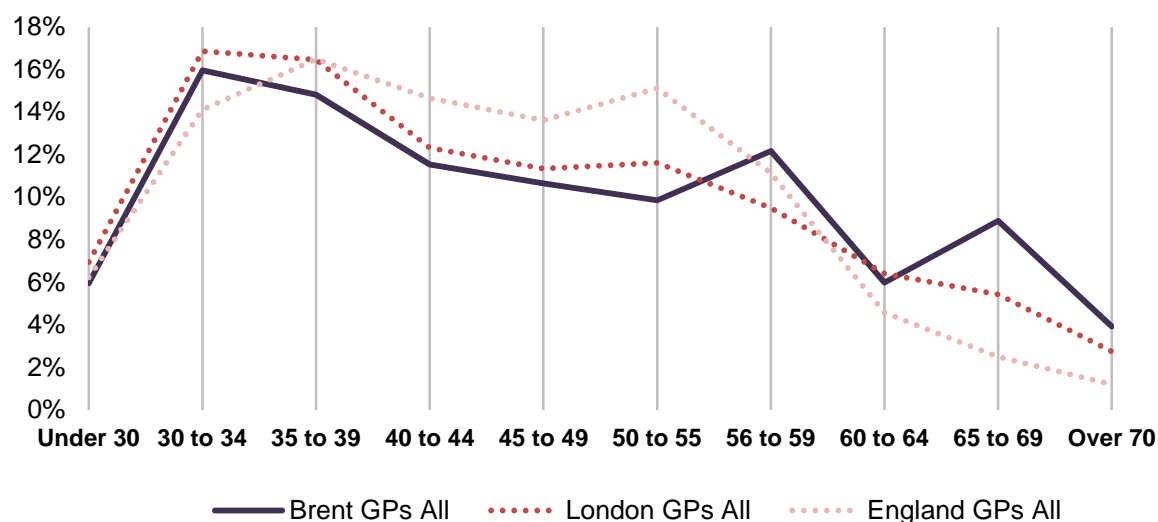
³⁶ HSCIC

Table 8: GP headcount and full-time equivalent (as at 30 September 2014)³⁶

Role	Headcount	Full-time equivalent
GPs	254	200.20
GP Provider	158	133.23
GP Registrar	25	22.20
GP Retainer	3	1.33
GP Other	68	43.44
Practice Staff	744	460.81
Direct Patient Care staff	97	45.88
Admin staff	499	352.68
Other staff	43	9.60
Nurses	105	52.65
Advanced Nurses	13	8.65
Extended nurses	12	3.37
Practice Nurses	80	40.63

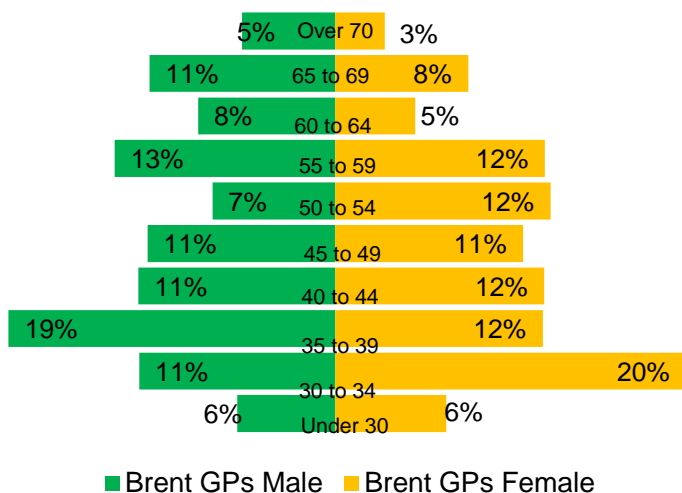
In Brent 16.0% of GPs are aged between 30 and 34, in line with National and London averages. Brent CCG has a lower proportion of younger GPs (under 50) than England, and slightly below that of London (CCGs within the London Commissioning Region) and a higher proportion of GPs in older age groups (65 and over) than London or England.

Figure 15: FTE GPs by age groups³⁶



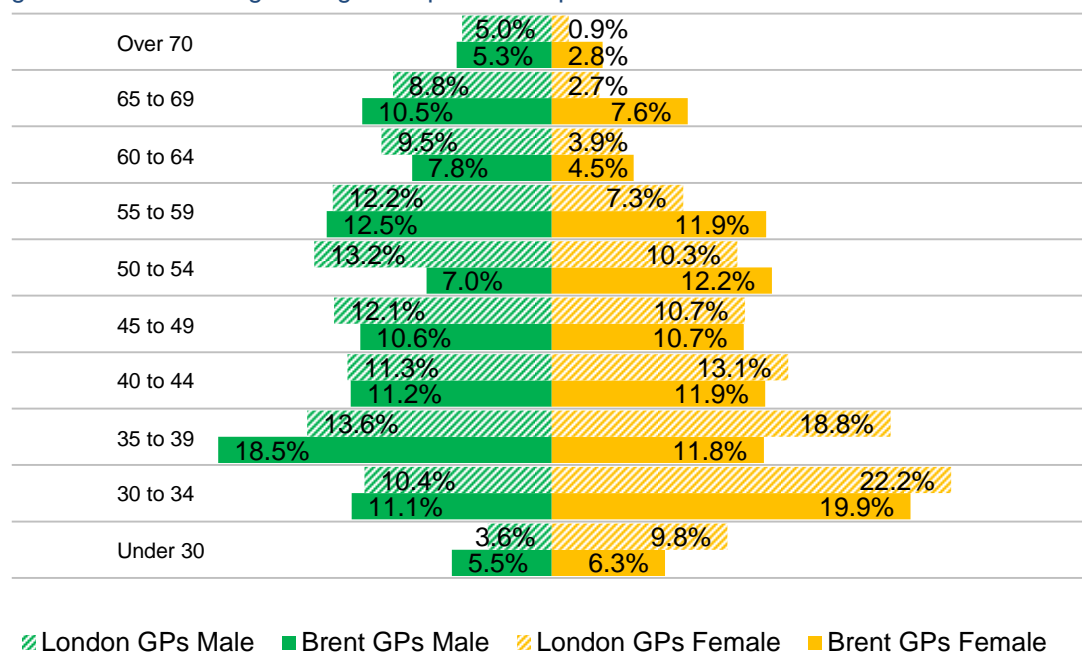
There are more female GPs in Brent than male GPs, with 110.0 female GPs compared to 90.2 male GPs (FTE). When the headcount is considered, there is a more marked difference, with 149 female and 105 male GPs. This suggests that men are generally working more hours than their female colleagues. Figure 16 shows the number of male GPs within each age group as a percentage of all male GPs and the number of female GPs in each age group as a percentage of all female GPs.

Figure 16: GPs in Brent³⁶



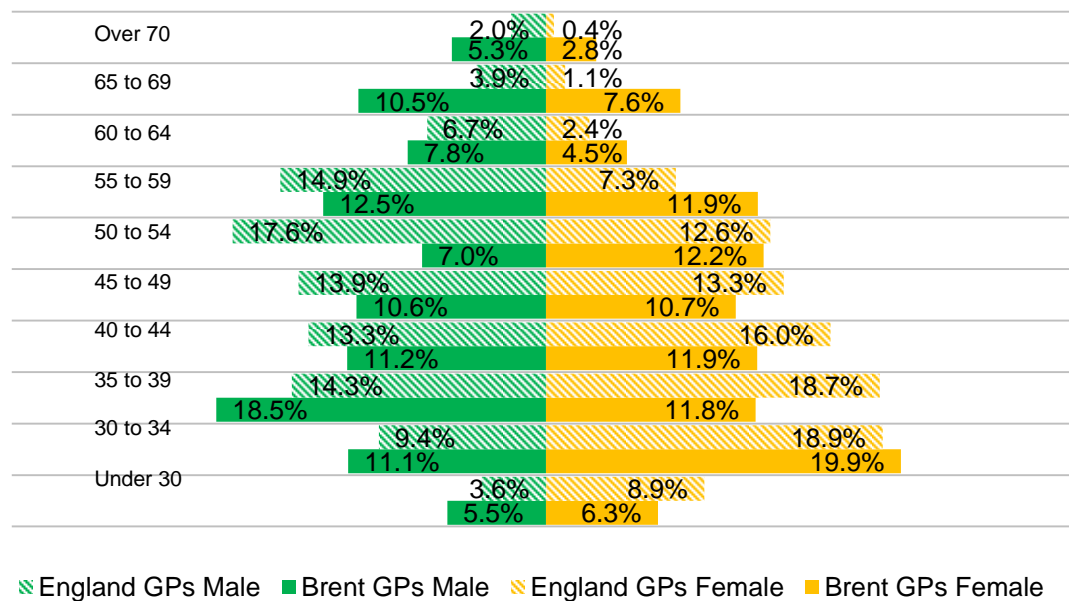
There is a noticeable discrepancy between male and female GPs in their 30s, with a greater proportion of women aged between 30 and 34 and a greater proportion of men between 35 and 39. Comparing this pattern with London and England averages, the higher proportions of female GPs aged 30 to 34 seems typical, while the higher proportion of male GPs aged 35 to 39 is more unusual.

Figure 17: Brent GP age and gender profile compared to London³⁶



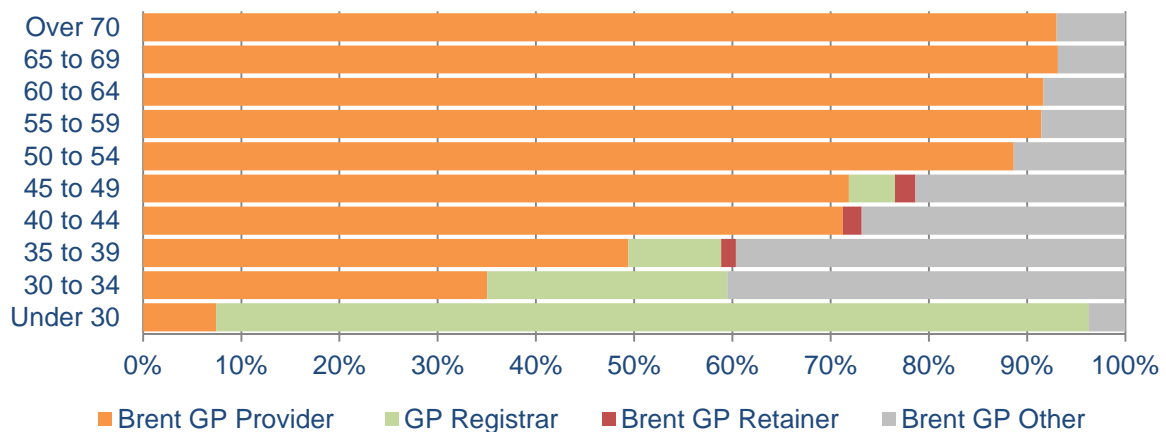
There are slightly more men in older age groups in Brent, with 43.1% of male GPs and 39.0% of female GPs are over 50. Comparing Brent with London and England, the tendency for male GPs to appear in older age groups is much more marked. Across London and England, almost half of male GPs are over 50 compared to around a quarter of female GPs. However, as outlined above, there is a higher proportion of GPs in Brent aged 65 and over compared to London and England.

Figure 18: Brent GP age and gender profile compared to England³⁶



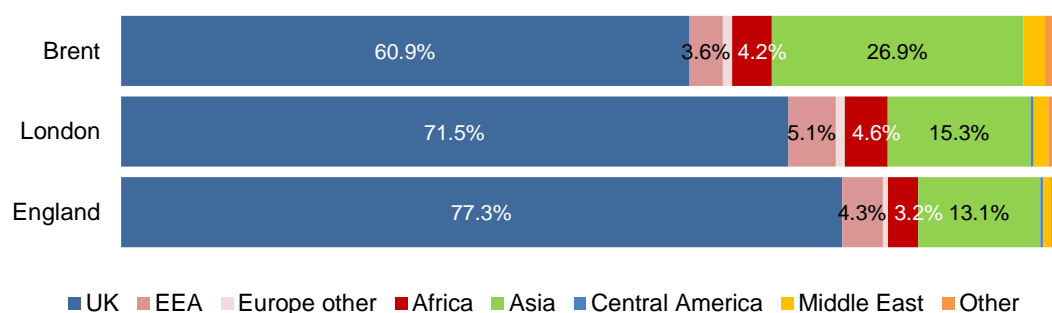
Of the types of GP classified, GP Registrars (those being trained for general practice) are generally the youngest. In Brent, around 90% of GPs under 30 and a quarter of GPs aged between 30 and 34 are GP Registrars with fewer than 10% in the older categories. Brent's distribution of GP types to age groups is in line with London and England.

Figure 19: Brent GP type and age³⁶



Around 60% of GPs in Brent qualified in the UK, about 10% lower than London and 17% lower than England. A further breakdown of county of qualification is included in the primary care workforce profile in appendix 5.

Figure 20: Country of qualification³⁶



District nursing

District nurses are commissioned by the CCG and provided as part of LNWHT Community Services. The service cares for patients in the community and has a close working relationship with primary care. District nurses provide individual healthcare needs assessment, care planning and provide nursing care within the home. Issues regarding recruitment and retention were raised during the review. This requires further investigation in looking at plans to increase the workforce in Brent. Feedback received during the review included a need to develop a programme to support district nursing, to ensure an effective, motivated and responsive service is in place. This service is key to the delivery of the out-of-hospital strategy. The task group have some concerns regarding the issue of recruitment and retention and the impact this may be having on residents and GPs ability to access the service. The task group felt that clearer commissioning commitments to an extended and enhanced district nurse workforce were needed.

Investing in the workforce

In January 2015 a £10 million investment to expand the general practice workforce was announced by NHS England. Building the Workforce – the New Deal for General Practice (NHS England 2015) sets out a ten point action plan and outlined NHS England’s commitments to tackle workforce issues. NHS England has developed a range of initiatives in collaboration with Health Education England (HEE), the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) to increase the number of GPs and develop the role of other primary care staff such as nurses and pharmacists. This includes a marketing campaign to promote general practice and recruit newly trained doctors into general practice in areas that are struggling to recruit. It would ensure that GPs are retained through offering part-time work opportunities for individuals considering a career break or retirement and encourage doctors to return to general practice through the introduction of a new induction and returner scheme. There will be targeted investment to encourage GPs to return to work in areas of greatest need.

The investment and initiatives outlined above have been developed to tackle workforce issues. It will be a while before the outcomes are fully realised which will not address current issues in balancing capacity and demand. At the same time as pressures on capacity, the expectation and demands for what GPs are being asked to deliver in terms of quality and quantity has increased. The Local Medical Committees (LMC) outlined that the ambition is for 20 minute patient consultations, where required, in their discussion with the task group. At present this is constrained by both GP numbers and premises, with investment in doctors surgeries required.

Key Learning and Insight

The task group acknowledge and welcome the initial investment in the recruitment and retention of GPs but realise the impact of new initiatives to address the national shortage in GPs will take time to be realised. It was also felt, with a growing role of primary care, further investment will be required to fully address pressures on the service and ensure the workforce is resourced to support the move to community based care outlined in transformation programmes.

There has been a reduction in the number of GPs in Brent between 2013 and 2014 and figures show a higher proportion of GPs in older age groups (65 and over) compared to London and England. Any additional shortfall in capacity will place further strain on services already under pressure. There are also additional concerns regarding support for district nursing.

Recommendation 10

Brent CCG in partnership with LNWHT Community Services investigate the extent of the gap in recruitment and retention of district nursing in Brent and consider the need for a programme to support district nursing, focused on ensuring an effective, motivated, independent and responsive service is in place.

5.6 Responsive urgent and emergency care

Brent's residents have a number of routes to access urgent and emergency care, including A&E at Northwick Park Hospital, Urgent Care at Central Middlesex Hospital, Northwick Park Hospital, St Mary's Hospital or St Charles Hospital, Walk-in Centres in Wembley, Edgware or Cricklewood and out of hours cover at General Practice. Results of the patient survey 2013/14, as outlined in section 5.2. show that only 44.2% of patients know how to access out of hours care.

Urgent Care Centre

Brent CCG commissions the Urgent Care Centre (UCC) at Central Middlesex Hospital, delivered by Care UK. The UCC offers medical care 24 hours a day, seven days a week, to treat minor illness and injuries that require urgent and immediate attention. The UCC is a GP led service with an interdisciplinary team of GPs, nurse practitioners and Health Care Assistants. The Centre receives patients through the NHS 111 service, the London Ambulance Service and walk-in patients. The task group visited the UCC at Central Middlesex Hospital as part of the review. Prior to the visit, the task group were concerned with access, facilities, waiting times, patient experience and utilisation of the centre.

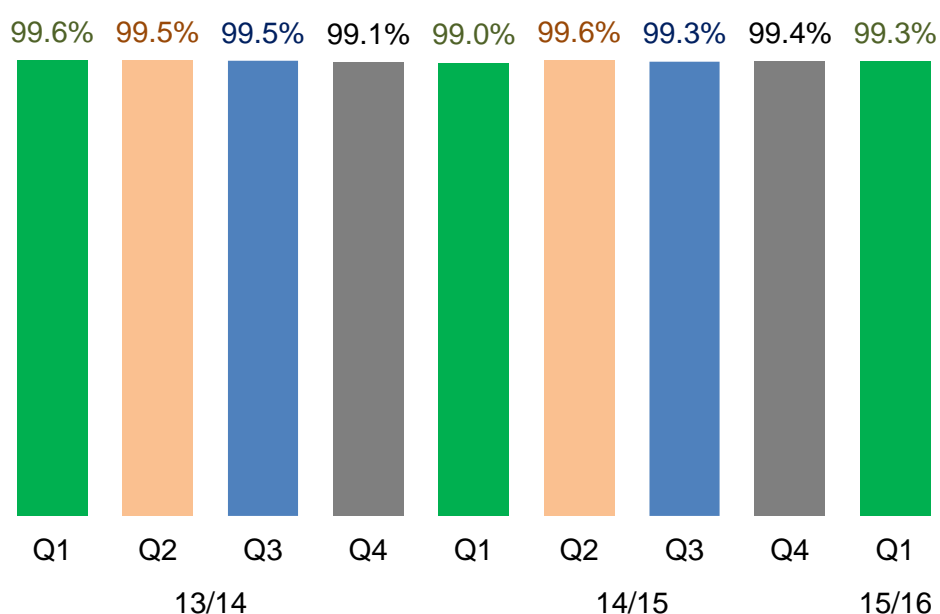
During the task group visit, members were informed that steps had been taken to ensure that the UCC could respond to needs following the closure of the A&E department at Central Middlesex Hospital. Additional facilities and services have been commissioned including a holding bay to manage any transfer requirements and private ambulance service to support non-emergency transfers. Waiting times are reported to vary dependent on medical priorities. Over 99% of patients are seen at Urgent Care Centres and Walk-in Centres within four hours, as illustrated in figure 21.

UCCs are required to offer a breadth of expertise, seeing high risk patients, especially now the A&E facility has closed. It is recognised that access to the service will vary, as what is deemed urgent may differ between individuals and clinicians.

Figure 23 shows an increasing trend in UCC and walk-in centre (WIC) attendances, which may be a result of difficulty in accessing GP appointments. However, coverage of the UCC at Central Middlesex Hospital reported a decrease in UCC attendance in February 2015³⁷. This could have been following one of the clear dips (illustrated in figure 22) or might be that patients are unaware of the service and facilities or treatment provided at Central Middlesex Hospital; this requires further investigation.

There are still questions regarding residents' awareness of the service, as well as the success of the communication strategy to publicise the UCC. Barriers to accessing the facility were experienced during the task group visit, including poor signage and the cost of parking.

Figure 21: Percentage of patients seen at WIC and UCC within four hours 2013/14 to Q1 2015/16³⁸



³⁷

http://www.kilburntimes.co.uk/news/health/brent_urgent_care_centre_sees_decrease_in_patients_as_a_e_demands_rise_1_3971026

³⁸ Source: NHS England: A and E attendances and emergency admissions

(<http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/>)

Information for London North West Healthcare NHS Trust from Q3 2014/15 onwards; 2013/14 and Q1 and 2 2014/15 information for North West London Hospitals NHS Trust and Ealing Hospital

Figure 22: A&E and UCC weekly attendances³⁹

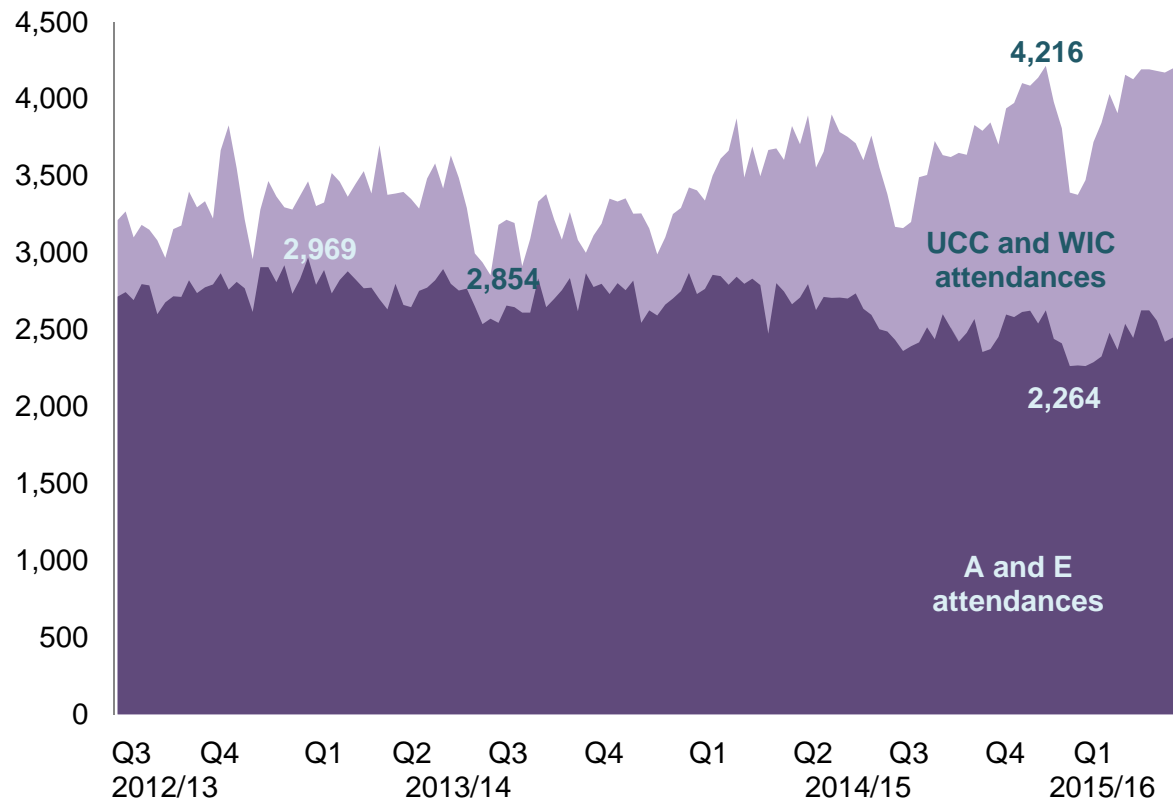
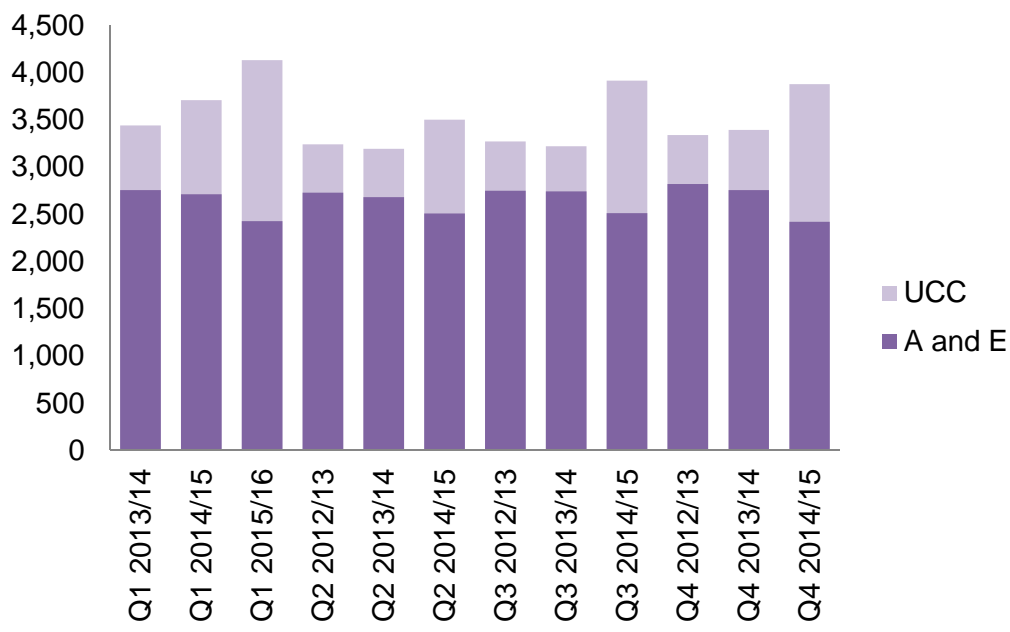


Figure 23: A&E and UCC attendances by quarter⁴⁰



³⁹ NHSE. Up to Q2 2014/15 – dataset for Ealing Hospital and NWL Hospital Trust. From Q3 2014/15 – dataset for London North West Healthcare Trust.

⁴⁰ NHSE

London Ambulance Service

There are currently concerns regarding the performance of the London Ambulance Service (LAS). National standards for responding to a life threatening or urgent case is eight minutes 75% of the time. Figures provided in January 2015, showed that the LAS were reaching 75% of the most seriously ill and injured patients in under 11 minutes. Brent is the fourth busiest borough in London for category A emergency calls. Of these calls, 56% were responded to within eight minutes and 92% within 19 minutes.⁴¹

The LAS staffing levels continue to be below where they need to be. London has the highest utilised staff in the country (utilised for 90% of the day, from job to job, compared to other parts of the country which are around 60%).⁴¹ There is a national shortage of paramedics and the recruitment and retention of staff is key to service performance. At the end of November 2014, LAS had 411 frontline vacancies. In January 2015, Brent had 55 vacancies.⁴¹ Frontline shortages are being addressed through a range of measures, including working with universities to roll out training programmes and a national and international campaign to recruit staff, with a targeted campaign in Australia. However, it appears that there was a delay in addressing staffing issues within the LAS and the task group has some concerns regarding how staff retention will be addressed, with factors such as the cost of living likely to have an impact on staff turnover in London.

Key Learning and Insight

There is a general increase in UCC and walk-in centre attendances. The services are required to offer a breadth of expertise and it is acknowledged that additional facilities have been commissioned for the UCC at Central Middlesex Hospital to provide care for patients. There still remain concerns regarding residents' awareness of these services in supporting individuals in accessing the right service at the right time.

Recommendation 11

Healthwatch Brent work with providers to develop a clear communication strategy for ensuring the public are aware of and informed of the Urgent Care Centres available to the residents of Brent, as well as the services provided at Central Middlesex Hospital.

Recommendation 12

Care UK and London North West Healthcare NHS Trust review access to the Urgent Care Centre at Central Middlesex Hospital, including the introduction of clearer road and access signs for the Urgent Care Centre and a review of the cost of parking at the centre.

5.7 Focusing on health and wellbeing

Managing expectations

The task group spoke with a range of people who were able to share their opinion and experience of services. A recurring theme within discussions was communication. An area raised was the need for further support to educate and support people in managing their own health care at home where appropriate. During the review, there were a number of examples shared in which patients attend appointments unnecessarily and educating

⁴¹ LAS (January 2015)

members of the public on how to access GP or other primary care services would free up time currently used to address non-medical issues. However, this needs to be carefully managed in ensuring those who do need medical care seek advice. Links with both schools and workplaces were viewed as important in educating people to make informed decisions in accessing GP services. A booklet has been produced to help improve access to primary care in Brent. The task group feel that publicity materials need to be distributed more widely in accessible ways across the borough.

Practices receive a lot of requests for admin. A number of areas which create additional workload were highlighted during the review; this is time which could be used to address medical issues. For example, GPs receive requests from schools to provide letters, requests from employers for sick notes (with regular requests for sick notes after just three days absence) and regular requests from housing departments, social workers and occupational therapists. All of which place additional pressure on GP practices.

Preventative services

NHS health checks are vital to early detection of chronic disease such as diabetes. The programme also offers economic benefits due to ill health prevention. Free NHS health checks are offered to people aged between 40 and 74 who are not on a related disease register (cardiovascular, diabetes, hypertension). Local authorities are responsible for offering a check to those who are eligible once every five years, inviting 20% of their eligible population each year.

22.3% (16,824) of the eligible population in Brent were offered a health check in 2014/15 of which 56% (9,424) received one. The invitation rate was higher than the England average of 19.7% but lower than the London average (23.7%). The uptake rate is higher than the London and England average of 48.8%. Since 2011, 71,650 have received an invitation to attend a NHS Health Check in Brent (93% of those eligible) of which 40,381 Brent have received a health check (53%)⁴².

The Brent Health and Wellbeing Strategy outlines a number of key challenges in Brent. These include poor oral health amongst children, rising obesity levels, low levels of physical activity, alcohol-related hospital admissions, mental health, high levels of many long-term chronic conditions and rising levels of dementia amongst older adults.⁴³ As outlined in section 5.1., heart disease, strokes and cancers are the biggest killers in Brent. In addressing these issues, the Health and Wellbeing Strategy, outlined the need to increase access to and expand preventative and screening programmes.

Preventative services are commissioned by both Public Health and the NHS. There are a range of preventative services across the borough, a number of examples of which were shared with the task group during the review, including diabetes champions.

Diabetes is one of Brent's biggest health challenges with 7.8% of Brent's population having type 2 diabetes. The risks of type 2 diabetes can be reduced by changes in lifestyle and early diagnosis. Good diabetes management is important to staying healthy. To address this issue, Brent Council is working with Diabetes UK to recruit and train diabetes community champions. The aim of the project is to help raise awareness of diabetes and enable people to spot the signs. Since being recruited, the diabetes champions have carried out 31 events at various locations in the borough, with over 2,000 people attending.⁴⁴ Success will continue be monitored against a list of key outcomes.

⁴² NHS Health Checks Annual Performance Report 2014/15

⁴³ Brent Health and Wellbeing Strategy 2014-2017

⁴⁴ Brent Public Health

Brent Council has invested in outdoor gyms across the borough to help address the low levels of physical activity and to overcome identified barriers to exercise, including cost and lack of access. Evaluation of the outdoor gym project was carried out in 2014. Findings showed an increase in the use of outdoor gyms between 2013 and 2014. Further actions have been identified to increase the take up of facilities including more targeted promotion.⁴⁵

Supporting access to services

Through discussions held it was recognised that GPs are often viewed as a route to accessing support. GPs can be a key service for linking with individuals who may be socially isolated. Care plans are an opportunity to screen for unmet needs and can be used as a reference point for clinicians and patients; this includes social isolation and loneliness. With changes to the traditional day services model and access to community activities, social isolation and loneliness was perceived to be an issue within the borough. Areas mentioned included difficulty in accessing day services and a waiting list for befriending service. HSCCs have a key role to play here and are currently supporting individuals at risk of social isolation. A new project, the Social Isolation in Brent Initiative, has also been established and will help address some of these concerns.

It is also recognised that there are a number of people who do not register with a GP. This includes the homeless, hard to reach communities and residents new to the borough who take time to register and may only do so when they require the service. This highlights the need for a flexible model to meet different levels of need for primary care services across the borough.

Key Learning and Insight

There is recognition that to provide good general practice to meet both current and future needs, new models of care are required. Some of the challenges are around access to appointments but there is a need to for this to be balanced with managing expectations and the promotion of self-care.

The need to improve access to and extend preventative services across the borough has been recognised. The task group feel that this work needs to continue to actively promote take up of preventative services and screening.

Recommendation 13

Brent Council, Brent CCG and Healthwatch Brent develop a communication strategy with targeted activities across the borough, including establishing links with schools, workplaces and local faith groups, in promoting the right access to services, raising awareness of the range of services available and promoting self care. This should include using a range of communication methods across our diverse communities.

Recommendation 14

Brent Council's Public Health Department continues work with NHS England and Brent CCG to improve the take up of preventative services, including health checks.

⁴⁵ Brent outdoor gym evaluation (2014)

6. CONCLUSION

The review focused on understanding what is working well and where improvements are required in delivering extended GP services and primary care in Brent. The task group has reviewed data gathered and feedback from a range of partners who commission, deliver or access local services in drawing conclusions and making recommendations. The aim of these recommendations is to help improve access to primary care for the residents of Brent.

It is recognised that people will have different views and experiences of primary care. It is also acknowledged that good access to GP services will mean different things to different people. However, access to GP services appears to be of concern and through this review a common issue raised has been the recognition of current pressures placed on primary care services, and in particular local GP practices.

Changes in patients' health needs and expectations, an expected increase in long term health conditions, as well as ongoing budget pressures, continue to present real problems for both health and social care services. In expanding primary care services there is a commitment to offer access to primary care 24 hours per day, seven days a week. To respond to these changes and meet this commitment, it is recognised that investment in capacity as well as new models are required. The task group feel that these models and any changes to services need to be informed by Brent's residents in ensuring that services meet the needs of local people, improve patient experience and reduce dependency on emergency care. This should also be supported by further promotion of self-care across the borough in managing current and future demand.

7. LIST OF PARTICIPANTS, REFERENCES AND APPENDICES

7.1 List of Participants

Brent Clinical Commissioning Groups	Assistant Director – Primary Care Deputy Chief Operating Officer Director of Finance for Harness Care Cooperation Ltd Local GP representatives
Brent Council	Director of Public Health Strategic Director – Adult Social Services Team Leader – Research and Intelligence
Central London Clinical Commissioning Group	Chair
Central Middlesex Urgent Care Centre	Medical Lead GPs Service Manager
Healthwatch Brent	Coordinator Director
Local Medical Committee (LMC)	Chair – Brent LMC Medical Director, Londonwide LMCs
London Ambulance Service	LAS Operational Manager
Multi Disciplinary Group (MDG)	Willesden and Kingsbury MDG Harness MDG
NHS England	Head of Primary Care
Patient Participation Groups	Chair

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7.3 List of Appendices

1.	Growth rates by Brent GP Practice January 2014 to January 2015
2.	Numbers of Patients Registered at a GP Practice (April 2015)
3.	Location of services in Brent
4.	Healthwatch Brent – Report for Scrutiny Task Group 07/01/15
5.	Primary care workforce profile