Brent / NHS North West London Clinical Commissioning Group	**Brent Health and Wellbeing Board** 16 March 2022
	Report from Brent Borough, part of the NWL CCG

Primary Care Update – Priorities for General Practice

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt:	Open
No. of Appendices:	None
Background Papers	None
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1.0 Purpose of the Report

1.1 This report sets out the high level priorities for general practice and primary care as defined by national, regional, NW London and local priorities. Health and Wellbeing members are requested to note the context and opportunities for joint working

2.0 Recommendations

2.1 To note the primary care priorities for primary care and the areas of joint delivery across system partners.

3.0 Detail

3.1 GPs have one of the highest public satisfaction ratings of any public service, at over 83%i but we know improving access to primary care services is a top priority for patients. General practice is undeniably the bedrock of NHS care with GP practices providing over 300 million patient consultations each year, compared to 23 million A&E visits. Yet a year's worth of GP care per patient costs less than two A&E visits, and we spend less on general practice than on hospital outpatients. For the past decade funding for hospitals has been growing around twice as fast as for family doctor services.

3.2 The General Practice Forward View and the Long Term plan set out a detailed, costed package of investment and reform for primary care. It will mean more convenient access to care, a stronger focus on population health and prevention, more GPs and a wider range of practice staff, operating in more modern buildings, and better integrated with community and preventive services, hospital specialists and mental health care.

3.3 The national priorities for primary care have translated to a number of areas of focus for the current and upcoming year, these include improving access to primary care within core hours and out of hours and agreeing standards for delivery across all

practices, similarly agreeing standards across Care Homes and delivery of services, the slide below set out the current NW London ICS priorities for primary care

NWL ICS Delivery - Key areas of focus

Priority	Area	Description
GP appointments	GP appointments	• Agree standards for Access to primary care, including core and out of hours provision. • Support a blended offer of improving GP access (virtual and face to face) • Accurate data on appointments provided and their type. • Standardising data collection and reporting • GP appointments be broken down by face to face and non-face to face
Extended Access Hubs	Extended Access Hubs	• Increase utilisation of Access Hub appointments • Impact of the new specification (to support the transfer of provisions to PCN)
111 referrals	111 referrals	• Increase referrals from 111 into general practice for primary care conditions. Both in hours and out of hours.
eConsultations	eConsultations	• The majority of e-consultation are for General Advice (228,953) and Administrative help (193,023) with the next highest being skin problems (55,898). Developing on line offer in line with patient needs especially for general advice and administrative help? • Confirm that all practices in PCN offer option to online consultations • Alternative solutions to eConsult – what are the benefits.
Care Homes	Utilisation of Emergency & Acute Services	• Standardising care home support – consistent delivery model across sector • Addressing high levels of LAS calls and A&E attendances from Care homes/ residential homes
	MDTs with Community Partners	• Working with Community Care providers and other Integrated Care Partners in developing Multi disciplinary teams (MDTs) that support the Standardisation of Care to Care Home residents
Workforce – ARRS	Planned Recruitment	• Improving utilisation of ARR roles across Borough, assisting PCNs in recruitment, retention and development of roles • Ensure ARR roles meet needs of future workforce, plans to develop ARR roles inline with priorities.

NWL ICS Delivery - Key areas of focus

Priority	Area	Description
Diabetes	Diabetes	• Delivery of nine care process and 3 outcome targets as an outcome target to supporting patients to live healthier lives, supporting education and training and patient empowerment. • Supporting PCN and practices in developing diabetes care in the community with community providers, sharing of best practice across Boroughs • Mapping delivery across PCNs/practices through local dashboards, providing intervention as required • Developing Virtual Group Consultations (VGC) and addressing reported high DNA rates and poor engagement. • How are borough teams ensuring the swift dissemination of funding to PCNs or GP federations to deliver the ES? • Working towards stretch target achievements for 22/23
SMI health checks	SMI health checks	• SMI Health check achieve trajectory of 65% • Supporting PCN/ practices to achieve target
Additional priorities	CQC Ratings	• Improvement of CQC ratings, supporting practices to embed CQC standards in daily delivery. • Development of PCNs to develop practices within PCN grouping to meet CQC standards
	Cancer screening	• Improve cervical and breast cancer screening performance (currently below national standard). • Access Hubs and weekend clinic to support improved uptake
	Child Imms	• Improvement on Child immunisation uptake • At scale delivery and weekend working to support uptake
	Flu	• Improve uptake of flu immunisation programme, reduce variation in deliver, • Out reach and community groups support • Development of PCN to delivery at scale, housebound programme.

3.4 The investment into enhanced services and primary care has historically been weighted towards the inner boroughs. The levelling up proposal agreed across NW London will seek to ensure investment into the outer boroughs. The levelling up proposal spans a period of four years, with year one being 2021/22, for Brent this equated to an investment of circa £2.4m for Diabetes and SMI Health checks enhanced services. A further three years of proposed levelling up will support additional investment in primary care and subsequent outcomes for patients. For Brent Borough the priorities as set out above are explored in further detail alongside an analysis of the current delivery model and challenges facing the Borough.

4. GP access

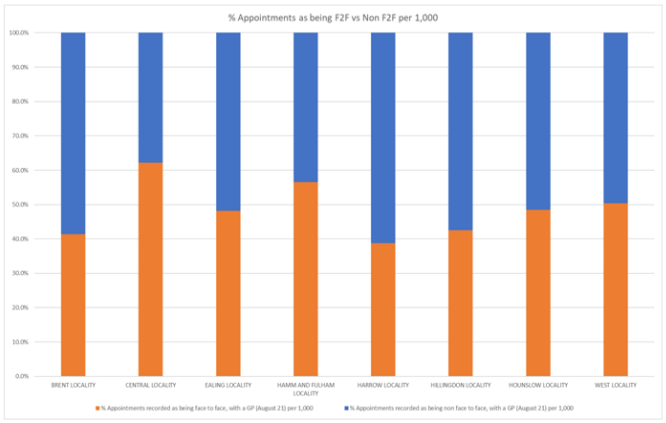
4.1 Access to primary care is a key priority both at NW London level and at local level. The recommendation of the GP Access Task & Finish Group form part of the key deliverables for this work stream, alongside the national specification for improving access at PCN level. The long awaited national PCN Access DES is due for release in October 2022, which will shape the delivery of GP access at PCN level. The recommendation of the GP Access Task and Finish group are available at the following location (agenda item 10) : - https://democracy.brent.gov.uk/ieListDocuments.aspx?CId=548&MId=6610&Ver=4

4.2 While GP practices continue to offer in excess of 149,959 appointments (August 2021 data, Source NHS Digital) the demand for GP appointment continues to rise, this increase demand is mapped against limitations within workforce and recruitment capacity. Recruitment for registered healthcare professional including GP and Nurse is a limiting expansion of services locally for example additional access at scale. Slide below sets out the GP appointments per 1,000 patients in Brent is comparable with other boroughs.

Graphs below show GP appointment data for August 2019 (pre-pandemic) mapped to post pandemic GP appointment delivery (August 2021) by NHS Digital. The graph below (to the right) highlights that approx 350 appointments per 1,000 patients were offered in Brent in Aug 21 (orange bar). Caveats: Coding of appointments remains a challenge, data extracted for August which is quietest month in year for GP access. West London, Central and Ealing commission additional GP appointments.

The bar chart to the left shows percentage of face to face to digital consultations undertaken per 1,000 patients. For Brent 40% of appointment were face to face (orange section) with remaining 60% (blue section) managed digitally, Harrow shows the highest number of digital appointments.

Graph represents number of GP appointments offered per Borough per 1,000 patients in August 2021 in correlation to August 2019 (pre-pandemic). Arrow highlights Brent data.



Graph represents number of face to face appointments offered in correlation to remote consultation per 1,000 patients in August 2021. First bar chart represents Brent data.

4.3 NWL have agreed to support a blended offer of improving GP access (virtual and face to face) and a new re-procurement of the on-line consultation provider is currently underway to enable an improved on line experience for patients and clinicians. Include ability to work at scale across practices, 'speech to text' conversion and a more user friendly digital platform. Feedback from patients on alternate languages is being explored; however, these features may require development time as we work with the new provider. The Committee members are requested to note the continued work required with patient groups, champions and communities to support on-boarding of patients, with greater focus on IT access, training and education.

4.4 The increases in primary care activity at Urgent Treatment Centres (UTC) and to NHS 111 further demonstrate the increased demand for GP appointments. The variation in activity at alternate settings, forms part of the Borough teams focus on reducing variation and improving patient outcomes. The Winter Access initiative, GP at front door of UTC has been successful in supporting Winter pressures in A&E. This model

requires further development alongside the e-consultation model to improve access to advice and guidance. The current re-direction model is not cost efficient, option to explore a digital option have been in development pre-pandemic and would offer a cost efficient solution to re-direction at front door of UTC.

4.5 GP access is also deemed as a measure of practice level delivery and achievement of targets. Practices where access remains low in general demonstrate lower achievement on targets such as flu, child immunisation and screening targets. Improving access to the right clinician first time is crucial to improving outcomes. The work of the Health Inequalities team and the Winter Access Fund has made some traction into supporting practices to level up delivery of services. Further targeted support at practice level with support packages will aim to further reduce variation. As PCNs develop the role of the PCN Clinical Director (CD) would be to support practices and aim to reduce variation in care across member practices.

4.6 Regular GP appointment activity at practice level has recently started to be extracted (from December 2021) to enable mapping of GP access in correlation to practice list size. The data is currently shared as an aggregate for the Borough, the data shows a clear increase in appointments offered to patients. GP appointments are also broken down by face to face and non-face to face, see above graph for breakdown. Brent as the digital innovator site in NW London adopted on line consultation earlier than most other Borough, the transition to this method of consultation ensured patients continued to access primary care services during the early days of the pandemic. Indeed, during the pandemic Brent remained one of the few Boroughs where continued access to primary care was maintained, where GP practices continued to offer routine and pro-active care.

4.7 Standards for GP Access is a key priority area for NW London ICS for the coming financial year. The investment in cloud based telephone from March 2022 through to March 2023 will enable all practices to offer a much more efficient telephone service for patients, including call waiting, diversion of call to central access points, out of hours call diversion, statistics on usage and peak time for better planning. Where practices are located in NHS Property Services sites (e.g. Welford Centre) the telephone infrastructure is limited and antiquated leading to poor patient survey results for telephone access.

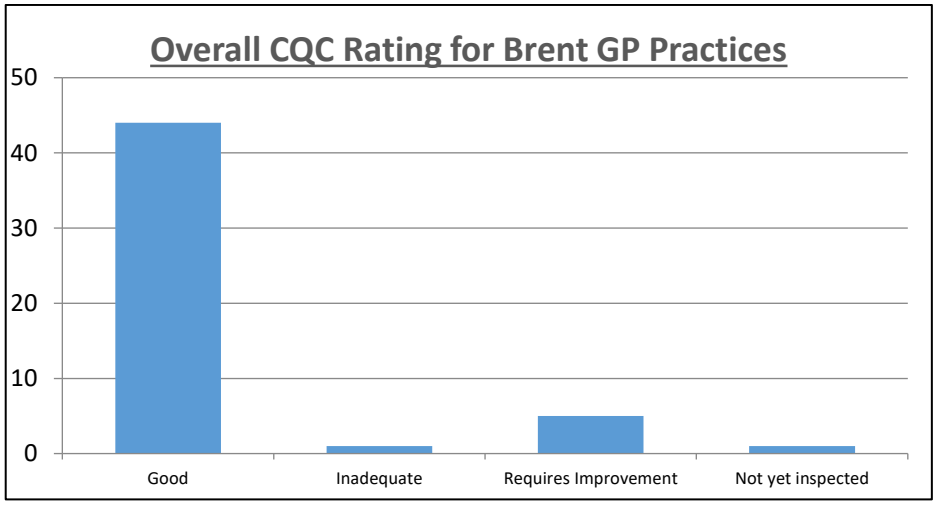
4.8 In addition to GP Access, the delivery of consistent, high standard of care through a developed and motivated workforce remains a priority which sits alongside improving access. The education and training agenda remains a high priority area. The development of primary care staff to meet future health needs requires further mapping and support offered to staff to be released to enable education opportunities to be taken up. Clinicians supported to develop staff on the job and opportunities for staff progression are in place. The Education Hub across NW London will host the training budget with each Borough identifying its priorities for training.

4.9 The Winter Access Fund (WAF) introduced an additional investment of over £1m for improving access to primary care. This time limited offer enabled additional investment in improving Access on the weekend (with all GP practices encouraged to open one day on the weekend), additional core hour provision (for on the day demand), additional PCN level weekend hubs (for Child immunisation, Cervical cytology where Nurse availability is limited). In addition, further investment into Bereavement support, Care Homes, and Community pharmacy consultation service was also supported, alongside the UTC re-direction pilot. Recurrent and long term investment into GP Access is required to improve and sustain the level of care enabled through the WAF.

5. Care Quality Commission (CQC)

5.1 The role of the CQC (Care Quality Commission) as an independent regulator is to register health and adult social care service providers in England and to check, through inspection and ongoing monitoring, that standards are being met. All GP practices in England must be registered with the CQC. The CQC gather information from GP practices once a year. This request involves updates about any changes at the practice since the last inspection and/or annual regulatory review. For each practice that the CQC inspect, they rate at two levels. Level 1: A rating for each key question for the location/service. This is based on relevant evidence of how GP practices personalise people's care and provide care for different groups of people. Level 2: An overall rating for the service. This is an aggregated rating informed by findings at level 1.

5.2 Graph below shows ratings for Brent practices. The recommencement of routine CQC inspections since the pandemic years may result in a change to the current reported numbers. To pre-empt the upcoming visits further training sessions have been commissioned to raise the profile of CQC inspections and ensure practices are embedding CQC standards into routine care. PCN CDs are also encouraged to prepare practices for upcoming visits and ensure the two-week window from notification to visit is fully utilised to prepare the practice.



There are currently seven practices which are being supported on a one to one basis to meet standards set out by the CQC for primary care.

6. Practice Variation

6.1 Variation in care across the 51 GP practices us mapped through the monthly Practice packs. The focus on booster doses has resulted in this work being paused. The variation packs map activity at PCN and practice level and aims to empower PCN CDs and lead clinicians to address variation. Data on access, patient satisfaction, utilisation of digital services, outpatient activity, elective activity, cancer screening, flu uptake, immunisations etc are mapped against local practices and benchmarked. Practices are encouraged to review packs in PCN meetings and at practice meeting and develop action plans. Those practices identified as requiring more support are contacted for monthly review meeting by Borough team. PCN Clinical Directors are encouraged to attend the practice level discussions, to ensure PCN level support is in place for practices who may be experiencing delivery issues e.g. workforce changes, sickness absence etc.

7. Additional Role Reimbursement (ARR)

7.1 The Network Contract DES went live on 1 July 2019, under this DES funding is made available to PCNs through a new Additional Roles Reimbursement Scheme (referred to as 'ARR') to recruit up to an additional 20,000 full time equivalent posts across specific roles, over the next five years. The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage in general practice. Reimbursement through the new Additional Roles Reimbursement Scheme will only be for demonstrably additional people (or, in future years, replacement of those additional people as a result of staff turnover). This additionality rule is also essential for demonstrating value for money for the taxpayer and reimbursement claims is subject to validation thorough the national ARR portal. GP practices will continue to fund all other staff groups including GPs and nurses in the normal way through the core practice contract.

7.2 More flexibility was introduced beyond the five original staff grouping, with the addition of more roles such as nursing associates and trainee nursing associates from October 2020, plus paramedics, advanced practitioners and mental health practitioners from April 2021. This means that from April 2021, PCNs are able to recruit staff for the following roles, to be reimbursed through ARRS: social prescribing link worker, clinical pharmacist, first contact physiotherapist, physician associate, pharmacy technician, community paramedic, occupational therapist, dietician, chiropodist/podiatrist, health and wellbeing coach, care coordinator, nursing associate, trainee nursing associate, and mental health practitioners (including Improving Access to Psychological Therapy [IAPT] practitioners). Advanced Practitioner roles include: clinical pharmacist, physiotherapist, occupational therapist, dietician, podiatrist, and paramedic. PCNs can decide which roles are required depending on their existing workforce and local needs. For a PCN with a registered population of 30,000 patients, funding of £208,800 is available for the current year; this will increase to £448,300 in 2023.

Table 1	2019/20	2020/21	2021/22	2022/23	2023/24
Total National Workforce funding	Maximum reimbursable amount in 2019/20 (equivalent to 9-months)[8]	£257,000,000	£415,000,000	£634,000,000	£891,000,000
PCN Size (weighted)					
15,000	53,942.25	74,358	104,400	159,900	224,200
20,000	53,942.25	86,200	139,200	212,700	298,900
25,000	53,942.25	107,800	174,000	265,900	373,600
30,000	53,942.25	129,300	208,800	319,000	448,300
40,000	53,942.25	172,400	278,400	425,400	597,800
50,000	53,942.25	215,500	348,000	531,700	747,200
80,000	53,942.25	344,900	556,900	850,700	1,195,600
100,000	107,884.50	431,100	696,100	1,063,400	1,494,500
150,000	161,826.75	646,600	1,044,100	1,595,100	2,241,700

7.3 The availability of qualified staff to take up roles on offer, the competition for staff across England, the demanding nature of primary care coupled with high turnover has meant the challenge of recruiting to ARRs roles has left this welcomed investment underutilised. In additional the national claims process has at time proven to be cumbersome and its limitation have been challenging, leading to cash flow issues at PCN level. Further support required to PCNs to assist with the recruitment process and claims for ARR roles.

7.4 Recruitment to ARR roles across the seven PCNs has been variable with some PCNs maximising on the opportunity while others have yet to fully benefit from the funding. The table bellows shows posts recruited under ARR by PCN grouping. Clinical pharmacists have been particularly welcomed as a staff grouping supporting general practice. In addition to the ARR roles there are a number of practice employed staff including pharmacists.

Harness PCNs	Care Coordinator	Clinical Pharmacist	Dietitian	Health & Wellbeing Coaches	Pharmacy Technician	Social Prescribing Link Workers	Grand Total
North	2	10	1	2		2	17
South	2	5		1	1	5	14
Grand Total	4	15	1	3	1	7	31

K&W PCNs	Advanced Practitioner	Clinical Pharmacist	First contact Physiotherapist	Social Prescribing Link Workers	Grand Total
K&W Central	1	5	1	3	10
K&W North	1	3	1	2	7
K&W South		6		2	8
K&W West		4		3	7
Grand Total	2	18	2	10	32

Kilburn PCNs	Clinical Pharmacist	Social Prescribing Link Workers	Pharmacy Technician
Kilburn	4	4	1

8. Mental Health –Learning Disability Health (LD) and Serious Mental Illness (SMI) checks

8.1 People with a learning disability and aged 14 or over are entitled to an annual health check. An annual health check takes place once a year and is used to find any problems early, help keep people healthy and make sure the right care is being given. Patients with learning disability can be more likely to have health problems, an annual health check is a good way to pick up any conditions early and prevent future ill health.

The annual health check will look at the following:

- Physical health, such as weight, heart rate, blood pressure
- Ways to stay well and what help is needed for this
- Medication
- Mental health
- Vaccinations
- Making a plan to help with meeting health goals

8.2 The Borough team is working with GP practices to help improve the uptake of the LD health check. The projection of 75% uptake is challenging, added to the current issues of the coding and recording of reviews undertaken at practice level. The coding issues are currently resulting in Brent, Harrow and Hillingdon Borough showing low uptake of

the annual LD check. Borough teams are working alongside NW London teams to identify issues and address the data extraction issues for EMIS systems.

Learning Disabilities Annual Health Checks – Aged 14 and over

	Apr 21	May 21	June21	Jul 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Actual	1%	4%	10%	18%	23%	30%	38%	46%	50%	0%	0%	0%
Target	6%	13%	19%	25%	31%	38%	44%	50%	56%	63%	NHSE Projection 69%	NHSE Projection 75%

8.3 The life expectancy for people with SMI is 15–20 years lower than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked. Individuals with SMI also have double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidaemia (imbalance of lipids in the bloodstream) than the general population. Individuals living with SMI require appropriate and timely physical health assessments due to their higher risk of poor physical health, further development is required to ensure this offer is in place and to ensure patients are being supported to use available health information and advice or to take up tests and interventions that reduce the risk of preventable health conditions.

8.4 The Five Year Forward View for Mental Health, NHS England committed to leading work to ensure that by 2020/21, 280,000 people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year. In Implementing the Five Year Forward View for Mental Health and the NHS Operational Planning and Contracting Guidance, NHS England stated that “CCGs should offer NICE-recommended screening and access to physical care interventions to cover 30% of the population with SMI on the GP register in 2017/18, moving to 60% population from the following year”. This commitment was reiterated in the March 2017 publication of the Next Steps on the NHS Five Year Forward View. Further, the guidance on Refreshing NHS Plans for 2018/19 published in February 2018 highlighted the same requirement to deliver annual physical health checks and interventions.

8.5 The table below sets out the uptake by Borough of the SMI Health Checks. Continued focus on delivery by Borough clinical lead and Borough team have seen a steady increase in health checks, issues with needle phobia and lack of engagement been highlighted as current issues to uptake. Outreach work is being explored with PCN CDs.

SMI Physical Health Checks

Date	Brent	Westminster	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow
Mar-21	20.90%	42.10%	39.80%	31.30%	11.10%	17.10%	51.20%
Apr-21	45.40%	45.00%	40.70%	34.90%	41.70%	16.90%	52.60%
May-21	44.60%	46.30%	42.20%	35.50%	40.80%	16.50%	53.70%
Jun-21	43.60%	47.30%	41.80%	35.90%	39.60%	16.10%	53.50%
Jul-21	48.90%	47.20%	42.30%	35.50%	42.80%	20.80%	53.20%
Aug-21	47.80%	48.20%	42.60%	36.20%	43.00%	21.70%	52.80%
Sep-21	47.50%	49.40%	44.30%	37.20%	43.90%	24.10%	53.60%
Oct-21	48.20%	52.10%	46.80%	37.10%	45.60%	29.10%	53.60%
Nov-21	48.20%	55.10%	49.40%	37.80%	48.00%	32.90%	54.00%
Dec-21	49.30%	58.10%	51.00%	40.30%	51.70%	38.90%	57.00%

8.6 Dementia Diagnosis

Dementia diagnosis is a key priority nationally. Current diagnosis prevalence for Brent is 1752 expected to increase to 2624 in 2022. We have one of the largest predicted prevalence of dementia from BAME communities in London meaning that local work also specifically targets BAME communities working with our local communities and faith groups. The target for diagnosis rates is 66.7% and we expect to meet that with Primary Care continuing to pro-actively work with secondary care to improve dementia diagnosis rates. There is a strong commitment locally to ensuring that people living with dementia and their families and carers are valued, respected and supported to live as normal life as possible for as long as possible. Additionally, Brent has been recognised as working towards a Dementia Friendly borough. The challenge for Brent is to continue to improve and increase diagnosis rates, provide appropriate quality support for people living with dementia and deliver on the pledge for a dementia friendly Brent focusing on the authentic lived experience of our communities. The table below shows our position for meeting the 66.7% target and how we compare across NWL.

Dementia Diagnosis Rates

	Close of 21/21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21
Brent	66.2%	66.2%	66.2%	66.2%	67.6%	68.0%	68.0%	67.5%	67.1%	67.3%	67.1%
Central London	62.4%	62.4%	63.2%	63.6%	64.2%	67.1%	66.9%	66.7%	62.7%	63.0%	63.1%
Ealing	69.9%	69.9%	69.7%	69.5%	69.8%	69.9%	69.9%	69.9%	69.1%	69.6%	69.9%
Hammersmith and Fulham	55.6%	55.6%	56.0%	57.1%	58.2%	58.4%	58.0%	58.8%	59.0%	60.2%	60.2%
Harrow	61.3%	61.3%	61.9%	62.9%	62.7%	63.7%	63.8%	64.8%	66.1%	66.4%	66.6%
Hillingdon	63.7%	63.7%	64.1%	64.4%	64.6%	66.0%	65.8%	66.1%	65.0%	65.3%	65.4%
Hounslow	65.2%	65.2%	65.1%	65.5%	65.6%	66.6%	66.5%	67.0%	65.6%	65.6%	65.8%
West London	61.8%	61.8%	61.4%	62.0%	62.5%	65.4%	65.7%	65.6%	62.6%	62.2%	62.2%
NWL Total	64.0%	64.0%	64.2%	64.6%	65.0%	66.1%	66.1%	66.3%	65.3%	65.6%	65.7%

9. Children and Young People's Mental Health and Well-Being

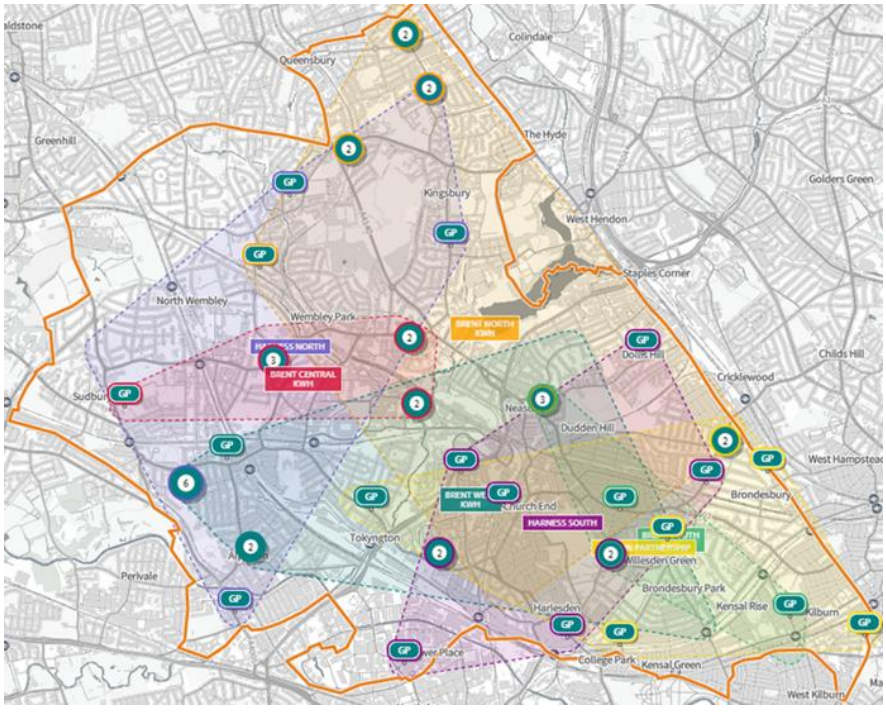
9.1 Children and young people's mental health is a high priority for Brent. Covid 19 has increased the demand for Mental Health Services locally. Brent is experiencing 25-35% increase in referrals to Specialist CAMHS and the experience locally is that we have limited capacity in the service and increased waiting times. There is a need to increase specialist clinical capacity to provide more timely assessments and interventions. Local pathways alignment to ensure a more comprehensive system-wide response to needs. A gap has been identified in the needs and support for moderate to high need presentations that do not meet current CAMHS criteria. Pathways need to ensure access to parental well-being support. There is a need for improved integration with primary care networks. Level up funding is required for Brent to ensure a more comprehensive and accessible offer for Brent children and young people. Brent has the lowest access to mental health services for children and young people in NWL and is amongst the most deprived areas in NWL and in the UK. (Gov.Uk Indices of Deprivation in Children and Young People 2019). It also has the highest proportion of BAME children and young people in NWL. Additional resources and service redesign are essential to address this inequality in service delivery

10. PCN Alignment

10.1 There are currently seven individual PCNs in Brent, which vary in size from circa 38,000 to 71,000 patients registered. The group of the seven PCNs into three Federations enables funding to be pooled and shared across PCN areas e.g. managerial support. The seven PCNs are:

- Harness South PCN
- Harness North PCN
- K&W North PCN
- K&W Central PCN
- K&W West PCN
- K&W South PCN
- Kilburn Partnership PCN

10.2 While the map below shows overlap in PCN geographical areas there are currently discussions ongoing on geographical alignment of practices to enable place base commissioning to be further established, with system partners re-aligning teams to support the integrated care pathway development.

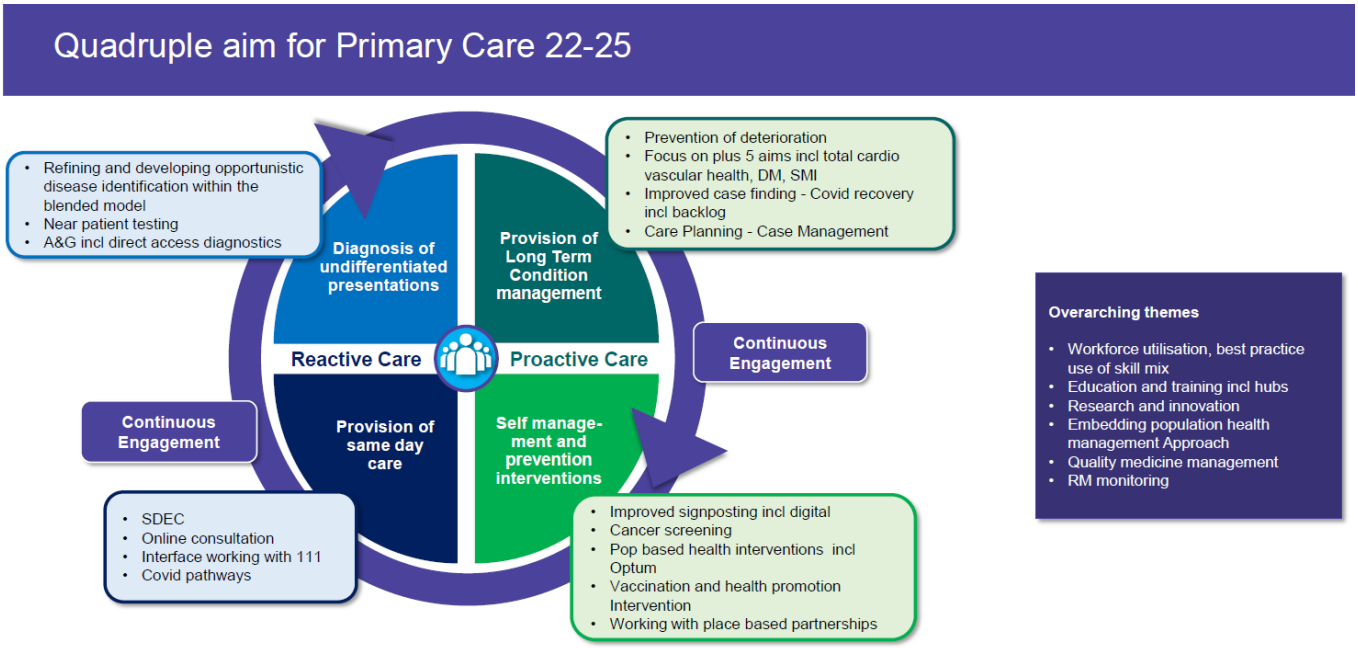


10.3 Initial discussion to align PCNs to the Brent Health Connect areas as show in the map below has been considered, further discussions are required to ensure equity in distribution of size of each PCN to enable a more equitable distribution of funding, thereby ensuring equity in delivery of services to patients.

11. Forward Plan

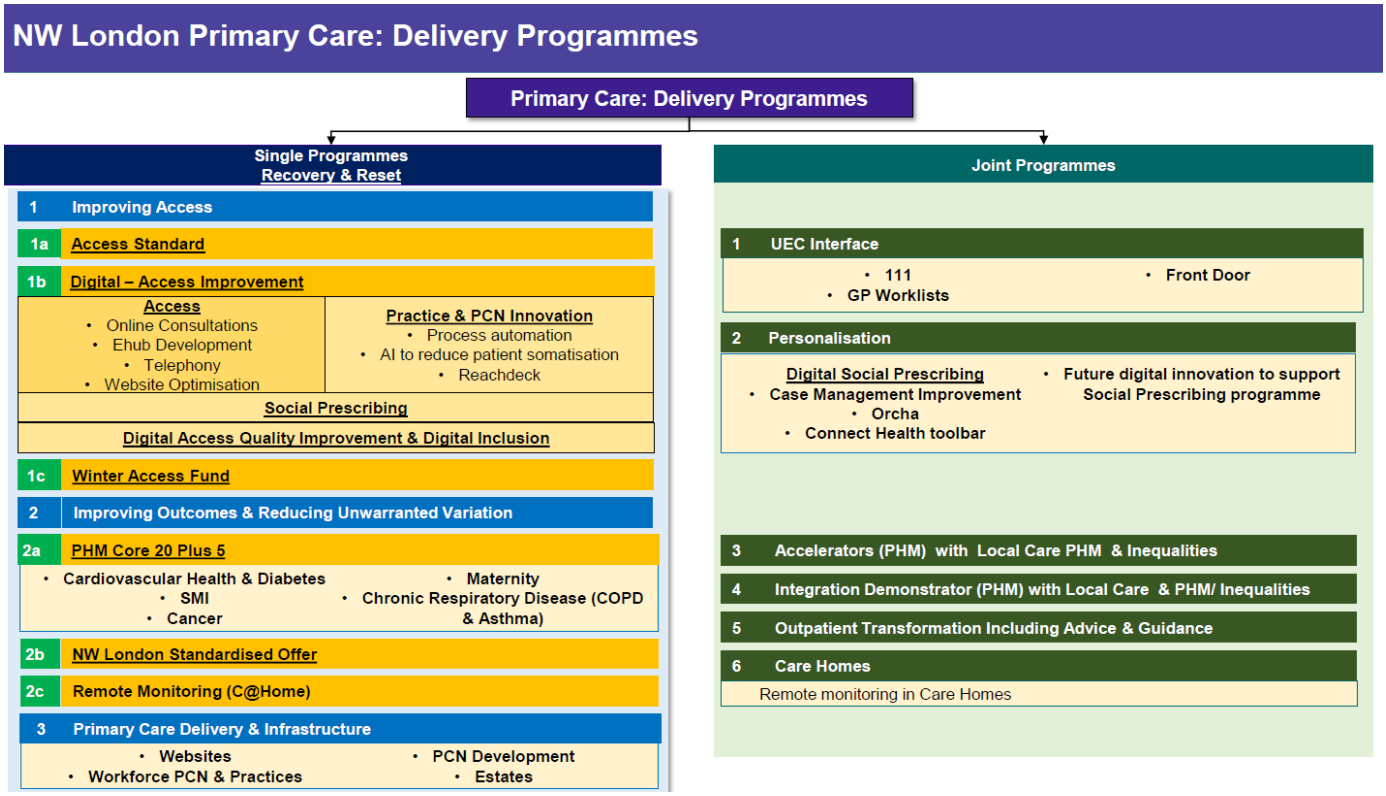
11.1 Upcoming financial year priorities includes a focus on case finding and management of patients with Hypertension, with the existing cardiovascular disease diagnosis and prevention service being expanded. Alongside this will be a requirement on PCNs to deliver two new services as part of GP Contract changes via the Network Contract Directed Enhanced Service (DES) of anticipatory care and personalised care.

11.2 The Reset and recovery programme for the current and upcoming years will focus on four areas, including quadruple aims for Primary Care including Long term condition management, self-management/prevention, same day care and early diagnosis.



11.3 The slide below sets out the programme of delivery, the section to the left (highlighted in orange) are priorities for primary care as single programmes of delivery, specifically delivered by local GP practices in the area.

11.4 The joint programme of work is highlighted in green to the right of the slide pack, these provide opportunities for system partners to jointly delivery outcomes for local patients. The Urgent Elective Care (UEC) interface programme commenced in Brent in December 2021 and the benefit of this joint programme has shown good returns with Acute provider team, primary care and urgent care provider working as one.



12. Financial Implications

12.1 Investment for delivery of programme to be secured from national and local allocations.

13. Legal Implications

13.1 None

14. Equality Implications

14.1 To be scoped to ensure equity of access and engagement from all patient populations.

Report sign off:

Fana Hussain, Brent Borough

[i] https://www.england.nhs.uk/statistics/statistical-work-areas/patient-surveys/