Brent	**Scrutiny Committee** 16 June 2015 **Report from Scrutiny Task Group**
For Information	Wards Affected: ALL

Access to Extended GP Services and Primary Care in Brent - Interim Report

1.0. Summary

1.1. This report provides interim feedback on the work of the Scrutiny Task Group focused on Access to Extended GP Services and Primary Care in Brent. The report outlines the task group scope and methodology and provides an overview of emerging findings and recommendations.

1.2. Brent Clinical Commisisoning Group (CCG) and London North West Healthcare NHS Trust are changing the way healthcare is provided in Brent. The Scrutiny Task Group was established to review the primary care element of Brent CCG's transformation programme and assess the extent of the changes and investment made in the Brent GP networks and primary care services for the effective implementation of the changes to the acute sector set out within Shaping a Healthier Future (SaHF).

1.3. Access to the right care, in the right place, at the right time, is a common theme throughout transformation plans. The intention is for hospitals to concentrate on providing specialist services. Other services will be provided in a community setting, which will require additional capacity in primary care and a greater link between health and social care in ensuring patients receive a more integrated and coordinated service. This should prevent the need for more acute interventions.

1.4. The review was primarily concerned with the capacity within the Brent GP network, access to out of hours care and the delivery of out-of-hospital services to provide enhanced extended primary care to meet the needs of local residents. 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.

2.0. Recommendation

2.1. Members of the Scrutiny Committee are recommended to note the progress that the task group has made to date.

3.0. Detail

Scope of the Review

3.1. The aim of the Scrutiny Task Group was to assess the extent of the changes and investment made in the Brent GP networks and primary care services necessary for the effective implementation of the changes to the acute sector set out within SaHF.

3.2. 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?

Task Group Membership

3.3. The task group included:
Councillor Reg Colwill (Chair)
Councillor Amer Agha
Councillor Rita Conneely
Councillor Mary Daly
Councillor Claudia Hector
Councillor Wilhelmina Mitchell Murray

Review Methodology

3.4. 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 between January and March 2015.

3.5. 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 Brent CCG's 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 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 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 will be detailed in the final report.

3.6. 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.

Emerging Findings

Demand for Primary Care

3.7. There is growing demand for primary care due to an ageing population, increased long-term conditions and changing expectations. Brent's population increased by 1.7% from 311,215 in 2011 to 320,190 in 2013[1]. Brent's population will continue to grow, rising by 10,456 over the next five years, from 320,781 in 2015 reaching 331,237 in 2020, an increase of 3.3%[2].

3.8. 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 London[1]. This has increased since 2011, where BAME groups made up 63.7% of the population. About one third (36.0%) of the population are Asian; 35.0% white and 21.1% black[1].

3.9. The number of older people is increasing. Between 2011 and 2013, the largest increase was in people aged 80 and over; this population grew by 10.8% from 8,048 in 2011 to 8,917 in 2013[1]. This places increased pressure on both health and social care services.

3.10. Population growth, widening health inequalities and complexity are driving up demand on general practice nationally. General practice undertakes 90% of NHS activity for 7.5% of the cost, seeing more than 320 million patients per

[1] Brent JSNA – People and Place (2014)
[2] GLA SHLAA based population projections, 2013 rnd

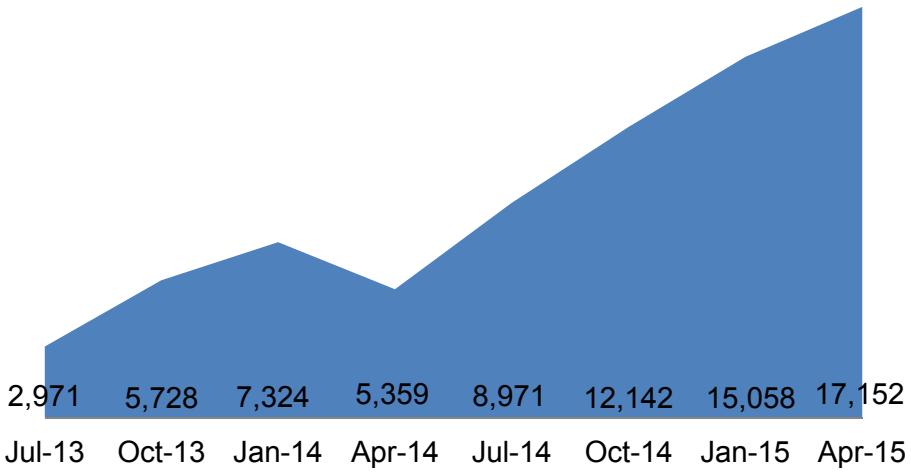
year[3]. Changes in patients' health needs and expectations, an expected increase in long term health conditions (now taking up 70% of hospital and primary care budgets in England[4]), as well as ongoing budget pressures, present real problems for health services.

Access to Primary Care

3.11. The review found that there is an overall feeling that public confidence in individual GPs is good. The biggest concern is access. In 2012 there were 69 GP practices in Brent and 339,381 registered patients. In April 2015 there are 67 GP practices in Brent, with 365,165 registered patients[5].

3.12. The number of registered patients across the 67 practices has risen since 2012 and is continuing to rise. The number of registered patients increased from 360,155 to 363,071 between October 2014 and January 2015[5]. This is an increase of nearly 3,000 patients in a relatively short time. Figures published by the HSCIC in April 2015 showed a further rise in the number of registered patients within the borough to 365,165[5]. A patient doesn't have to live in Brent to register with a Brent GP.

Figure 1: New patients registered since April 2013



3.13. Population projections for Brent, outlined in paragraph 3.7., 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[1].

[3] NHS England –Transforming primary care in London (2013)
[4] NHS England
[5] HSCIC – Number of Patients Registered at a GP Practice

3.14. Brent CCG has lower patient satisfaction results compared to the national average with regards to accessing primary care. Opening times and access to appointments outside of working hours vary across practices. Out of the 67 Brent GP practices, 37 open after 6pm, including 15 that open until after 7pm. 37 practices open at 8.30am or before. Of these, three open at 7.30am and ten at 8am[6]. 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. Whilst 71% of people would recommend their practice to someone moving to the area, this is the 200th best result of 211 with 112 CCGs scoring above 80%[7]. The CCG's plans to extend access to primary care aim to improve access and increase patient satisfaction rates.

3.15. Through discussions held, access by telephone was identified as an issue for practices, with a need to invest resources. Concerns with GP premises were also highlighted through the review and the constraint these place on delivering services.

Extended GP Services

3.16. The development of GP Hubs in Brent was seen as a way of freeing up capacity, managing demand differently and providing access to care out of hours in delivering a seven day service. It is dependent on practices working together in networks in order to provide extended access to GP appointments. The extended GP hub model was also driven by an opportunity to offer choice to the patient in obtaining an appointment rather than having to wait to see their GP. Patients can still go to their GP but it remains hard to get an appointment with certain GPs.

3.17. 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 hubs are not walk-in centres. The pilot scheme of GP Access Hubs provided a hub in each clinical network across Brent CCG at the following locations:

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

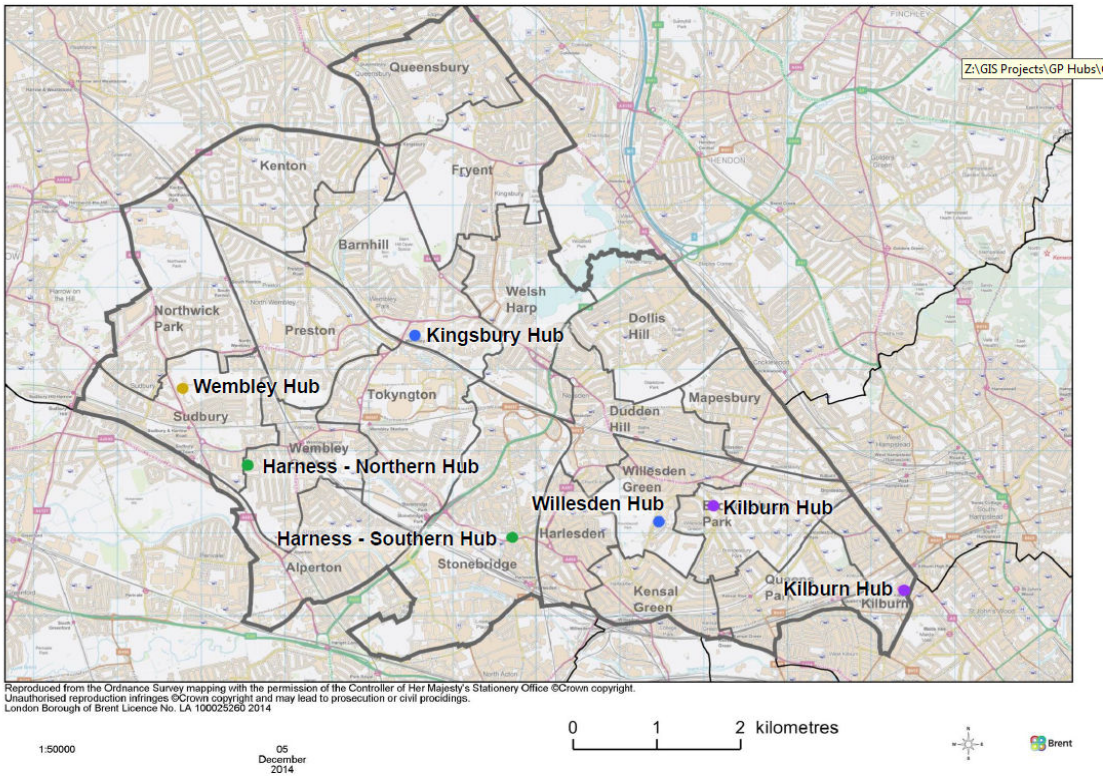
3.18. Following a review of the pilots, the CCG carried out a procurement exercise for a longer-term service in 2014, with the implementation of a three year contract from April 2015. The model is also being rolled out to additional sites. This was based on a revised service specification for the future service, which details both national and local defined outcomes for the service. The

[6] NHS Choices: GP opening times, downloaded 05/02/2015 *one practice did not have opening times recorded

[7] Brent CCG – Service Specification for Primary Care Access Hubs

main changes include removing week-day afternoon appointments at hubs due to NHS England requirements that the service should not overlap with core GP hours and changes to Saturday and Sunday appointments (revised hours of 9am to 3pm on Saturday and Sundays and to include bank holidays).

Figure 2: Map of GP Hubs Pilot



3.19. 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 in managing demand 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.

3.20. In March 2015, the hubs had delivered an additional 70,000 GP and nurse appointments in primary care[8]. The task group has requested a breakdown of recent utilisation of GP hub appointments to gain a better picture of the impact of the hub model in delivering extended access. There is also further information required in analysing the implications for local residents resulting from additional travel requirements in attending GP hub appointments.

3.21. Evidence received during the review highlighted that awareness of the GP hubs during the pilot phase had been relatively low across the borough. A survey carried out by Healthwatch Brent during November and December 2014, found that the majority of respondents did not know what a hub was and that 15% of people surveyed had used a hub appointment[8]. Lower take-up of

[8] Brent CCG

weekend appointments also raises questions as to whether appointments are being offered at times that meet local residents' needs.

Out of Hospital Strategy

3.22. 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.

3.23. 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 target to prevent 2,300 admissions in 2014/15 (figures provided in March 2015 showed 2,796 preventions[9]).

3.24. Services to deliver 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).

3.25. Concerns regarding district nursing, providing support to patients who are housebound or find it difficult to access regular healthcare, were raised during the review. The District Nurses work closely with GP surgeries and in partnership with other health and social care professionals in providing healthcare needs assessments, care planning and nursing care within the home. Issues regarding recruitment and retention were raised during the review. This requires further investigation but feedback received included a need to develop a programme to support district nursing, to ensure an effective, motivated and responsive service is in place.

3.26. If, as outlined in the transformation plans, hospitals will focus on the provision of specialist services, other services need to be fully established in a community setting. With services in the early phases of implementation and no robust data available, it is too early to evaluate the impact.

[9] Brent CCG

Integrated Care Programme

3.27. The Integrated Care Programme (ICP) was introduced in 2012 with the aim of improving care for people with a long term condition such as diabetes, coronary heart disease, respiratory problems and those over the age of 75. The programme has received good feedback from patient surveys carried out.

3.28. 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. Figures provided by Brent CCG in March 2015 show that in excess of 8,500 care plans have been completed to date, 142 multi-disciplinary group meetings held with 477 patients discussed.

3.29. A new role of Health and Social Care Coordinators (HSCCs) has been developed, with appointments 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, which highlighted good outcomes in individual cases in terms of delivering interventions to reduce dependency on GP services and avoid unnecessary hospital admissions.

3.30. The value of the role of HSCCs is acknowledged. The HSCC role has been introduced as part of a pilot programme. The task group identified areas for consideration in reviewing the pilot and planning future arrangements for the role. For example, 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.

3.31. Brent CCG carried out evaluation of the ICP through 600 patient surveys, which provides 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. 75% of care planned patients said their family or carer was involved in decisions about their health as much as they wanted them to be. The outcomes delivered through the programme also included a reduction of 398 non-elective (emergency) admissions according to analysis provided by the CCG in March 2015.

3.32. The task group wish to carry out further analysis of the full results of the patient survey in gaining a clearer picture of the impact of the ICP.

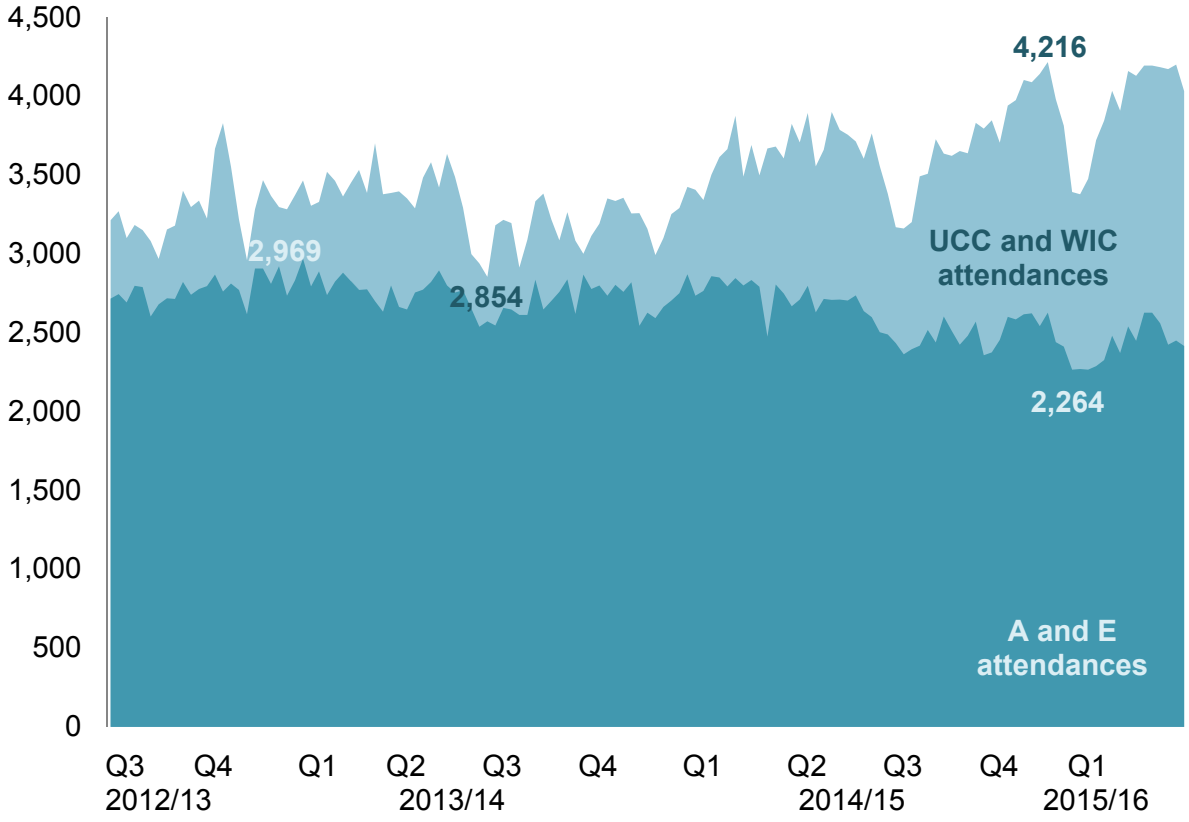
Emergency and Urgent Care

3.33. 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 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.

3.34. 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 but it was felt that patients are realistic about waiting.

3.35. 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.

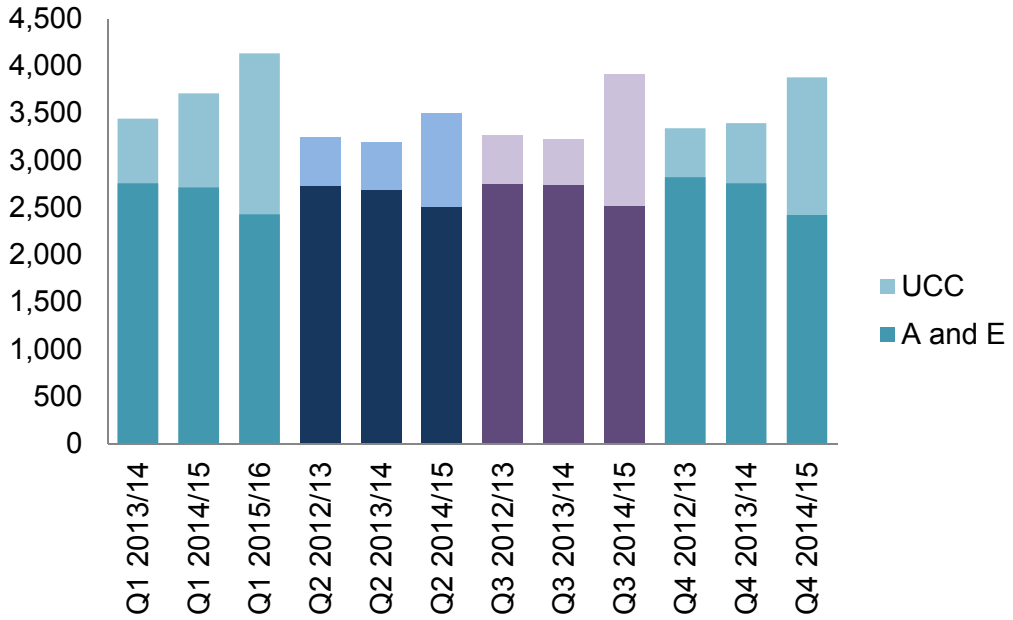
Figure 3: A&E and UCC Weekly Attendances[10]



[10] 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.

3.36. Figures three and four show an increase in trend in UCC and walk-in centre (WIC) attendances, which may be a result of difficulty in accessing GP appointments. However, recent coverage of the UCC at Central Middlesex Hospital reported a decrease in UCC attendance in February 2015[11]. This could have been following one of the clear dips 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 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 for the UCC.

Figure 4: A&E and UCC Attendances by Quarter[12]



3.37. The additional ambulance service has been commissioned to manage non-emergency transfers. There are currently concerns regarding the performance of 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 achieving the standard in under 11 minutes (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 in eight minutes and 92% in 19 minutes.[13]

[11] http://www.kilburntimes.co.uk/news/health/brent_urgent_care_centre_sees_decrease_in_patients_as_a_e_demands_rise_1_3971026

[12] NHSE

[13] LAS (January 2015)

3.38. 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%).[13] 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.[13] 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.

Managing Expectations

3.39. 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 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 in making informed decisions in accessing GP services. A booklet has been produced to help improve access to primary care in Brent.

3.40. 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. This places additional pressure on GP practices.

Emerging Recommendations

3.41. Full recommendations are still being finalised and will be informed by the additional evidence required in presenting a full picture of access to extended GP services and primary care in Brent. Key insight and lessons learned through the range of discussions and visits held, as well as an analysis of the findings to date, have highlighted some areas for consideration.

The following emerging recommendations have been identified:

- The development of a clear, borough-wide, publicity campaign to provide information on GP Access Hubs.

- To carry out a detailed review of utilisation 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 attendances.

- The development of a clear communication strategy for ensuring the public are aware of and informed of the Urgent Care Centre and the services provided.

- Introduction of clearer road and access signs for the Urgent Care Centre and a review of the cost of parking at the centre.

- The development of a communication strategy, including targeted activities with schools and workplaces across the borough, in promoting the right access to services, raising awareness of the range of services available and support to manage care at home where appropriate.

Next Steps

3.42. There is further evidence required to support the task group in drawing conclusions and finalising recommendations. A final report will be presented to the Scrutiny Committee in the Autumn.

4.0 Financial Implications

4.1 There are no direct financial implications arising from this report.

5.0 Legal Implications

5.1 There are no legal implications arising directly from this report.

6.0 Diversity Implications

6.1 There are no diversity implications arising directly from this report.

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