NHS
Central London
Clinical Commissioning Group

Interim BME Health Forum Director
80a Church Street
London
NW8 8ET

15 Marylebone Road
London NW1 5JD

Tel: 020 3350 4321
Email: clccg@nhs.net

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Dear Sir/Madam

Firstly I would like to thank the BME Health Forum for conducting the unscheduled care insight project. The final report is extremely comprehensive and provides Central London Clinical Commissioning Group (CCG) with valuable information which will be helpful to help shaping the design of future healthcare services.
Within the report there are several recommendations to the CCG which I would like to respond to regarding the services that we currently commission.
A guarantee to patients that when they have an urgent need they can be seen by a GP in a GP surgery, Urgent Care Centre, Walk-in Centre or Out Of Hours service within 4 hours.

In line with the NHS constitution, within Westminster if you have an urgent care need you should be seen within 4 hours of accessing the urgent care provider. If for any reason your GP cannot see you within 4 hours, a GP can see you in one of our Urgent Care Centres or Walk-in centres

Pilot drop in clinics that are open late in the evening (e.g. until midnight)

GPs are contracted to provide services from 8:00AM-6:30PM, however some of Central London CCG's GP practices offer an 'enhanced service' to provide primary care services beyond these hours. The CCG will explore the viability of increasing the number of practices offering the enhanced service.

As part of the wider whole systems project GP practices will be working together in 'sub-locality units' to offer extended hours for patients. This is a pilot and timescales have not yet been set, but we will share more information with you as it becomes available.

Currently within Westminster, four GP practices are open at weekends offering a walk in service and same day appointments. You do not need to be registered at one of the practices to be able to use the service. More information can be found at: www.centrallondonccg.nhs.uk. There are also other services which are currently available after 6:30PM such as walk in

centres and urgent care centres. A list of these can be found at http://www.nhs.uk/service-search. There is also a mobile phone app in production which will be able to tell you urgent care services located near you. We will share the details with you as soon as it is available.

Raise awareness on the availability of Out Of Hours services through direct conversations with patients as this group of patients do not access information though mainstream publicity such as GP practice websites.

The CCG is happy to support any patient groups and send representation to forums where requested to discuss our work and healthcare matters such as Out of Hours care.

Ensure every GP practice has an effective and consistent appointments system for seeing urgent cases, particularly children and older people within 4 hours during their opening hours.

For urgent cases all practices will offer emergency same day appointments. This will be easier once SystmOne, the new GP system, being rolled out to GPs in Westminster is fully implemented across the local area. This is also a requirement of the Prime Minsters Challenge Fund.

Bring certain aspects of the experience of A&E that people value to primary care. Patients reported that at A&E they felt that they were seen by experts, had tests done and felt more involved in their care (See Findings 1.4.2, Sections 5.8, 5.9, 5.10, 5.11, 5.12). In line with the CLCCG's Better Care, Closer to Home strategy (2012-2015), it may be possible to bring some of these aspects to primary care wherever possible.

GPs and consultants are both senior clinicians who have completed their training are considered to be the same level of seniority. If an individual is to attend A&E with a primary care issue they are more likely to be seen by a junior doctor, whereas GPs are trained specifically for primary care and therefore are better suited for the needs of the patient. It may be perceived that the more tests a patient has in A&E means that they are receiving better care, but GPs are very skilled at selecting the appropriate diagnostics for the presenting complaint and this does not compromise care. The CCG will look into providing educational sessions to community groups about how to use the NHS and the role of the GP.

Where practical investigations should take place in primary care rather than in the hospitals. If patients do not get referred to hospitals for tests but are able to have tests within primary care, this may improve the perception of primary care as expert providers. Also, it could at some point be possible for patients to do some tests by themselves at home, e.g. urine tests (see section 5.6).This may be able to reduce unnecessary visits to the GP as well as A&E.

As part of the commitment to deliver the CCG out of hospital strategy we are undertaking procurement for a community diagnostics service so that patients can have a number of diagnostics in the community such as access to X-rays.

Inform patients more about GPs' Special Interests. Use these to rationalise appointments so patients feel they are seen by an expert. If possible refer patients to other GPs who have a particular expertise.

Some GP practices already publish on their websites if any particular GPs have special interests, and we will recommend that they all put this information online. The CCG is also looking into the possibility of inter-practice referrals.

Every effort should be made to involve patients in their care so that they do not feel more involved in their care at A&E than at their GP practice.

This is a priority for Central London and forms the backbone of new NHS strategy of 'no decision about me without me. All Central London practices have signed up to North West London's whole systems pilot where co-production (GPs and patients being treated as equals) has been the key to developing a new way of working, such as involving the patient in key decisions when writing their care plan. This is also the underpinning factor behind the new unscheduled care admissions enhanced service where the patient is involved in their care planning and personal health goals are also included.

A minority of patients are unhappy with their relationship with their regular GP (See Findings 1.4.3). This could be caused by some poor clinical practice or poor communication. For some patients it may be better to change GP practice.

Ensure all patients know how to change GP and are aware that this will have no consequences for their care. This information should be visible in GP waiting rooms and cascaded through community groups. This project found that a substantial minority (20%) did not know how to change GP (see Section 5.20).

The CCG has recently produced a leaflet to explain how to register with a GP in English and easy read. We acknowledge that there are no specific comments about changing practice and we will seek to rectify this in future iterations. This leaflet will be distributed amongst member practices, community groups and local voluntary sector organisations. If any organisations would like this information in a different language, the CCG would be happy to arrange this.

Ensure wherever possible that patients with language needs have easy access to an interpreter. Language line and face to face interpreting services already exist and should be utilised systematically.

The CCG commissions both face to face and a telephone interpreting service which is available at all practices. The CCG is also currently undertaking an insight project to understand communication barriers patients' experience. We will use this report to how we can better reduce communication barriers. The CCG is also adopting a new approach to patient questionnaires at registration which will include fields for interpreting needs and language spoken. The use of a standard form across the CCG should ensure a consistent approach to capturing this information at the point of registration. We will also remind all practices of the service available to their patients.

Reception staff should be trained in working with a diverse community and particularly in working with people whose first language is not English and/or people who suffer from anxiety or mental distress (see Section 5.22).

As part of our Right Choice First Time (RCFT) strategy we are looking to work with non-clinical patient-facing staff to assist them with developing in areas such as those described, so that they have the confidence to support these patients. All practices within the CCG will be provided with the training.

Further research should be carried out with patients who attend A&E repeatedly to find out why they do so and what would make them decrease the repeated use of A&E.

We will be introducing a scheme whereby practices will be incentivised to review patients who frequently attend A&E. This will involve a consultation with the patient to understand the reasons behind the repeat attendances to better identify how we can address underlying reasons.

Improve referrals to community organisations and to community run health programmes (such as the community champions, health trainers, Wellwatch, Diabetes Mentoring Scheme, Expert Patient Programme, Diabetes Prevention Scheme, mental wellbeing programme and other health & wellbeing services, etc) as these may be able to support patients to stay well and to understand how to access NHS services appropriately.

The CCG has commissioned a patient referral service to support patients with referrals to such services. In addition, the CCG is undertaking a sub-locality unit based needs assessment and asset mapping exercise, which will allow us to measure the impact of initiatives and drill down to local health inequalities. This, in turn, will help us target our work with the voluntary sector to best address the health inequalities in each sub locality unit.

Provide workshops for GPs and Practice staff on what local community organisations are providing that can support patients.

Currently the CCG provides information to practices on a weekly basis via an emailed bulletin. We also have an educational bimonthly meeting for GP practices which potentially

organisations could attend to promote their services if it fits with the topic of the agenda. This information will be provided to the BME health forum.

When patients visit A&E inappropriately their experience should be as similar as possible to attending a GP practice (see Findings 1.4.2 and Section 5.5 and 5.8). For example:

Patients could be told that they cannot be seen at A&E and have an appointment booked for them with a GP where they can be seen with 4 hours.

As part of North West London's Shaping a Healthier Future strategy all Urgent Care Centres will have a mechanism to book patients back into General Practice from April 2015.

Patients could be seen by a GP at A&E who would follow the same processes as a GP based in the community (same access to tests etc).

In an Urgent Care Centre, GPs have access to only a limited amount of tests similar to that of a local General Practice.

Ensure that when a patient goes to A&E the staff have access to the patient's records to ensure that no unnecessary tests are done or repeated to avoid giving patients the impression that an examination at A&E is more thorough.

At Central London we are currently working with providers to have an IT system that is inter-operable with our GP IT systems. This would allow clinicians at UCCs/Walk-in Centres and A&Es to see the GPs records. This should be available from April 2015.

Recommendations for Changes in Community Provision

Community organisations could be involved in delivering a community education programme that raises awareness within different BME communities about when to utilise which NHS services and what the different services provide. The community education programme should also engender a sense of responsibility with communities in relation to how and which services they access and the cost of utilising emergency and urgent care as opposed to GP and other services. Such a programme could be delivered alongside other community health education programmes such as ESOL for Health or the Expert Patient programme.

1. *Make some provision for community health advocacy which could support patients who have unresolved issues with their primary care in order to ensure they are able to access appropriate primary care and do not attend A&E as a default.*
2. *Provide a structured health education programme targeting people who do not speak English that can support people to manage their long term conditions and teach them how to best manage their appointments with their GP, book double appointments if needed, and make complaints. This could be done in the Expert Patient model with sessions run in Arabic, Somali and Bengali, and in the ESOL for Health model to support people improve their English at the same time.*

The CCG will look at how to take this recommendation forward; it was presented at the RCFT steering group and is on the agenda to be discussed at the next meeting. The CCG currently commissions the expert patient programme and is currently looking to offer this service in different languages. This will be completed within the financial year.

a. Recommendation for changes in the collection of Ethnicity data

The BME communities constitute 38.4% of the population in Westminster but 48.6% of the sum total of all A&E attendances. Individual groups of 'categorised' BME communities do not represent high A&E usage compared to the different white categories except for the category 'Any other ethnic group.' The 'Any other ethnic group' constitutes 11.1% of the local population and yet has 26% attending A&E (see Section 4).

1. *NHS Trusts delivering A&E and urgent care services for the population of Westminster have a contractual obligation to collect ethnicity data. This needs to be done to a higher standard in order to identify who the 26% attending A&E are in order to target the community education programme towards these groups. To achieve this, it is likely that more ethnicity categories would have to be used that are not in line with the categories used by the ONS such as Arab and Somali. For example the African category realistically does not provide very useful data as Africa is a very large continent with many different countries, ethnicities, cultures and languages. Effective targeting will only be possible if the data collected can identify more precisely the ethnicity of the patients (see Section 3.2 where participants were asked to describe their ethnicity).*

This information is collected at a national level and will be continued to be collected in this way for national benchmarking purposes. The CCG and overarching collaborative body is, however, looking into adapting these categories at a local level by adding subsections to the generic sections. This way a more localised approach to reporting can be obtained by selecting the other highest prevalent groups for our area. The CCG / Collaborative will be in touch if we need any support and we aim for this new method to be ready from April 2015.

I would again like to thank you for the report and if you have any further questions or recommendations then please do not hesitate to write to me.

Yours faithfully,

Dr Paul O'Reilly

Chair of the Right Choice, First Time Steering Group

Chair: Dr Ruth O'Hare, MB, BChir, MRCP
Chief Officer: Daniel Elkeles
Managing Director: Matthew Bazeley

CWHHE is a collaboration between the Central London, West London, Hammersmith & Fulham, Hounslow and Ealing Clinical Commissioning GroupS

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