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ISLINGTON

Governance and Human Resources
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE HEALTH AND CARE SCRUTINY COMMITTEE

A meeting of the Health and Care Scrutiny Committee will be held in on, **16 September 2014 at 7.30 pm.**

John Lynch
Head of Democratic Services

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Despatched : 9 September 2014

Membership

Councillors:
Councillor Raphael Andrews
Councillor Jilani Chowdhury
Councillor Osh Gantly
Councillor Mouna Hamitouche MBE
Councillor Gary Heather
Councillor Jean Roger Kaseki (Vice-Chair)
Councillor Martin Klute (Chair)
Councillor Kaya Makarau-Schwartz

Substitute Members

Substitutes:
Councillor Alice Donovan
Councillor Tim Nicholls
Councillor Nurullah Turan
Vacancy
Vacancy

Co-opted Member:
Bob Dowd, Islington Healthwatch

Substitutes:
Olav Ernstzen, Islington Healthwatch
Phillip Watson, Islington Healthwatch

Quorum: is 3 Councillors

A.	**Formal Matters**	**Page**
1.	Introductions	
2.	Apologies for Absence	
3.	Declaration of Substitute Members	
4.	Declarations of Interest	

If you have a **Disclosable Pecuniary Interest*** in an item of business:

- if it is not yet on the council's register, you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent;
- you may **choose** to declare a Disclosable Pecuniary Interest that is already in the register in the interests of openness and transparency.

In both the above cases, you **must** leave the room without participating in discussion of the item.
If you have a **personal** interest in an item of business **and** you intend to speak or vote on the item you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent but you **may** participate in the discussion and vote on the item.

***(a)Employment, etc -** Any employment, office, trade, profession or vocation carried on for profit or gain.
(b)Sponsorship - Any payment or other financial benefit in respect of your expenses in carrying out
duties as a member, or of your election; including from a trade union.
(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body
in which one of you has a beneficial interest) and the council.
(d)Land - Any beneficial interest in land which is within the council's area.
(e)Licences- Any licence to occupy land in the council's area for a month or longer.
(f)Corporate tenancies - Any tenancy between the council and a body in which you or your partner have
a beneficial interest.
(g)Securities - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

This applies to **all** members present at the meeting.

5.	Order of business	
6.	Confirmation of minutes of the previous meeting	1 - 6

7.	Chair's Report	
	The Chair will update the Committee on recent events.	
8.	Executive Member Update	
	The Executive Member for Health and Wellbeing will give an update to the Committee.	
9.	Health and Wellbeing Board Update	
B.	**Items for Decision/Discussion**	**Page**
1.	Primary Care Foundation - Improving Access and Urgent Care in General Practice	7 - 20
2.	Camden and Islington Mental Health Trust- Quality account report 2014/15	
3.	Prioritisation of scrutiny topics	
4.	Work Programme 2014/15	21 - 22

The next meeting of the Health and Care Scrutiny Committee will be on 21 October 2014

Please note all committee agendas, reports and minutes are available on the council's website:
www.democracy.islington.gov.uk

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London Borough of Islington

Health and Care Scrutiny Committee - Wednesday, 30 July 2014

Minutes of the meeting of the Health and Care Scrutiny Committee held at Committee Room 4, Town Hall, Upper Street, N1 2UD on Wednesday, 30 July 2014 at 7.30 pm.

Present:	**Councillors:**	Andrews, Gantly, Heather, Kaseki (Vice-Chair) and Klute (Chair) and Nicholls.
Also Present:	**Councillors**	Councillor Burgess
	Co-opted Member	Bob Dowd, Islington Healthwatch

Councillor Martin Klute in the Chair

1 INTRODUCTIONS (ITEM NO. A1)

Councillor Klute welcomed everyone to the meeting. Members of the Committee and officers introduced themselves.

2 APOLOGIES FOR ABSENCE (ITEM NO. A2)

Apologies for absence were received from Councillor Schwartz.

3 DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. A3)

Councillor Nicholls for Councillor Schwartz.

4 DECLARATIONS OF INTEREST (ITEM NO. A4)

Councillor Kaseki declared a personal interest in Item B9 as a governor of Camden and Islington NHS Foundation Trust.

5 ORDER OF BUSINESS (ITEM NO. A5)

The order of business would be as per the agenda.

6 CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING (ITEM NO. A6)

RESOLVED:

That the minutes of the meeting of the Committee held on 18 March 2014 be confirmed and the Chair be authorised to sign them.

7 CHAIR'S REPORT (ITEM NO. A7)

Councillor Klute reported that there were still concerns regarding the Whittington Hospital, particularly their application to be a Foundation Trust. An acting Chief Executive was in post but the first round of interviews for a permanent replacement had failed to find a suitable candidate. There had been two new appointments at Director level but these were both temporary one year appointments. The Chair had written to ask why these were short term appointments when the Trust should be seeking stability. The Committee still hoped the Trust would be able to achieve their Foundation Trust status.

The Chair had been alerted to new GP hosted prescription collection points. The Local Pharmacy Committee Chair had written to him to outline their concerns that this would undermine pharmacies which would see the loss of the add on services pharmacies could provide. It was suggested that such a change would be contrary to the GMC's guidelines on prescriptions and against directives that patients should not be sent to any one particular place.

The N19 Care pilot had been successful.

The review of GP services in Bunhill and Clerkenwell headed up by Neil Roberts had been conducted. The review had been prompted in part by the rise in housing in that part of the borough and related concerns that there had not been an adequate uplift in primary care provision. The CCG understood that the review had been completed and would chase the report authors for a copy of their final report.

The guide to Local Health Scrutiny Document that had been circulated to councillors was a concise guide to local scrutiny and also gave information about new proposals to make council meetings more inclusive.

8 HEALTH AND WELLBEING BOARD UPDATE (ITEM NO. A8)

Councillor Burgess updated the Committee on the work of the Health and Wellbeing Board and the Executive. Councillor Burgess agreed that there should be investment in primary care in the Bunhill and Clerkenwell area and also said that Finsbury Park and Archway were areas for concern.

She was interested to hear the update about pharmacies and noted that the Health and Wellbeing Board had a duty to complete a JSNA for pharmacies. Councillor Klute said there had been a helpful response from the CCG on pharmacies offering their support. The JOSC had heard evidence that there was a VAT imbalance between private organisations and pharmacies that favoured private organisations as they could reclaim VAT. Councillor Burgess stated that pharmacies could offer extended services and were a vital part of the local health economy.

The Health and Wellbeing Board had met since the election and were in the process of refreshing their priorities. They were going to hold summits to check how the priorities were working and would keep the Committee informed of their progress.

9 SOCIAL DISTRESS (ITEM NO. B1)

Wendy Wallace, Chief Executive, Camden and Islington NHS Foundation Trust gave a presentation to the Committee.

In the discussion the following points were made:

- If an individual had a predisposition towards psychosis then cannabis use at a young age could trigger an episode but would not necessarily cause an exacerbation of the condition.
- Three quarters of all suicides were not known to services beforehand.
- A significant number of letters had been written regarding the changes to benefits taking up a huge amount of clinical time.
- Alcohol use in itself did not necessarily correlate with inpatient admissions but there was a clear link with drug use.
- There was evidence that the dislocation and trauma suffered by refugees could cause long term health issues. There were good links with the Freedom from Torture organisation at Iseldon Road and those experiencing consequential depression or psychosis would receive support.
- Stress was a common mental health condition and although stress in the workplace was a factor, there were often other contributing causes.
- There were a range of mental health services available and ICope had seen many thousands of cases a year.
- There was a clear weekend related spike in mental health admissions.
- Turnover of staff in the police force was an issue but training programmes were ongoing to inform staff about dealing with individuals with mental health issues.

- The Trust were aware that there was a high proportion of older people in the group affected by benefit reforms. There were definite examples of distress caused to individuals going through the process.
- Councillors would like to attend a training session on mental health covering issues such as surgeries and dealing with constituents on the doorstep. Although the intensive two day session would not be feasible for many councillors to attend they would be interested in a two hour session covering the issues specific to their role.
- Islington had a high number of younger people with mental health issues in the borough. This number would be boosted by numbers gravitating to London as they left home and the number of universities in the borough.
- The ICope service performed very well on referral times with patients being seen within six weeks compared with up to a year for talking therapies.
- There was an 89% success rate in challenging appeals but patients would often attend up to four appointments before raising their concerns over benefits cuts. It would take up to 40 minutes to prepare one report taking up a significant amount of clinical time.
- There was a wide range of students living in Islington and whilst rates of psychosis were low in that population it was very difficult to manage.
- The CCG were looking at the significant amount of time spent on benefits appeals and were considering the possibility of central funding.
- Work had been undertaken to put more mental health support into schools and materials on mental health were also made available at LIFT and the Platform Youth sites.

RESOLVED:
That the presentation be noted and that Wendy Wallace be thanked for her very helpful presentation.

10 PRESENTATION FROM ISLINGTON CLINICAL COMMISSIONING GROUP (ITEM NO. B2)

Dr Gillian Greenhough Chair of Islington Clinical Commissioning Group and Alison Blair, Chief Executive of Islington Clinical Commissioning Group gave a presentation to the Committee.

In the discussion the following points were made:

- The CCG Board meetings were held in public and members of the public were encouraged to attend. A Healthwatch representative sat on the Board to ensure that there was an opportunity for the concerns of the wider community to impact on the operation of the Board.
- The Joint Strategic Needs Assessment (JSNA) considered levels of disease in the borough and there had been Londonwide work on stroke services.
- The over 75 age group were at high risk of social isolation, stroke and chronic disease. The CCG had a lead on this area and a Board member with responsibility for elderly care.
- There were high levels of deprivation in the borough and this had a clear link to higher levels of certain diseases. The population in Islington had a very different profile to neighbouring boroughs such as Camden and only one Islington ward was not in the top 20% of the most deprived areas in the country.
- The CCG had found the Health and Wellbeing Board to be a useful exercise. This was particularly due to the influence the Board members could exercise in their individual fields. By bringing together individuals who covered different areas effective strategies could be devised to target specific areas such as smoking cessation or an audit of alcohol use in the borough.

- The CCG had amended their constitution since it had been adopted and this had been done in consultation with groups such as 38 degrees to take some of their concerns into account.
- The CCG worked very closely with pharmacies.
- A number of strategies for reforming care were being looked at such as longer nurse appointments for patients with chronic diseases to reduce the overall amount of appointments they needed.
- The CCG had a reasonable relationship with NHS England but they had a very small local team in place which meant they had to be reactive rather than proactive.
- The report commissioned on GP Appointments was discussed and the Committee requested that the draft report be circulated to the Chair.

Julie Billett, Joint Director of Public Health, Camden and Islington gave a presentation to the Committee.

In the discussion the following points were made:

- The amount spent on Alcohol, Substance Misuse and Sexual Health services was highlighted. The Committee noted that those kinds of services were clinically and resource intensive but that all services would be looked at as part of the savings exercise. There was to be a stronger emphasis on recovery interventions but services had been slow to adapt. However, there had been a solid improvement in performance and outcomes with figures closer to the national average.
- GPs and primary care were just one setting for patient care and many services were looking more closely at what could be provided by the voluntary and community sector.

RESOLVED:

That the presentations be noted and that Dr Gillian Greenhough, Alison Blair and Julie Billet be thanked for attending.

11 SHORT BREAKS FOR CHILDREN'S CARERS (ITEM NO. B3)

The Committee noted that the reports had been provided for noting in response to the action points raised at the last meeting.

The Committee noted that the introduction of the Children and Families Act 2014 would have an impact on services and a presentation should be requested for later in 2014 or the start of 2015.

RESOLVED:

That the update be noted.

12 MEMBERSHIP, TERMS OF REFERENCE AND DATES OF MEETINGS (ITEM NO. B4)

RESOLVED:

That dates of meetings of the Health and Care Scrutiny Committee for the municipal year 2014/15, the membership appointed by Council on 12 June 2014 and the terms of reference, as set out at Appendix A be noted.

13 WORK PROGRAMME 2014/15 AND PRIORITISATION OF SCRUTINY TOPICS (ITEM NO. B5)

In the discussion the following points were made:

- In order to balance their workload the Committee would carry out one major review and receive presentations on smaller areas of interest.
- There were a number of items the Committee may be interested in receiving including presentations on –
    - Children and Families Act 2014
    - Primary Care Call to Action
    - Integrated Care/Care Close to Home
    - N19 Care Pilots
    - Better Care Fund
    - An update on FGM services
    - Food for Life Partnership
    - Sexual Health budgets
    - Adult Safeguarding
    - Local Quality Account
    - Peer Review from Social Services
- The two possible areas for the Committee's major review were Older People's Access to Care and Patient Feedback.
- The Committee noted that a DVD had been produced by Carers in partnership with Islington Learning Disabilities services and Bob Dowd could arrange a viewing for members as required.

RESOLVED:

That the work programme and the points raised in discussion be noted.

MEETING CLOSED AT 10.30 pm

Chair

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Access & Urgent Care in General Practice

Report prepared by the Primary Care Foundation, June 2014

Urgent Care in General Practice
Primary Care Foundation, 161 High St, Lewes,
East Sussex BN7 1XU
www.primarycarefoundation.co.uk

Improving Access and Urgent Care in General Practice

June 2014

1. Background

In March 2013 Islington Clinical Commissioning Group launched a Local Enhanced Service (LES) to improve access for patients to GP practices across the Borough. The initiative had two options:

Option A; the "Doctor First" approach, or

Option B; dedicated support to undertake a bespoke review of current systems and processes, through the Primary Care Foundation (PCF)

This report is designed to provide a summary of Option B, showing the differences on a practice by practice view.

2. Process

Initially 27 GP practices accepted the PCF option. The process is that GP practices capture data about their systems, processes, consultations, telephones and staffing for a sample week. This data is uploaded via a web portal to the PCF website, where it is checked, analysed and published in a practice specific report. The report includes a comparison of the practice's indicators against evidence based benchmarks, describing, amongst many other things, an optimum balance of:

- Available patient appointments for GPs, nurses and other health care professionals
- The split of appointment availability across the primary care team
- How soon patients can get an appointment and the availability of appointments they can book in advance
- Comparative activity of GPs and nurses, when looking at national indicators
- How easy it is to get through on the phone and how often they are asked to call back
- What happens when patients request a home visit
- What patients say about access to routine and urgent appointments and their overall experience of making an appointment
- How consistent their reception staff are in dealing with a range of requests for urgent appointments, their level of confidence and how recently they have received training

Within each practice report there are approximately nine pages of information that describe these findings. Included also is additional information describing the generic background, evidence and rational that underpins their report, together with suggestions about what GP practices find helpful in reviewing their systems and processes.

The PCF met with the GP practices to talk through the findings and offer any clarification or additional information necessary to help the GP practice move forward, together with any further support required to complete their changes (round 1). In addition there are a number of requirements within the LES that are not managed by the PCF.

An action plan was produced by each practice, with support from the PCF, to help them plan and implement any necessary changes.

The CCG commissioned a repeat of this process to help understand the impact of any changes made by the GP practice since round 1 (shown in round 2).

3. Status

The participating GP practices (see appendix 1) have completed their round 1 requirement, with most gathering their data during a period from March - May 2013. All GP practices received their reports and follow up visits during the summer of 2013. In addition to the original 27 practices, 1 further practice joined (for round 1 and 2) and a further practice more recently (for round 2 only).

All 29 GP practices completed their round 2 work, received their reports and have been offered further support and a follow up meeting.

Finally, practices received a second detailed report, based on round 2, and also a comparison summary to help show the differences identified between round 1 & 2. A summary report has been included as appendix 2.

A short commentary describing the overall impact across Islington and within their respective localities is included on pages 5 -10.

4. Executive Summary

Many of the Islington GP practices have made significant efforts to understand and make appropriate changes to their systems and processes for access and urgent care. Some of these changes are already showing positive signs, although these changes can take time to be understood by patients and reflected in feedback.

It's also recognised that the dynamics can change for GP practices that have higher levels of patient deprivation or language problems; for instance, it's more likely that in these circumstances GP practices may need a higher proportion of same day appointments, compared to elsewhere. However, the principles are the same and it's good to hear from practices that experience these circumstances that they have been positive about the benefits these changes are bringing.

Like any other change, it's often a combination of processes that need review, across the whole GP practice system, and these will need ongoing monitoring and evaluation, rather than just a "quick fix".

The following pages set out information to demonstrate progress being made across the Borough.

Simon Lawrence
Primary Care Foundation, June 2014

Appendix 1: Participating GP practices by locality

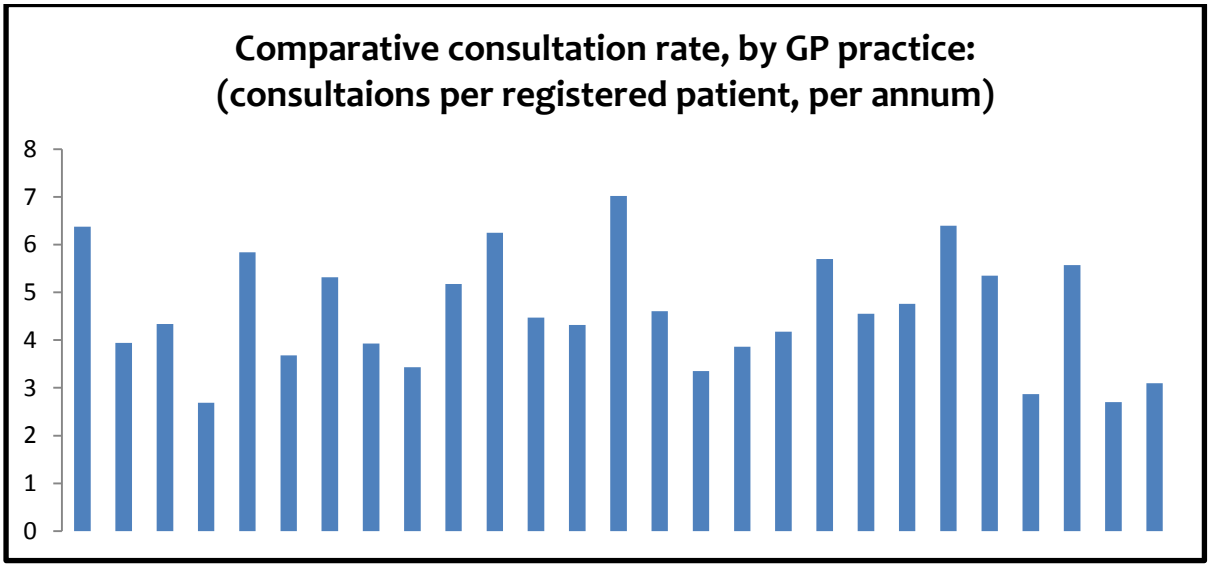
Goodinge Group Practice
Highbury Grange Medical Centre
Holloway Medical Clinic
Dr Ko's and Partner
The Miller Practice
Sobell Medical Centre
Andover Medical Centre
Archway Medical Centre
The Beaumont Practice
Dartmouth Park Practice
The Northern Medical Centre
The Rise Group Practice
St John's Way Medical Centre
Hanley Primary Care Centre
Stroud Green Medical Clinic
The Village Practice
Elizabeth Avenue Group Practice
The Family Practice
Islington Central Medical Centre
Mitchison Road Surgery
New North Health Centre
River Place Health Centre
Roman Way Medical Centre
St Peter's Street Medical Practice
The Amwell Group Practice
Clerkenwell Medical Practice
Bingfield Street Surgery
Killick Street Health Centre
Pine Street Medical Practice
Ritchie Street Group Practice

29 participating practices

What was the picture after round 1?

- Strong correlation with General Practice Patient Survey in many areas
- Some complex systems designed to "manage" demand; e.g. embargo's, which drive "phone/call early" culture
- Widespread variation in reception quiz results
- Continuity of care varied; part time GPs, popular GPs and duty GP systems can cause this
- Out of balance split between same day and book ahead availability (usually too high same day)
- High % of occasions when patients are asked to ring back (when appointments are all gone) in some practices, prompting pressure on staff and phones and inconvenience for patients
- Book ahead period too short (some concern about DNAs)
- Long wait for next routine appointment
- Mixed picture for home visiting; some assessments and visiting late in the day
- Skill mix quite varied; GPs, nurses, HCAs
- Few practices had consistent scripts for reception staff; quite a bit of variation and defaulting to next appointment rather than offering a choice
- Some variability of clinical practice e.g. consistency of care

But a typical picture; not unusual!



This chart, from round 1, demonstrates the differences between GP practice consultation rates.

Some of the important factors within GP practice control

Consultation rate, appointment availability and skill mix: why is this important?

Making sure GP practices have sufficient clinical consultations is obviously important; so we demonstrate how close to the expected number of consultations, weighted for the age and sex of their population, each practice is delivering.

However, it's not just the total number; the split of how consultations are shared across the healthcare team, the split between appointments booked for the same day and those booked in advance, as well as how soon the next routine appointment is available are also important indicators.

We sometimes find GP practices have far more appointments than we might expect; this can be for a variety of reasons. Whilst being higher or lower than average does not necessarily mean something is wrong, it can help to identify where some changes might be helpful; not just for the benefit of patients, but also the workload of the team.

When we meet with GP practices, we discuss this and some potential reasons why this might be, together with ideas that might help improve the balance. From this they can decide how they might adjust their systems and processes.

Please see the summary on page 7 which describes how GP practices have changed these arrangements to improve access and urgent care.

Telephone systems, capacity and demand: what makes the difference?

In our work with a large number of practices we have found that the patient survey result is normally a good reflection of the actual experience of accessing the practice on the phone. If the result is good in the survey (average or above average) then GP practices can be reassured that patients do not experience difficulty in getting through on the phone. If however the result is below average then it is likely they have issues that could be addressed.

There are four variables which will impact on the ability of patients to get through on the phone.

- Volume of incoming calls
- Number of lines
- Number of people answering
- Call lengths

The table we include in the GP practice report uses the Erlang formula to calculate the number of staff required to answer the phone in each hour to ensure that 90% of calls are answered promptly, based on the reported call volumes and length of the average call.

When we meet with the GP practice, we look at all of these factors and discuss how they might want to use this information to improve their systems and processes.

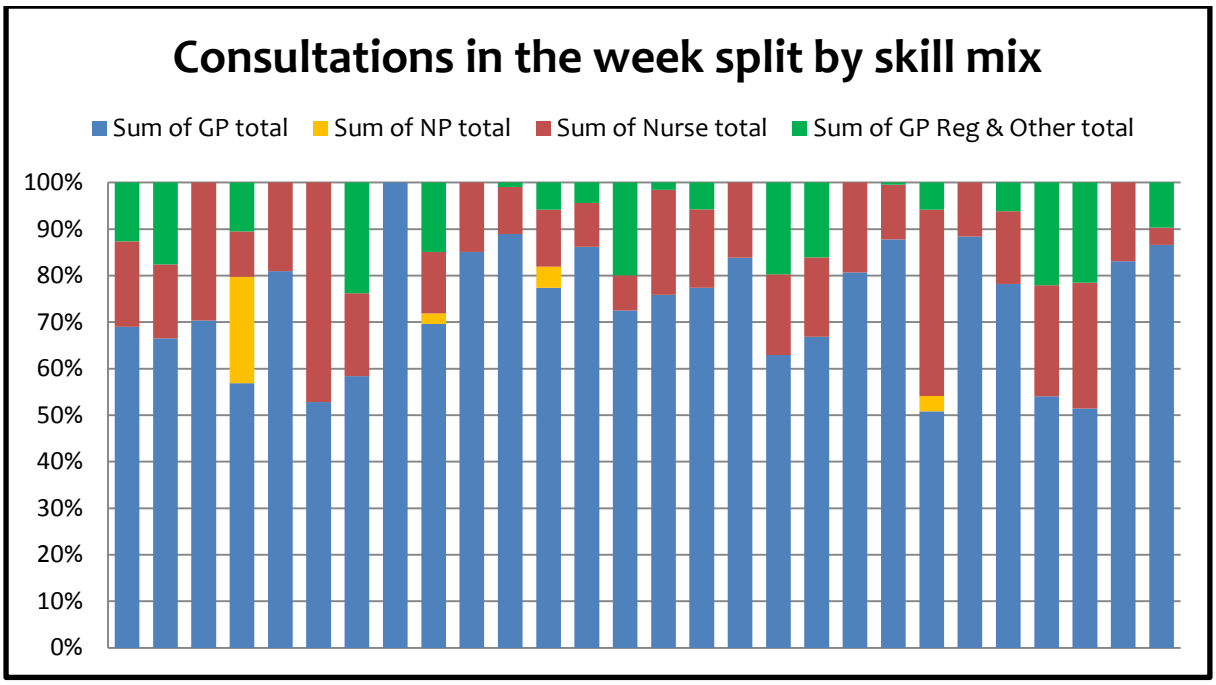
Please see the summary on page 9 which describes how GP practices have changed these arrangements to improve access and urgent care.

What did we find after round 2, compared to round 1?

Consultation arrangements

Central Locality	• 3 of 6 practices had a consultation rate closer to that expected • 3 of 6 practices had an improved same day/advance appointment ratio • 3 of 6 practices had a better balance of activity skill mix (GPs, nurses, HCAs) • 6 of 6 practices had increased their book ahead appointment window in line with the recommended length (usually about 6 weeks) • 5 of 6 practices had reduced the wait for the next routine book ahead appointment • 3 of 6 practices reduced the occasions when patients are asked to call back (when appointments run out)
Northern Locality	• 4 of 9 practices had a consultation rate closer to that expected • 5 of 9 practices had an improved same day/advance appointment ratio • 3 of 9 practices had a better balance of activity skill mix (GPs, nurses, HCAs) • 8 of 9 practices had increased their book ahead appointment window in line with the recommended length (usually about 6 weeks) • 4 of 9 practices had reduced the wait for the next routine book ahead appointment • 4 of 9 practices reduced the occasions when patients are asked to call back (when appointments run out)
South East Locality	• 3 of 8 practices had a consultation rate closer to that expected • 5 of 8 practices had an improved same day/advance appointment ratio • 5 of 8 practices had a better balance of activity skill mix (GPs, nurses, HCAs) • 4 of 8 practices had increased their book ahead appointment window in line with the recommended length (usually about 6 weeks) • 2 of 8 practices had reduced the wait for the next routine book ahead appointment • 5 of 8 practices reduced the occasions when patients are asked to call back (when appointments run out)
South West Locality	• 3 of 6 practices had a consultation rate closer to that expected • 3 of 6 practices had an improved same day/advance appointment ratio • 3 of 6 practices had a better balance of activity skill mix (GPs, nurses, HCAs) • 6 of 6 practices had increased their book ahead appointment window in line with the recommended length (usually about 6 weeks) • 3 of 6 practices had reduced the wait for the next routine book ahead appointment • 3 of 6 practices reduced the occasions when patients are asked to call back (when appointments run out)

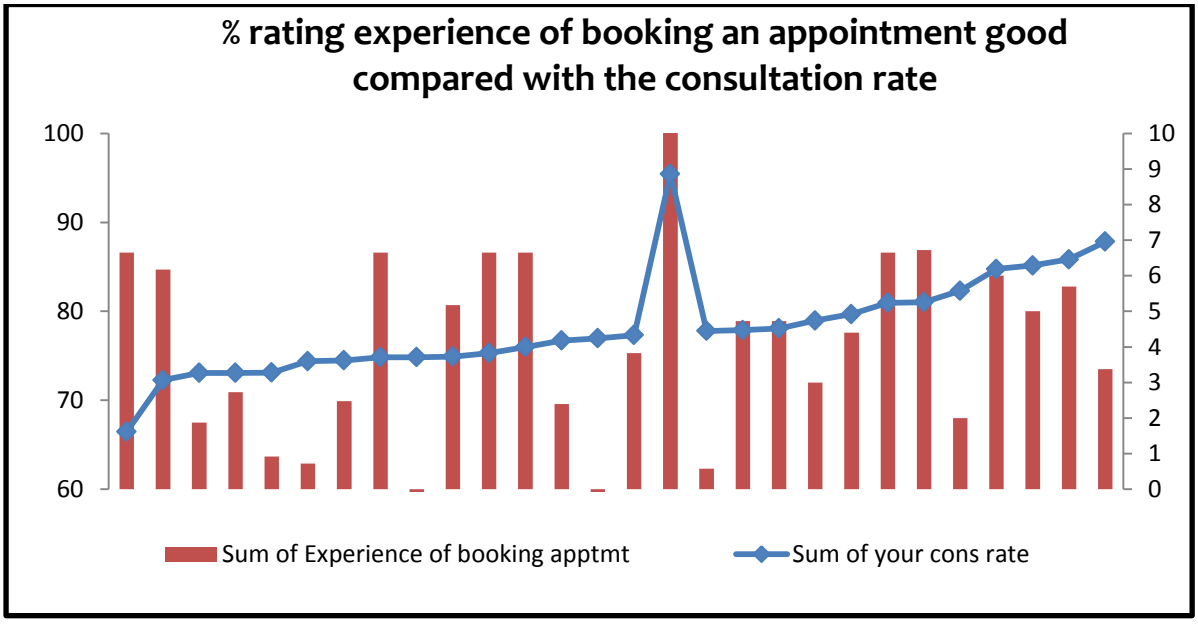
The majority of GP Practices have adjusted their systems and processes to deliver services more responsive to their patient's needs but these changes can also improve the work balance and experience of their staff.



This chart, taken from the round 2 data, shows the variation of clinical staffing across GP practices in Islington.

We know that the typical average workload in general practice is split, with about two thirds of consultations undertaken by GPs.

But the size of the GP Practice and the ability to recruit and train the right clinical staff can affect the skill mix.



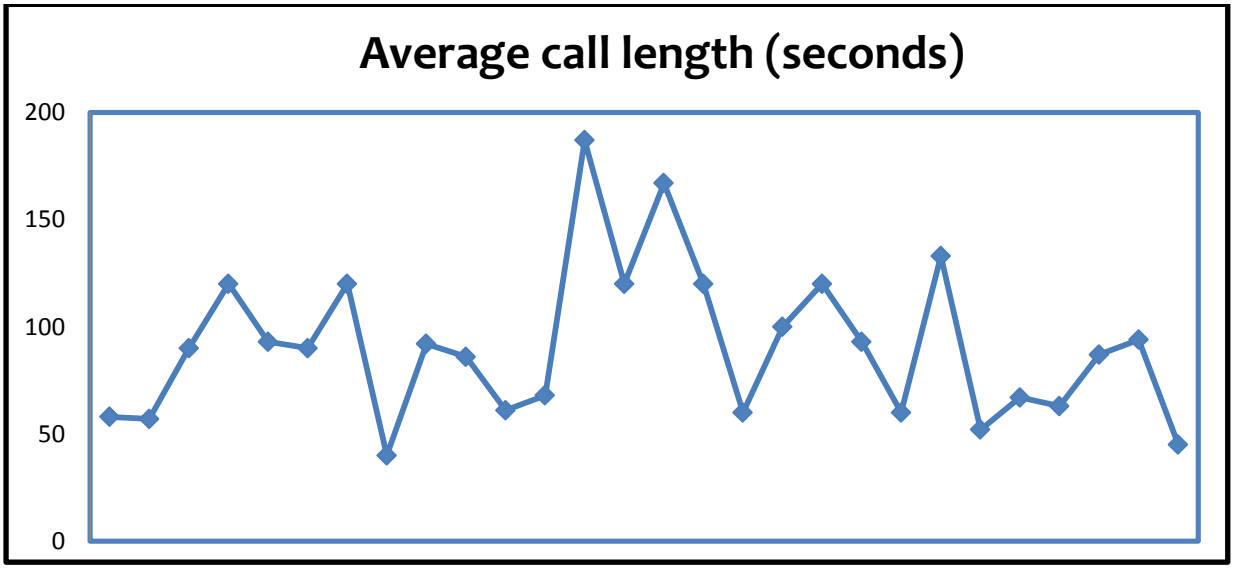
This chart, taken from the round 2 data, shows that a higher consultation rate does not necessarily improve patient satisfaction with booking an appointment; other factors such as continuity of care, ease of getting through on the phone and the availability of an appointment within the next few days will affect patient's experiences.

What did we find after round 2, compared to round 1?

Telephone arrangements

Central Locality	• 4 of 6 practices had reduced the time to complete calls resulting in better telephone staff capacity • 3 of 6 practices had improved their capacity overall, with better cover and response across the day
Northern Locality	• 3 of 9 practices had reduced the time to complete calls resulting in better telephone staff capacity • 5 of 9 practices had improved their capacity overall, with better cover and response across the day
South East Locality	• 5 of 8 practices had reduced the time to complete calls resulting in better telephone staff capacity • 5 of 8 practices had improved their capacity overall, with better cover and response across the day
South West Locality	• 4 of 6 practices had reduced the time to complete calls resulting in better telephone staff capacity • 4 of 6 practices had improved their capacity overall, with better cover and response across the day

This shows some good progress with many GP practices improving their systems and processes to ensure a good match between capacity and demand.



This chart, from round 2 data, demonstrates the variability between GP practices in how quickly they complete a call. This affects their overall capacity on the telephones.

Reception Staff Training; following up the reception quiz results

The purpose of the reception quiz is to check on the overall consistency or variation in managing patient calls or queries. The first part looks at practice protocols and training, as well as exploring staff confidence in recognising potentially life threatening conditions. The second part presents 13 different scenarios where patients call describing a particular health problem and the receptionist has to decide how they would respond, from calling an ambulance, through to getting immediate help from a doctor, to booking the patient for an appointment. This is less about whether the response is right or wrong (although with more serious conditions you will be looking for rapid intervention) but the level of consistency across the team. If there is substantial variation across the team the GP Practice may want to run a training session across the reception team, led by a clinician, to explore why there is variation, how much is acceptable, and how it can be reduced.

What did we find after round 2, compared to round 1?

Reception Quiz results

Central Locality	• 4 of 6 practices still had some variation in results across the reception team's answers
Northern Locality	• 6 of 9 practices still had some variation in results across the reception team's answers
South East Locality	• 3 of 8 practices still had some variation in results across the reception team's answers
South West Locality	• 3 of 6 practices still had some variation in results across the reception team's answers

This shows GP practices still need to offer ongoing support to their reception team; we have found this works particularly well where clinicians lead this process, perhaps using the scenarios from with the reception quiz or other typical local experiences.

Appendix 2

Individual Practice Summaries

The following pages show samples of the brief summary shared with each GP practice, comparing round 1 to round 2 outcomes.

Anonymous 1

Summary of Key Points

March 2013; round 1	March 2014; round 2
• Consultation rate 4.47 against expected 5.1	• Consultation rate 4.92 against expected 5.15
• Same day appointments 53.5% (about 1/3 same day would be expected)	• Same day appointments 34.9% (more book ahead appointments available)
• GPs undertake approximately 84.9% of appointments (about 66% would be expected)	• GPs undertaking 77.4% of appointments
• Next routine book ahead appointment 7 days	• Next routine book ahead appointment 1 day
• Book ahead window 2-4 weeks	• Book ahead window 4 weeks
• Average call length; 91 seconds	• Average call length; 68 seconds
• Phone demand and capacity; under pressure	• Phone demand and capacity; good cover across the day
• 15-30% of time patients asked to call back	• 15-30% of time patients asked to call back
• 6 reception staff not trained in last 2 years	• 0 staff not trained in last 2 years (all trained in last 2 years)

Practice action plan from round 1

• Increase clinical sessions (issues with recruiting nurses) • Re-dress same day/book ahead balance • Review GP practice in follow up appointments, etc	• Increase receptionist cover dedicated to answering phone • Training of receptionists in urgent care decisions

Commentary

The practice has made remarkable progress and improved against the indicators in most areas. The consultation rate has increased in line with need; same day appointments are in better balance and book-ahead appointments more readily available. The practice have clearly worked hard in reviewing systems and processes in reception with better cover dedicated to answering the phone, training and quicker call handling. Average weekly workload on GPs has reduced, although still higher than average.

The throughput of nurse practitioners has remained lower than expected.

Recommendations

It's recommended that the practice continues to review the availability of appointments, recommendations within the reports and their action plan. Areas for continued attention could include reducing the number of times patients are asked to call back for an appointment (this remains high) and maintaining support for reception staff with clinical leaders providing training. We have not considered the GPPS survey results from the second report (as the period is too short, data from before the first round is still included and it will take time for the changes to filter through to patients completing the survey).

Anonymous 2

Summary of Key Points

May 2013; round 1	April 2014; round 2
• Consultation rate 3.43 against expected (4.9)	• Consultation rate 3.27 against expected (4.63)
• Same day appointments 50.6% (about 1/3 same day would be expected)	• Same day appointments 62.7% (17% of patient's indicate they are looking for a same day appointment)
• GPs undertake approximately 81.3% of appointments (about 66% would be expected)	• GPs undertaking 83.1% of appointments
• Next routine book ahead appointment 2 days	• Next routine book ahead appointment 1 days
• Book ahead window 2 weeks	• Book ahead window 2 weeks + (unlimited reported)
• Average call length; 127 seconds	• Average call length; 94 seconds
• Phone demand and capacity; under pressure all day	• Phone demand and capacity; under pressure in the morning
• Less than 5% of time patients asked to call back	• We rarely ask patients asked to call back
• DNA rate 1.3%	• DNA rate 6.3%
• Only 1 member of staff completed the quiz	• Only 1 member of staff completed the quiz

Practice action plan from round 1

• Extend book ahead window • Train staff on telephone	• Increase nurse sessions • Text patients with appointment reminders to reduce DNAs

Commentary

The practice has made good progress in reducing call completion times and there is less pressure on phones during the afternoon. The book-ahead window has been extended for some appointments and the wait for a book-ahead appointment is low. Patients are less likely to be asked to call back for an appointment.

Whilst the GP and nurse are carrying out the average number of consultations per w.t.e, overall the availability of appointments is lower than expected. Same day appointments appear far higher than required. The percentage of GP consultations across the team is higher than average.

Recommendations

It's recommended that the practice continues to review the availability of appointments, recommendations within the reports and their action plan. Reviewing the availability of clinical consultations and skill mix might be worthwhile, as is the split between book ahead and same day appointments. We have not considered the GPPS survey results from the second report (as the period is too short, data from before the first round is still included and it will take time for the changes to filter through to patients completing the survey).

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HEALTH SCRUTINY COMMITTEE
WORK PROGRAMME 2014-15

16 SEPTEMBER 2014

1. Primary Care Foundation - Improving Access and Urgent Care in General Practice
2. Camden and Islington Mental Health Trust– Quality account report 2014/15
3. Prioritisation of scrutiny topics
4. Work Programme 2014/15

21 OCTOBER 2014

1. NHS Trust – Quality account report 2014/15
2. Drug and alcohol misuse – Annual Update
3. GP Appointments Scrutiny – Final Report
4. Islington Healthwatch Annual Report
5. New topic – Presentation and SID
6. New topic – Witness Evidence
7. Work Programme 2014/15

18 NOVEMBER 2014

1. Primary Care Co-Commissioning
2. NHS Trust – Quality account report 2014/15
3. Peer review Adult Social Services
4. Care Act
5. Local Account
6. Annual Adults Safeguarding Report
7. New topic – Witness Evidence
8. Work Programme 2014/15

13 JANUARY 2015

1. NHS Trust – Quality account report 2014/15
2. New topic - Draft Recommendations
3. New topic - Witness Evidence
4. Work Programme 2014/15

10 FEBRUARY 2015

1. NHS Trust – Quality account report 2014/15
2. New topic - Draft Recommendations
3. New topic – Final Report
4. New topic - Witness Evidence
5. Work Programme 2014/15

17 MARCH 2015

1. NHS Trust – Quality account report 2014/15
2. New topic – Final Report
3. Work Programme 2014/15

19 MAY 2015

1. Membership, Terms of Reference and Dates of Meetings
2. Child Protection in Islington – Annual Update
3. Work Programme 2014/15 and prioritisation of scrutiny topics

FUTURE ITEMS:
TBC