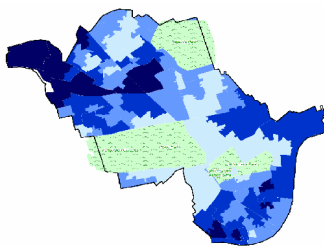


# **Primary Care Needs Assessment**

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**Westminster City Partnership**

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*This document contributes to Westminster's JSNA*

## Publication Summary

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<b>Intended audience:</b>	Westminster's Primary Care (GP) services, Primary Care commissioners, voluntary and Community Sector with an interest in preventative and primary healthcare, Local Authority preventative healthcare commissioners and providers.
<b>Synopsis:</b>	This report describes primary care health need in Westminster, existing services and recommends future commissioning priorities.
<b>Acknowledgements:</b>	Sophie Ruiz, Rebecca McHale, Joe Gale, Samar Pankanti, Margaret Kelly, Edmund Cox, Anna Waterman, Lauren Dias, Emily Bigland, Michelle Elston, Vadis Mensah.

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# 1: Executive Summary

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This needs assessment has been produced to support high quality commissioning of General Practice services, based on a deep understanding of local health needs and the services and interventions that will be effective in meeting these needs. This report aims to enable commissioners in actively manage the provider market, reward and encourage providers that continuously improve quality and to support bringing in new providers where services are unresponsive or there is limited choice.

The report brings together the range of information sources that are held by NHS Westminster to support a wider understand of the nature, current position and future developments for primary care commissioning, and seeks to answer in particular the following questions:

- Are there people not registering with GPs and if not why not? What is the population profile?
- Are there groups of people/areas that are under resourced by GPs?
- Is the quality of services provided through primary care consistent across the borough and between different sub-groups in the population?
- Are there going to be changes to current services which may impact care in the future e.g. GP retirement, end of premise lease?
- What are the population trends for the future and how will they be affected by the changing policy context?

The first substantive section of the report identifies the primary care health needs of the Westminster population. All data sources indicate population growth in Westminster, which will result in a continual need to build the capacity of primary care services. In particular services should expect to see growth in the oldest population groups (particularly 90+ and the 'baby boom' generation around retirement age), and in the middle-aged groups. Westminster's population is also expected to become more ethnically diverse and there is a need for services to adapt to ensure they are appropriate and accessible to all groups. Levels of diversity vary greatly between wards and neighbourhoods resulting in the need to commission and performance manage services with reference to this to ensure appropriate provision.

The registered population in Westminster is highly transient (390 per 1,000 population) which presents some very specific challenges for both primary care commissioning and practice management. This highlights the importance of ongoing list maintenance by the commissioning organisation and challenges for providers in meeting the health needs of a changing population and new communities. Commissioning of primary care services needs to take into account the daily influx of visitors and workers, and what this means for the commissioning of primary care services for non-registered patients. This needs to be considered particularly in light of Government proposals to remove practice boundaries.

The impact of the proposed removal of practice geographical boundaries on access to primary care for residents, particularly those with the poorest health, needs to be assessed. This is particularly pertinent in West End and St James's wards which both have areas pockets of higher than average deprivation, a dense daytime population and low levels of service provision.

Registration levels in Westminster have been shown to vary, with some specific areas showing low levels of registration with a GP. The areas with lowest levels of registration are the more affluent areas of Westminster. The reasons behind this needs further explanation and could indicate higher use of private services or more limited access to NHS GP services. Some age-sex groups may be experiencing greater barriers in registering with a general practice. In particular older people aged 65+, men aged 15 to 34 and women aged 25 to 29. Two of the wards with the greatest proportion of older people (South West End ward and Abbey Road ward) are also those with the least primary care provision. It is likely this is a contributing factor to the surprisingly low numbers of older people registered with primary care.

A&E attendance figures have shown that up to 51% of A&E admissions are for minor conditions that could have potentially been managed more appropriately primary care. Chronic disease management varies significantly across both Practices and conditions. Levels of hypertension recording are extremely low, with a gap between expected and actual prevalence of 28,420 patients. Patients continue to report access to General Practice as a priority, both in relation to access to a GP of choice and to be able to access their GP in the evenings and at weekends; this is particularly the case of people of working age.

The report moves to consider the existing levels of primary care services provision in Westminster. The sizes of General Practice Contracts in Westminster vary significantly. Westminster's average list size is smaller than is found nationally, although some Practices are very large – twice the size of the national average. This needs assessment notes that the Practices with the highest list sizes per GP are found in Westminster's most affluent areas. The reasons behind this need to be explored in further detail as to whether they are is a lesser demand on services, fewer NHS GP Practices in these areas or patients accessing private healthcare provision.

The GP desert map has shown choice and access to General Practice services for Westminster GPs. This shows North West Westminster served well by services, with patients in the main having the choice of 2 or 3 surgeries within 500m of each other (national guidance). The map reveals central and north central Westminster are less well resourced by GP services, while South Westminster has coverage but less choice. Flexibility is allowed in the Contract in relation to core hours. Few Practices provide 52.5 hours per week. It is recommended that whilst this does not signal a contractual breach, Contract managers should assure themselves that the reasonable needs of patients are met.

Variations in access models are difficult to cross-evaluate due to the different needs of different practice lists. Monitoring improvements in access by comparing practices with similar demographics employing different models and by comparing improvements over time within individual practices would be productive in assessing practice management. Overall, Westminster patients report high levels of satisfaction with access to services (although there is wide variation between practices), although the response rate to the national patient survey is low year on year. However, cross-analysis of results show that there is significantly less satisfaction with access with people of working age and people from Black Minority Ethnic communities.

NHS Westminster has made significant investment in enhanced services in primary care which has resulted in increased performance amongst Contractors, although there is currently inequitable access to enhanced services across Westminster Practices.

Travel time to urgent care and non-bookable appointments is concentrated in North West Westminster, with the North Central area, North East and South West having longer travel times. Practice level data for A&E attendances should continue to be monitored to assess the impact of the current arrangements.

Patient feedback and research undertaken by Westminster's BME Health Forum have indicated that gaps currently exist in the provision of Interpreting services across Westminster. A guide for interpreting in General Practice has been developed and this should be further publicised amongst Practices. The voluntary nature of "opt-in" to some aspects of primary care services, such as enhanced services, creates inequitable access to particular primary care services and to do serve to address health inequalities.

Financially, there is significant variation across Contract price within primary care that does not show significant correlation to higher service performance. There are 13 Practices in Westminster in which the premises are owned by the Contract holders, 8 of which are single handed Practices. In 2 of these Practices, the Contract holder is aged over 60 years. This has important implications for succession planning. Levels of rent reimbursement vary significantly across Westminster, as do the size of Practices per list size;

There are very few primary care premises which are accessible to wheelchair users without assistance. Very few practices have services which are accessible for people with a visual impairment. Whilst the findings relating to the infrastructure of the building maybe challenging to address, this finding is not related to the building itself and therefore should be considered as a priority for action.

A fairly significant proportion of the GP workforce in Westminster is nearing retirement age. This is of particular significance in the Central London Healthcare cluster where a number of these are single handed practitioners. 12 Practices in Westminster do not over access to a female GP, either as a principle, assistant or regular locum. This may have implications for access to

primary care services for some of the population. Contracts can be terminated by GPs with 3 months notice. It is therefore essential that contingency arrangements are in place by the agency with the statutory Duty of ensuring access to primary care services.

The report concludes with the following recommendations for future commissioners of services to consider:

#### General recommendations:

- Any agency involved in the commissioning and development of Primary Care services in Westminster should base their decisions on review of this primary care needs assessment. In order to ensure it remains relevant, this needs assessment should be a living document and record changes in services, need and demand;
- A long term Primary Care Development Plan should be developed that has capacity and changes to the primary care workforce that can be anticipated as a significant focus. Capacity and equity of access for Westminster's resident population, particularly its most vulnerable and most marginalised groups, will need to be continually monitored as the population of Westminster grows and practice boundaries are removed allowing registration of Westminster significant daytime visitors.

#### Developing primary care capacity:

- Primary care capacity should be continually monitored as the population of Westminster grows;
- Capacity in primary care also needs to be reviewed in light of Government proposals to remove Practice boundaries. The daytime population in Westminster is significantly higher in the areas with the fewest primary care services;
- The Medical Director role should consider safety and access issues regarding the number of registered patients per WTE GP, as significant variation already exists in Westminster;

#### Contracts and Contract Management:

- Contract management in the future should be mindful of Practice size and investment in Contract support should be proportional to this;
- Equity in price and return on investment for General Practice services should be considered in line with national variations to the GP Contract.

#### Primary care commissioning:

- Future commissioning opportunities for primary care contracts should take into account the GP desert map and choice of provider in particular areas of Westminster. This would suggest a focus for future commissioning in the South West End ward and North Abbey Road ward.



- New commissioning opportunities should also take into account the demographics of the prospective patient list, appropriately tailoring specifications to reflect need.
- Commissioning of enhanced services in Primary Care should follow the recommendations of the extensive review and align this with the work and commissioning priorities of Practice Based Commissioning clusters to ensure enhanced services are designed to deliver strategic and operational objectives;
- The Balanced Score Card should continue to be applied as a measure to raise and achieve greater equity of performance in primary care and with a focus on supporting Practices to achieving CQC registration standards;
- Service providing access to urgent care or un-bookable primary care services are concentrated in North West Westminster, with low levels of access in the North Central and South Westminster areas. Future commissioning should identify appropriate models for these areas to meet local population health needs. The impact that they have on A&E attendance rates should be closely monitored.

#### Premises and workforce:

- Succession planning should be a priority for single handed Practices where the Contractor is aged 60 years or over. In particular, commissioners need to start discussions where the Contractor owns their premises to identify their future intentions and options of the local population;
- Access to a female GP should be considered an important aspect of primary care service delivery, and opportunities presented in new or existing service changes be maximised to ensure this;
- Contract management should implement a consistent programme across all Contractors to review rent reimbursement based on space used within Practices to delivery services as set out in the GMS Contract. From an assessment of size of clinical space to the size of the Practice list, opportunities to sweat assets should be maximised to support the delivery of community based primary care services. Commissioning clusters should prioritise discussions with member practices to fully utilise space available;
- A robust programme of rent reviews should be established to ensure a fair market rent is reimbursed to Practices in line with the conditions set out in the Contract.

#### Chronic and long term condition management:

- Focused work should be undertaken with Practices to explore and address the gaps between expected and recorded prevalence, particularly in the area of hypertension;
- The gap between expected and actual prevalence should be investigated further to understand if there are trends amongst particular population groups.

## **2: Introduction**

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### **2.1 Why a Primary Care Needs Assessment?**

The purpose of the needs assessment is to support high quality commissioning of General Practice services, based on a deep understanding of local health needs and the services and interventions that will be effective in meeting these needs. The aim of this report is to enable commissioners to actively manage the provider market, reward and encourage providers that continuously improve quality and to support bringing in new providers where services are unresponsive or there is limited choice.

The report brings together the range of information sources that are held by NHS Westminster to support a wider understanding of the nature, current position and future developments for primary care commissioning.

### **2.2 What is the issue and why is it important for Westminster?**

Westminster has a very diverse population with different needs who require diverse services from Primary Care providers. There is also a huge amount of variation in the provision of primary care services in Westminster; from a high proportion of single handed general practices to large multi-partnership health centres serving list sizes of over 10,000 patients. Westminster also has higher than expected use of costly hospital services that have potential to be more appropriately provided in a primary care setting.

With the proposed changes to the structure of the NHS<sup>1</sup>, this document provides a timely overview of the met and unmet needs for primary care services of Westminster's population.

More information about the health needs of Westminster residents can be found at:

<http://westminstercitypartnership.org.uk/Partnerships/Health%20and%20Wellbeing/Pages/JSNA.aspx>

### **2.3 What is the focus of this needs assessment?**

This needs assessments aims to ascertain:

- What is the population profile of Westminster? Are there people not registering with GPs and if not why not?
- Are there groups of people/areas that are under resourced by GPs?
- Is the quality of services provided through primary care consistent across the borough and between different sub-groups in the population?
- Are there going to be changes to current services which may impact care in the future e.g. GP retirement, end of premise lease?
- What are the population trends for the future and how will they be affected by the changing policy context?

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<sup>1</sup> Department of Health (2010): Liberating the NHS

It should be noted that the needs of homeless people, a sizeable population in Westminster, and the specialised primary care services commissioned to address them and support them to access mainstream primary care is outside the scope of this report. Reference to the concurrently produced report by the Commissioning Decision Support Service which presents a rapid appraisal of primary care provision for this client group is strongly recommended, along with the Homeless Health Needs Assessment available from the JSNA website address above.

## **2.4 Format of this report**

This report is divided into three distinct sections:

- Westminster profile and health needs
- Mapping existing GP services
- Identification of the infrastructure to support primary care
- Identifying priorities for the future provision of health care for Westminster residents

The purpose of this report is to assess the health needs of the Westminster population. Where the data is available to analyse at a cluster level, this has been included. The report focuses on universal primary care services and does not provide details of specialist primary care services, such as homeless services. It should also be noted that data, such as QOF data presented, focuses mainly on the adult population.

In writing this report, we are aware of the changing NHS landscape and that a range of organisations will be responsible for taking the recommendations forward: from GP Commissioning Consortia, the Local Authority, national/regional primary care commissioning organisations and the voluntary and community sector. These organisations will have particular roles and interests in interpreting the data to identify what these means for priorities for the future. We hope that this report is a living document that can be used as an information tool for future commissioners of services to support development and improvement into the future.

### 3: The Westminster population: profile and health needs

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#### 3.1 Resident population

Population estimates for Westminster vary greatly depending on the source. Many factors contribute to this such as the age of the last population census (2001), the quality of data reporting, the transience of our population and the diversity of the population. Some estimates are shown in Table 3.1:

**Table 3.1: Different population estimates for Westminster**

	2008	2009	2010	2011	2012
ONS 2008-based projection	249,400	251,900	257,600	262,900	267,900
GLA 2009-round projection	212,121	213,068	215,134	217,189	218,108
Experian Mosaic <sup>1</sup>	245,852	-	-	-	-
WCC Daytime Population (Weekdays)	-	-	1,036,443	-	-
Exeter GP registered population discounting those living outside Westminster, including those registered outside the borough	-	246,532	247,250	-	-

Estimates have not yet been published for cells marked '-'.

Source: ONS mid year estimates 2009, ONS population projections 2008, GLA 2009 round population projections, WCC modelling, Exeter extracted September 2010,

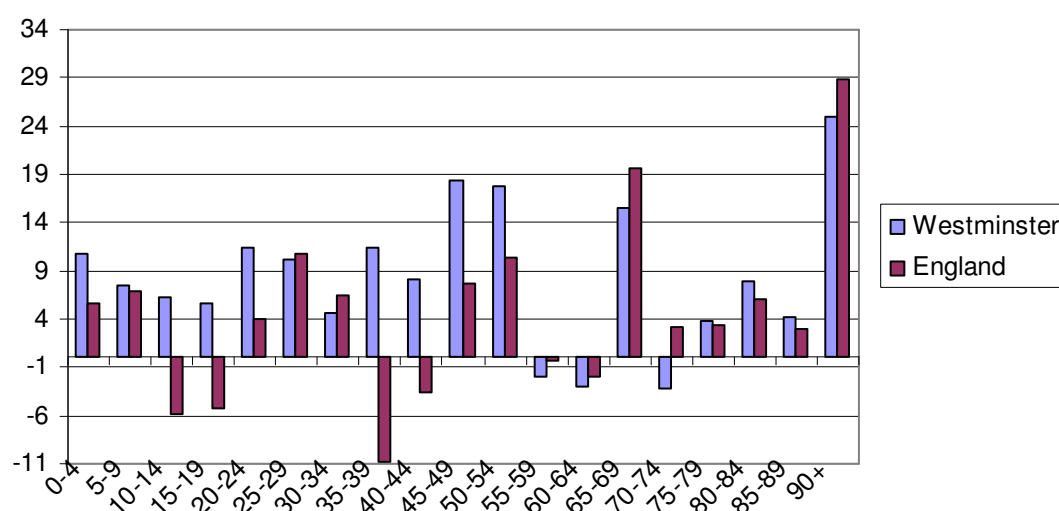
There is wide variation between the population estimates available. For the purposes of this needs assessment ONS population estimates are most commonly used. These are felt to most accurately reflect the population of Westminster and the estimates are also available in the most useful level of detail. ONS produces two population estimates: mid-year population estimates and population projections. The mid-year population projections are felt to be the most accurate reflection of the true population size. The most recent mid-year estimates are for 2008. These estimates are used for the following analysis on population characteristics.

Westminster's population is currently estimated at 249,400 (ONS, 2009). This is estimated to be increasing by an average of 4,525 people per year or 1.8% over the period of 2008 to 2012. Between 2008 and 2012 Westminster's population is expected to grow by 21,300 – the largest of any London borough (second is Southwark at 18,200).

Figure 3.1 shows the percentage change of the population of Westminster and England as a whole from 2008 to 2012. Overall it appears Westminster's population of 0 to 54 year olds will grow more than England as a whole. However Westminster's 55+ population seems to grow less than expected for England as a whole. The greatest growth in Westminster is for the 90+ age group, similar to England. This is most likely due to increasing life expectancy. The 10 to 19 and 35 to 49 age groups have a far more marked

increase compared to England as a whole. This suggests an increased influx of these age groups relocating into Westminster.

**Figure 3.1: Percentage change in population size from 2008 to 2012 by age group**



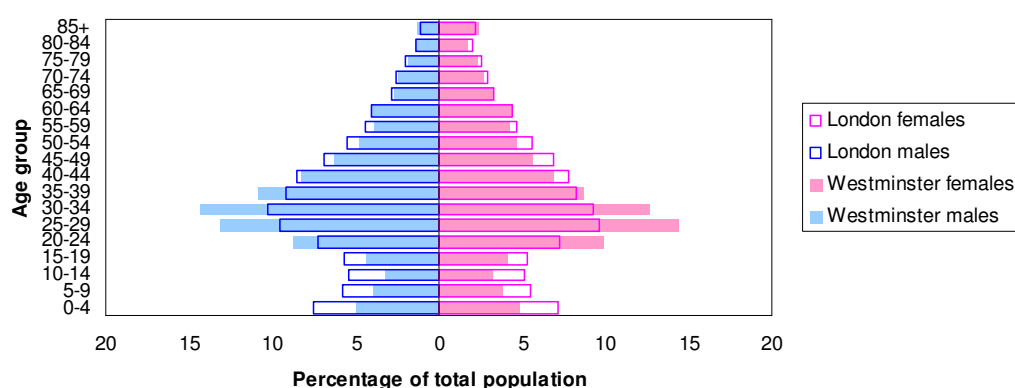
Source: ONS mid-year population estimates 2009

### 3.1.1 Age and Gender

Westminster has a high working age population compared to London and England as a whole (20 to 39 year olds). Westminster has a much lower proportion of children and young people compared to London and England (0 to 19 year olds). Westminster's population of people over 60 is similar to average levels across London as a whole, these levels are lower however than those seen across England. There are estimated to be slightly more women in Westminster than men, consistent with national trends.

**Figure 3.2: ONS resident population estimate for NHS Westminster, mid-2008**

Percentage of Westminster residents by age and sex



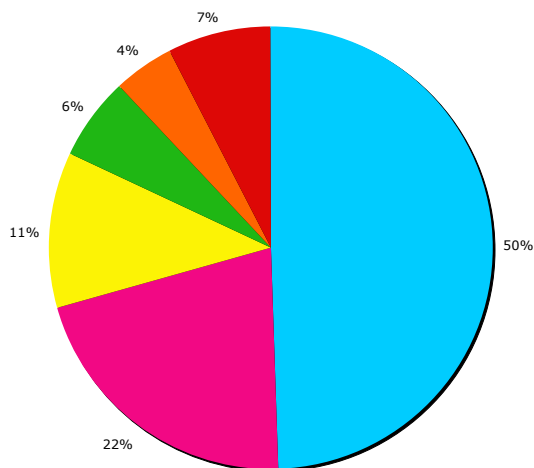
Source: ONS mid-year population estimates 2009

### 3.1.2 Ethnicity and spoken language

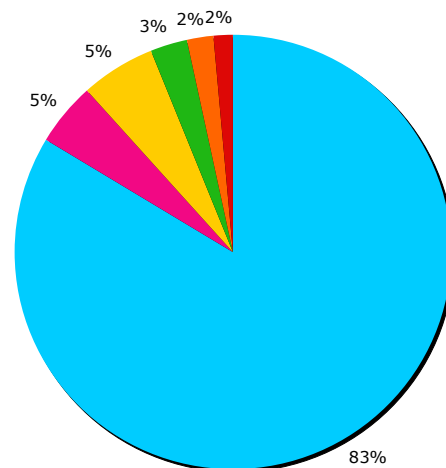
The population Census provides the most robust measure of ethnicity however the last census was conducted in 2001 and given the mobility of Westminster's population, is very out of date. ONS provide estimates of population size by ethnic group, based on census data, which are used for the analysis in this section. However more information on the diversity of the population can be found in the 07/08 Public Health Annual Report.

Westminster is ethnically diverse. According to ONS 2007 estimates 50% of Westminster's population are of White British ethnic origin, whereas 83% of England as a whole is of White British ethnic origin (Figures 3.3 and 3.4).

**Figure 3.3: Proportion of Westminster population in each ethnic group, 2007**



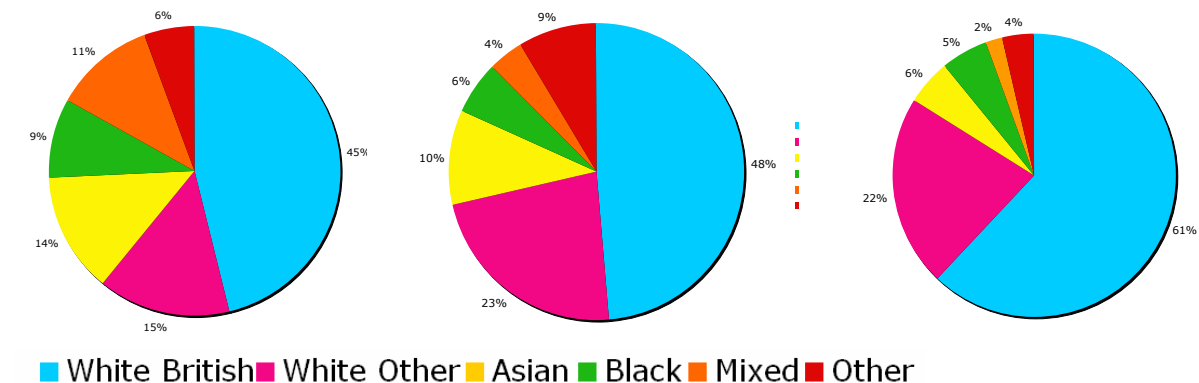
**Figure 3.4: Proportion of England population in each ethnic group, 2007**



■ White British ■ White Other ■ Asian ■ Black ■ Mixed ■ Other

Westminster's population is expected to become more diverse in the future. This is evidenced by the increasing diversity seen in the population sub-groups from older people, working age adults and children (Figure 3.5).

**Figure 3.5: Proportion of Westminster's population by ethnicity and broad age group**

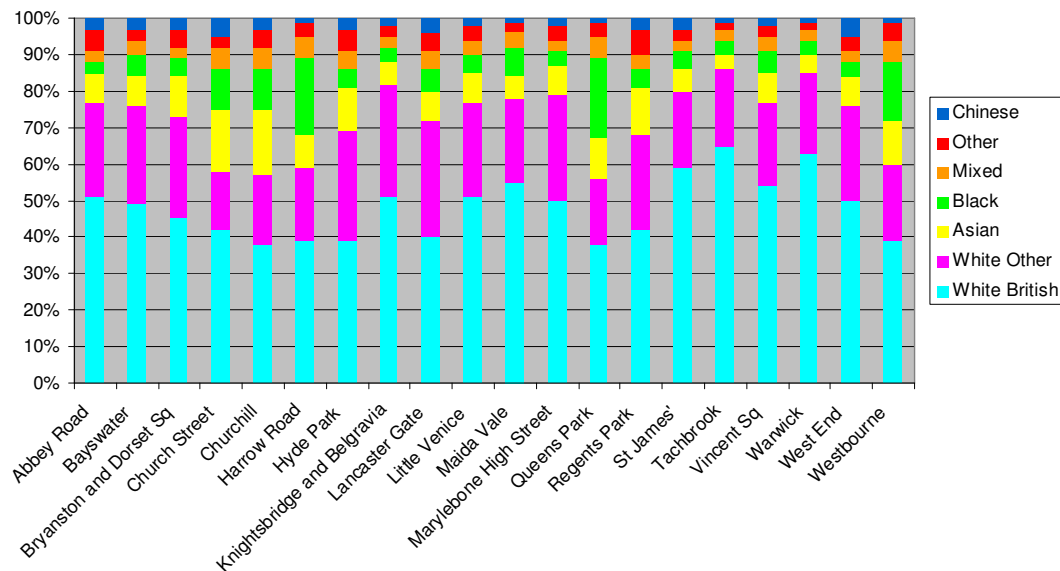


\* Males; \*\* Females

Source: ONS mid-year population estimates 2007

The diversity of Westminster residents also varies by ward of residence (Figure 6). The proportion of White British residents within Westminster's wards varies between 38 and 65%. The proportion of Black residents varies between 3 and 22%.

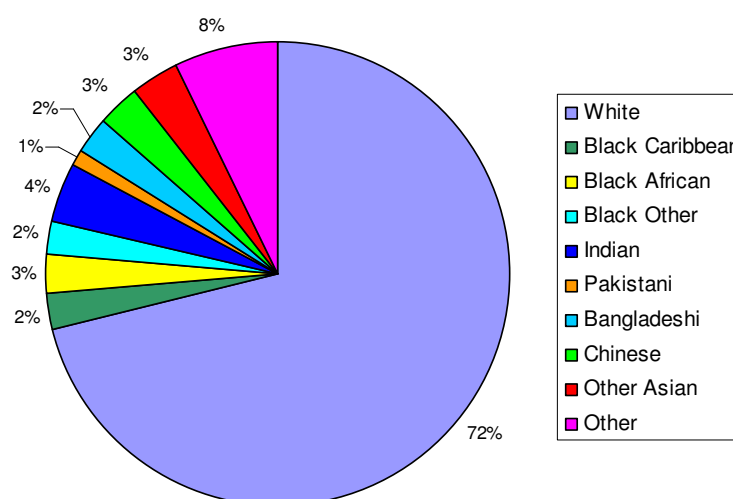
**Figure 3.6: Westminster's ward population breakdown by ethnicity**



Source: Census 2001

The Greater London Authority (GLA) have produced more recent ethnic population estimates that are available at Local Authority level. Figure 3.7 shows the GLA ethnic population breakdown estimates for 2010 with 10 categories:

**Figure 3.7: Westminster's ethnic breakdown, GLA 2010 estimates**



Source: GLA 2009 round population projections

A similar level of diversity is observed as for the ONS estimates, however these projections enable better understanding of the breakdown within broad ethnic groups.

### 3.1.3 Transience

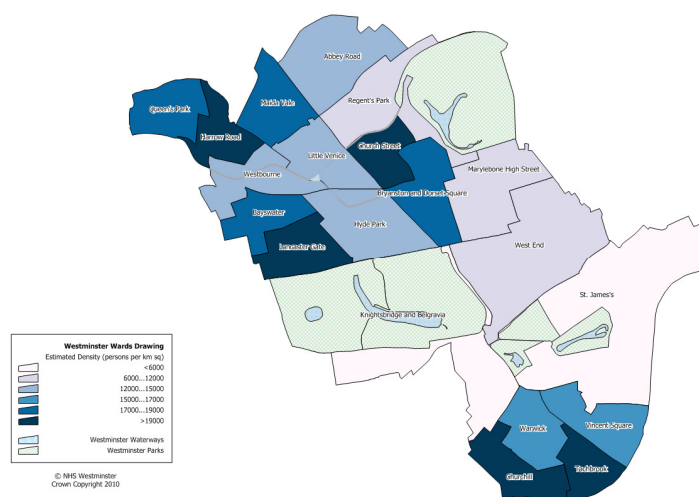
Transience in the population is very important for the planning of primary care services, as the population churn will directly impact changes to Practice's registered list sizes and profiles.

Mid-year estimates relate to the “usually resident” population, which includes international migrants who have the intention to stay a year or more, but not those who stay less than a year. During 2006–07, the population of London as a whole increased by 44,500, representing an increase of 0.6% in the total resident population of 7.56 million. There was a net outflow of internal migration of 81,410 (1.1%) and a net inflow of external migration of 51,220 (0.7%). Over the time period 2001–07, Westminster experienced an average annual population turnover rate (defined as the sum of inflow and outflow) of 313 per thousand population, the highest in London. During the same time period, the average annual ‘within borough’ population turnover rate (representing migration between London boroughs, which is included in the overall turnover rate) was 52 per thousand (PHAR 07/08).

### 3.1.4 Place

Westminster's resident population is concentrated to the north and south of the borough (figure 3.8).

**Figure 3.8: Resident Population Density (persons per square kilometre)**



Source: Based on ONS 2008 Mid-year estimate

Westminster is a business and tourism hub. As a result the population of Westminster changes dramatically throughout the day. The change of Westminster's population over the course of the day is dramatic and has been estimated based on ONS resident population estimates, the Annual Business Inquiry, Transport for London use and use of the hospitality industry (Table



3.2). There are limitations to this methodology but it provides a useful scale of change.

Based on these estimates it is predicted that the Westminster's population swells by more than 3 times its resident population during the day with 1.3 million people using Westminster over the course of a day.

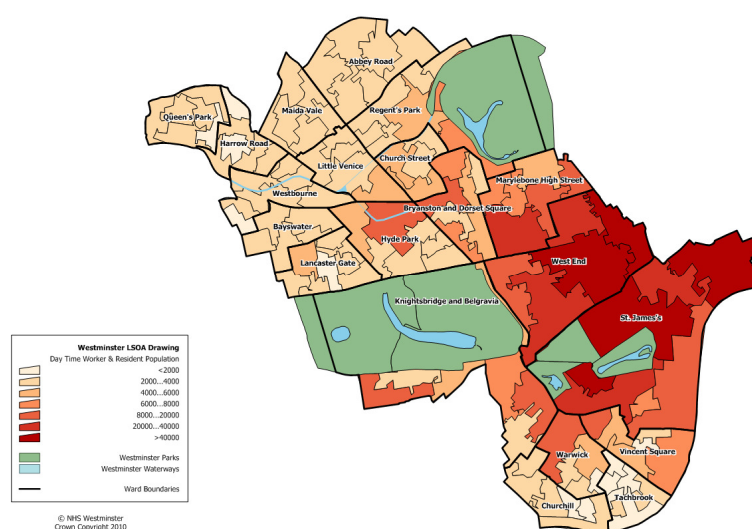
**Table 3.2: Summary of the daily estimated population change**

	Worker & Visitors Resident Population	Total
<b>Day</b>		
	686,509	193,313 879,822
<b>Night</b>	378,911	60,934 439,845
<b>Total</b>	1,065,420	254,247 1,319,667

Source: WCC, August 2010

The highest population density of residents in Westminster is in the most deprived wards in the north and south of the borough (Figure 3.8). However the majority of people visiting the borough head to St James' and West End wards (Figure 3.9).

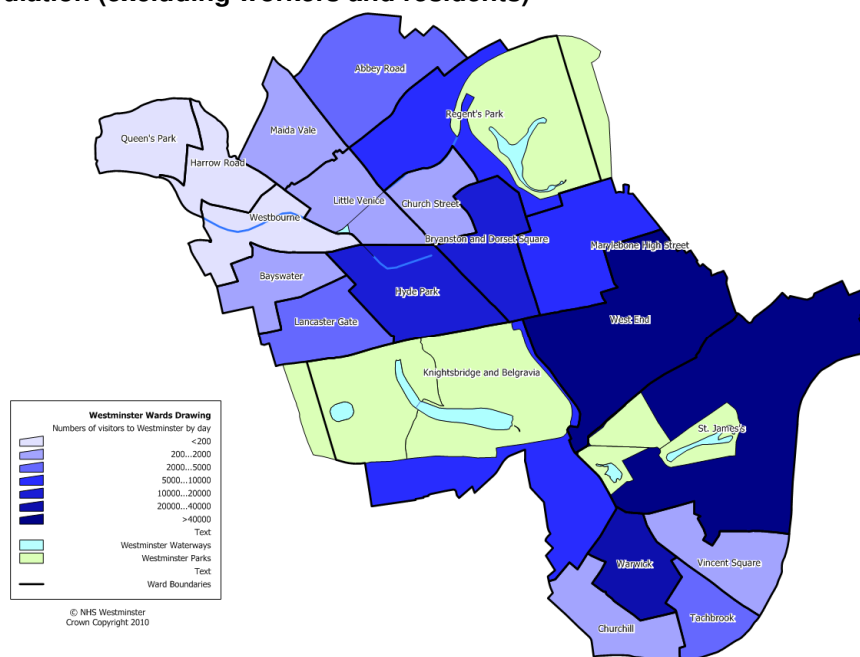
**Figure 3.9: Estimate of worker and resident population of Westminster**



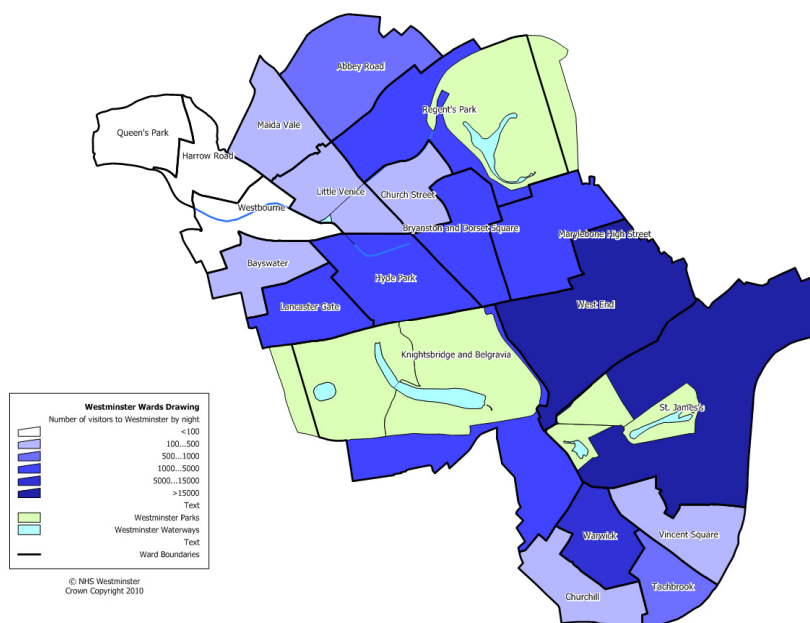
Source: WCC

Figure 3.10 shows significant population changes by day and in the evening, with the highest density resident areas becoming much less dense during these times. This will be particularly important to note with the proposals to changes to GP Practice boundaries.

**Figure 3.10: Estimate of Westminster's day time (top) and night time (bottom) visiting population (excluding workers and residents)**



Source: WCC

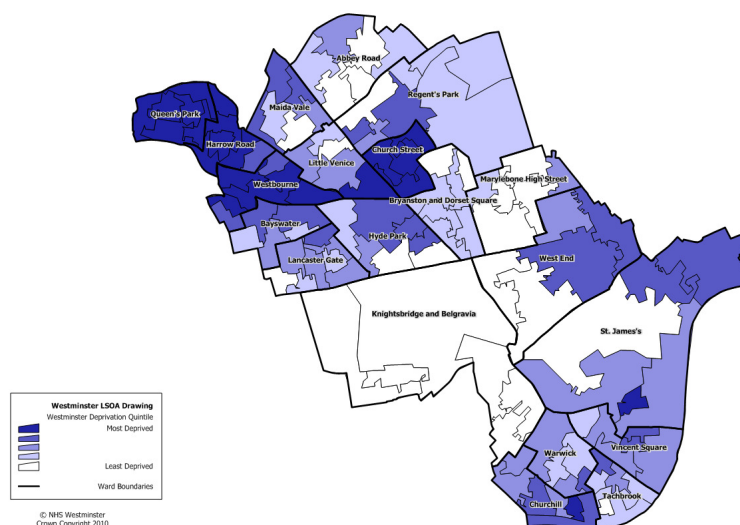


Source: WCC

### 3.1.5 Deprivation

The Index of Multiple Deprivation is a basket of indicators that give an overall score of how deprived an area is. Level of deprivation is found to correlate with most health risks and outcomes. Westminster has a marked variation in the levels of deprivation within the borough. As Figure 3.11 shows there are particular pockets of deprivation in the North West and South of the borough.

**Figure 3.11: Index of Multiple Deprivation by Lower Super Output Area**



Source: IMD 2007

## 3.2 Registered Population

As at October 2010, 247,692 people were registered with the 52 GP practices in Westminster (Table 3.3). However GP registration does not provide a complete picture of Westminster's population as some local residents may not yet be registered (eg newborns and new arrivals); and the database also includes people who have moved out of the area and have not yet de-registered with their GP – although list cleaning exercises are improving this significantly. GP registrations also include patients living outside the City of Westminster who are registered with Westminster GPs and some Westminster residents are registered with GPs in neighbouring primary care trusts (PCTs) (table 3.4).

**Table 3.3: Number of registered patients by Westminster GP practice**

Berger	6,386	Abouzekry	3,072
Buchanan-Barrow (prev Cornell)	5,528	Ahmed, G	3,638
Cavendish Health Centre	5,876	Ahmed, N	2,565
Kings College HC	7,249	Amakye	4,715
Cheung (Soho Square)	3,834	Bark (prev Murphy)	2,340
Constantinidou	6,578	Barnwell (prev Henebury)	5,081
Dexter	3,400	Bninski Mizgalski	1,612
Dicker	6,352	Charkin	10,124
El-Gazzar	3,738	Evans	6,938
Fluxman	4,266	Evans, THD	270
Goodstone	8,038	Garfield	4,233
Hickey	1,216	Honey	4,210
Maini	3,447	Jerjian	5,037
Malling Health	236	Lai Chung Fong	1,690
Milne House	3,034	Langdon	3,288
Mintz	8,279	Mackney	5,191
Muir	5,156	Mitchell	9,724
O'Hare	6,391	Nagarajan	3,131
Olufunwa	4,169	Nazeer	2,492
Purssell (prev. Elder)	8,432	Parry (prev. Tlusty)	6,255

Quilliam	4,916	Pathmanathan	2,614
Shakarchi	3,342	Rankine (prev Fogelman)	11,281
Shortall	7,811	Rowbotham	3
Silva	8,818	Srikrishnamurthy	2,417
		Weinreb	11,430
		Wiseman	223
		Wright	7,626

Source: NHS Westminster FHS department

**Table 3.4: Westminster Practices with registrations from neighbouring boroughs**

Practice	Brent	Camden	H&F	Barnet	Wands- worth	Barnet	Enfield	%age overall list size
Berger & Partners	50	44	0	0				1.5
Cheung	0	761	0	0				20
Constantinidou & Partners	23	416	0	0				6.7
Dexter	115	88	0	3				5.9
El-Gazzar	431	187	57	46				19.6
Fluxman	132	14	14	0				3.7
Goodstone & Partners	0	27	0	0				0.3
Mintz & Partners	2	54	0	0				0.7
Muir	0	0	0	0	319			6.3
Olufunwa	119	0	0	0				3
Purssell & Partners	1	79	0	0				1
Quilliam & Tate	148	0	0	0				3
Shakarchi	0	0	0	0	149			4.5
Shortall & Partners	38	35	39	0				1.5
Silva & Vranakis	378	45	164	29	3	9	1	7.1

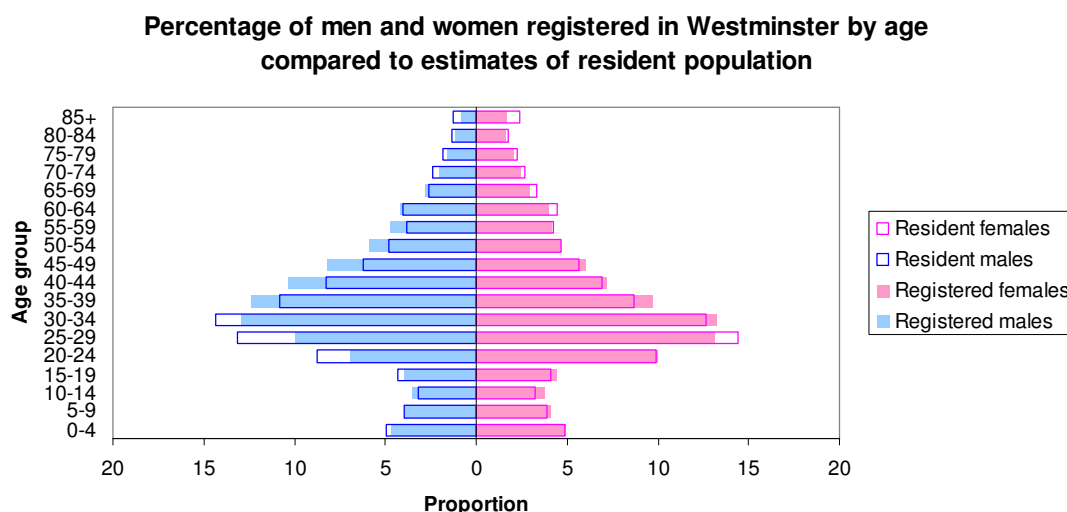
Source: NHS Westminster FHS department

A map showing the location, list size and Practice Based Commissioning Cluster of each GP practice can be found in section 4.2 of this report.

### 3.2.1 Age and Gender

The age structure of men and women in Westminster registered with a GP, compared to the age structure of the estimated population of Westminster are largely similar (Figure 3.12). There appears to be more males in the 35 to 59 age group registered than there are estimated to be resident in the borough. This may highlight a need for better list cleaning as men move out of Westminster. There are less registered males in the 15 to 34 age groups than expected. This may indicate that there are a high proportion of unregistered men in this age group. Similarly there are less registered males and females in the older age groups (80+) than expected. This may also indicate high levels of unregistered older people in the borough. This is of particular concern due to the increased health needs of the older population.

**Figure 3.12: Percentage of the Westminster population registered with a GP by age and sex**



Source: Exeter (June 2010) and ONS mid year population estimates 2009

### 3.2.2 Ethnicity and spoken language

The only indication of ethnicity available from GP registers is a free text field asking 'place of birth'. This has obvious constraints as a person's place of birth does not tell us what they consider their ethnicity to be. As it is a free text field the information provided varies widely making the data difficult to analyse. As a result NHS Westminster developed an Equalities Patient Profiling Local Enhanced Service (LES) for GPs to sign up to which aimed to improve their records of patient's ethnic origin.

During 2009/10 a total of 32 Practices participated in submitting data as part of the LES. These practices recorded their practice population's ethnicity and main spoken language through completion of short questionnaires.

Overall Ethnicity recording stood at 73.81% of the practice populations of participating practices.

A total of 5 Practices recorded the ethnicity of over 90% of their Practice Population.

- The Health Centre, 574 Harrow Road
- Soho Square General Practice
- Milne House Medical Centre
- Soho Square Surgery
- The Westbourne Green Surgery

Overall Main Spoken Language recording stood at 37.14% of the registered practice population.

A total of 3 Practices recorded the Main Spoken Language of over 70% of their Practice Population

- Dr. Victoria Muir's Practice
- Soho Square General Practice
- Queens Park Health Centre – Dr. Lai

Most practices have embedded systems for capturing the Ethnicity and 1<sup>st</sup> Language of their new patients upon registration but there is continued work required in order to capture the Ethnicity and 1<sup>st</sup> Language of existing members of their practice population, particularly those that do not often attend the practice.

It is currently not possible to accurately compare the ethnic breakdown of practice populations with expected resident populations. Therefore no conclusions have been drawn on whether some population subgroups may be experiencing unmet needs based on their ethnicity. Data obtained has shown increased levels of diversity amongst the Westminster population, which supports estimated projections based on Westminster's resident population.

The Equalities Practice Profiling LES has achieved a better understanding of this population and work to understand what this means for individual practices is currently ongoing. This needs assessment recommends sustained support for this work.

### **3.2.3 Place**

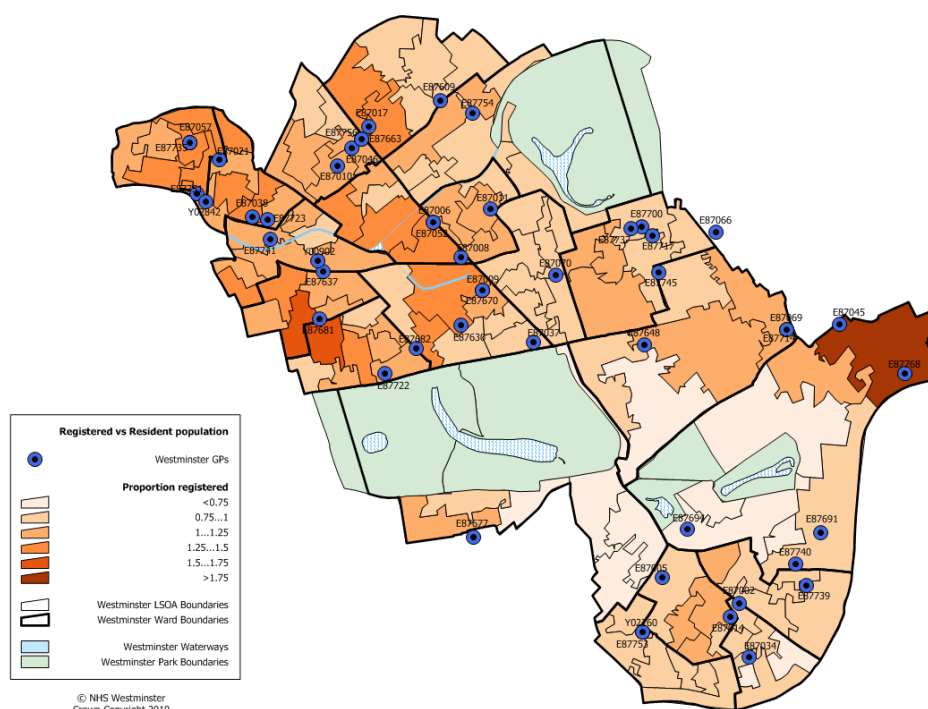
Understanding the difference between the proportion of residents in a small area that are registered with a GP practice can identify outliers for further analysis. For example low uptake of GP registration could imply inadequate provision, or that residents are experiencing barriers to accessing services or greater use of private healthcare.

This difference has been calculated by comparing the ONS resident population estimate to the registered population at Lower Super Output Area (including those resident in Westminster but registered with a non-Westminster GP). Lower Super Output Areas (LSOAs) are small geographical areas of about 1000 to 1500 residents. Interpretation of this analysis must be treated with caution as population estimates are based on old data (Census 2001) and therefore may over or under-estimate the true population.

Ideally 100% of the population in each LSOA would be registered with a GP. This would equate to a 'proportion registered' score of 1 on the map below (Figure 3.13). However there is wide variation in the proportion registered by LSOA, with a slight positive correlation between registration levels and deprivation (the more deprived areas have higher levels of registration). The LSOAs with the lowest proportion of registered people (pale orange) are in the most affluent areas of Westminster. This could in part be a result of high numbers of patients registered with private GP practices or alternatively an

indication of poor access to NHS GPs. The very dark area to the east is due to a very high number of registered people compared to expected numbers resident. The majority of these registrations are for GPs located outside the borough which may indicate poor data records for GPs located outside Westminster. Practice E87681 (located north of Hyde Park) borders two LSOAs with higher than expected registrations which could indicate a need for improved list maintenance.

**Figure 3.13: Proportion of the expected Westminster LSOA population that are registered with a GP**



Source: Exeter and ONS

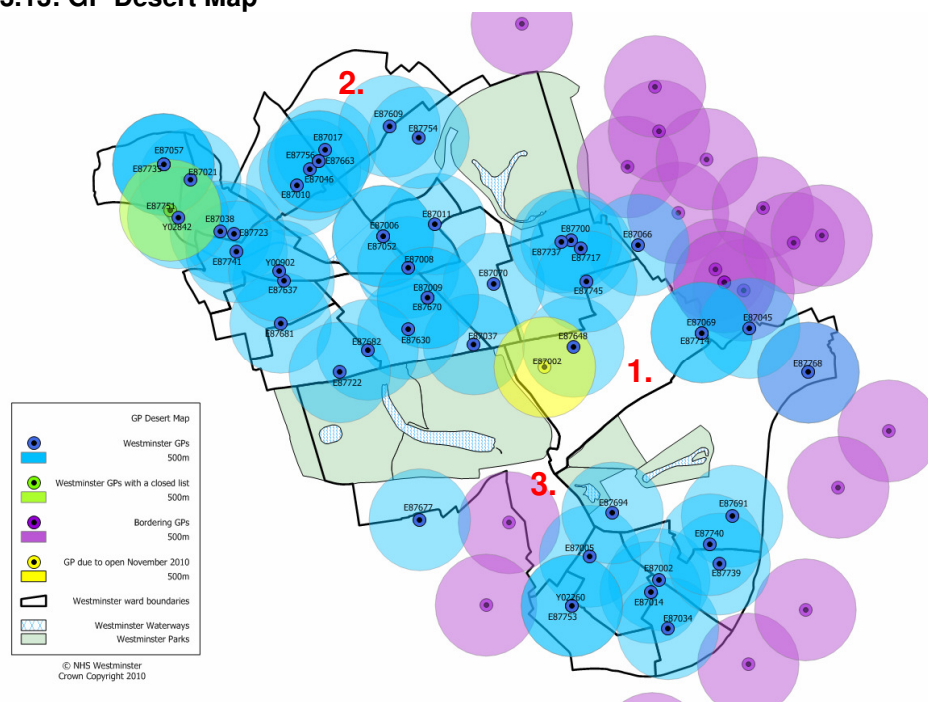
Figure 3.14 highlights particular 'deserts' in Westminster (i.e. areas in which the closest GP Practice is greater than 500 meters away).

More information on the demographics of Westminster's wards can be found in the JSNA Ward Profiles 2010 available on the JSNA website:

<http://westminstercitypartnership.org.uk/Partnerships/Health%20and%20Wellbeing/Pages/JSNA.aspx>.



**Figure 3.13: GP Desert Map**



**Note:** Each Practice has a 500m border around it. Areas left white do not have a Practice within 500m distance. Blue indicates Westminster GPs, purple indicates bordering GPs, the green practice has a closed list and the yellow practice opens in November 2010.

Some of the deserts are areas of low residency that can be explained by wasteland (such as around train tracks) or office blocks. However comparing the GP desert map with the proportion of the expected resident population that are registered, has identified the following areas that may be experiencing a level of unmet need (indicated in red on the map):

1. South West End ward: This area covers north of Piccadilly and the roads surrounding Regent Street and the east end of Oxford Street. This area has a medium population density. The area to the east has a medium level of deprivation and a high proportion of young people due to the universities in this area. This ward is one of six with the highest proportion of older people.
2. North Abbey Road ward: This area covers roads surrounding Finchley Road. The area has a medium level of deprivation. This ward has a high proportion of older people and has a slightly higher proportion of children compared to Westminster as a whole. The area covers George Eliot Junior and Infant School.
3. South of Knightsbridge and Belgravia ward: although this ward is highly affluent the area highlighted includes Imperial College. There is very low registration in the area and young people experience particular health needs.

### 3.2.4 Transience

A greater level of mobility of Westminster's population is observed through GP registrations compared to ONS data sources with already signalled the highest turnover rate in London. Over the period from mid-year 2007 to mid-year 2008, the inflow of patients was 210 per thousand registered patients



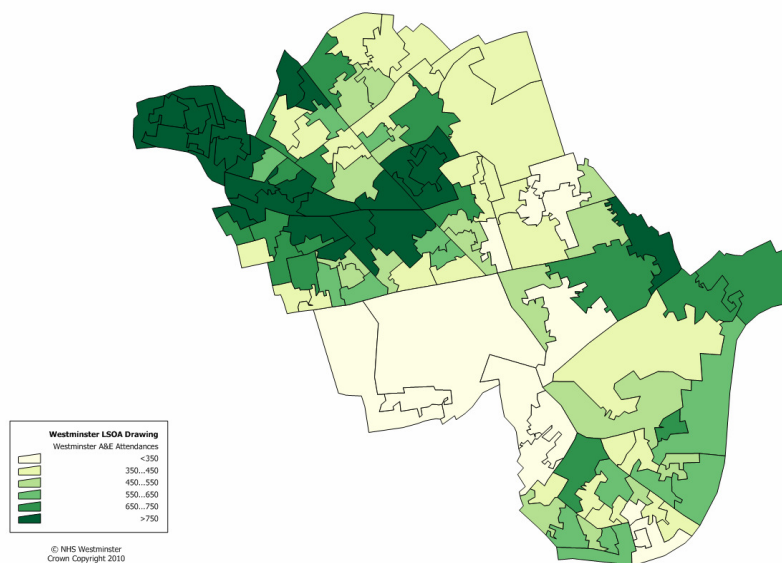
and the outflow 180 per thousand registered patients. This gives a population turnover of 390 per thousand registered patients (ONS: 313 per thousand).

### 3.3 Hospital admissions

Primary care plays an important role in preventing unnecessary hospital attendances and admissions.

In the one year period between January 09 to December 09 there were 78,870 recorded attendances to A&E by Westminster residents. Figure 16 shows a clear correlation between the number of A&E attendances and deprivation by Lower Super Output Area.

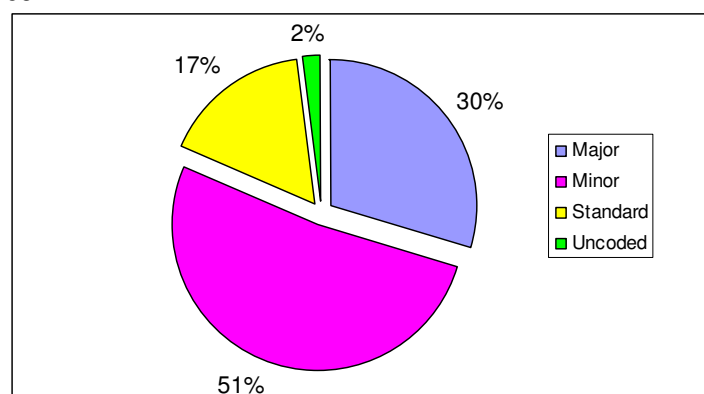
**Figure 3.14: Number of A&E attendances by Lower Super Output Area**



Source: SUS

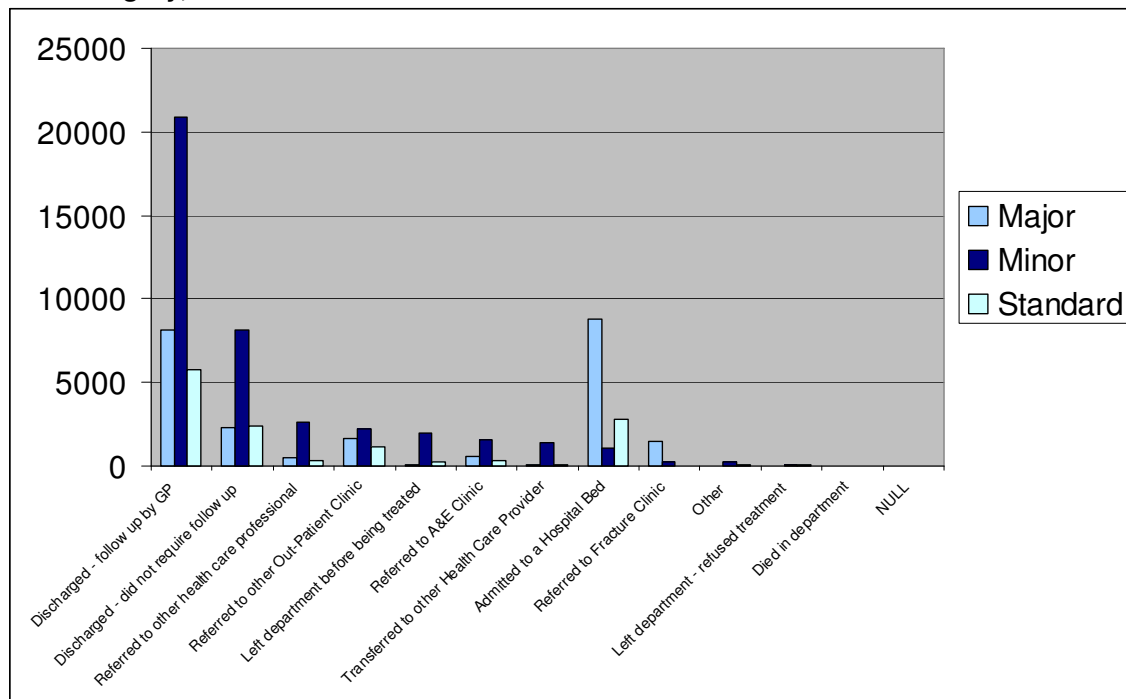
Over half (51%) of the conditions patients presented at A&E with were classified as 'minor' by HRG categories (Figure 16). Of all A&E attendances those classified as minor are most likely to be more appropriately treated in a primary or community care setting (Figure 17).

**Figure 3.15: A&E attendances for Westminster residents by HRG category, Jan 09 to Dec 09**



Source: SUS

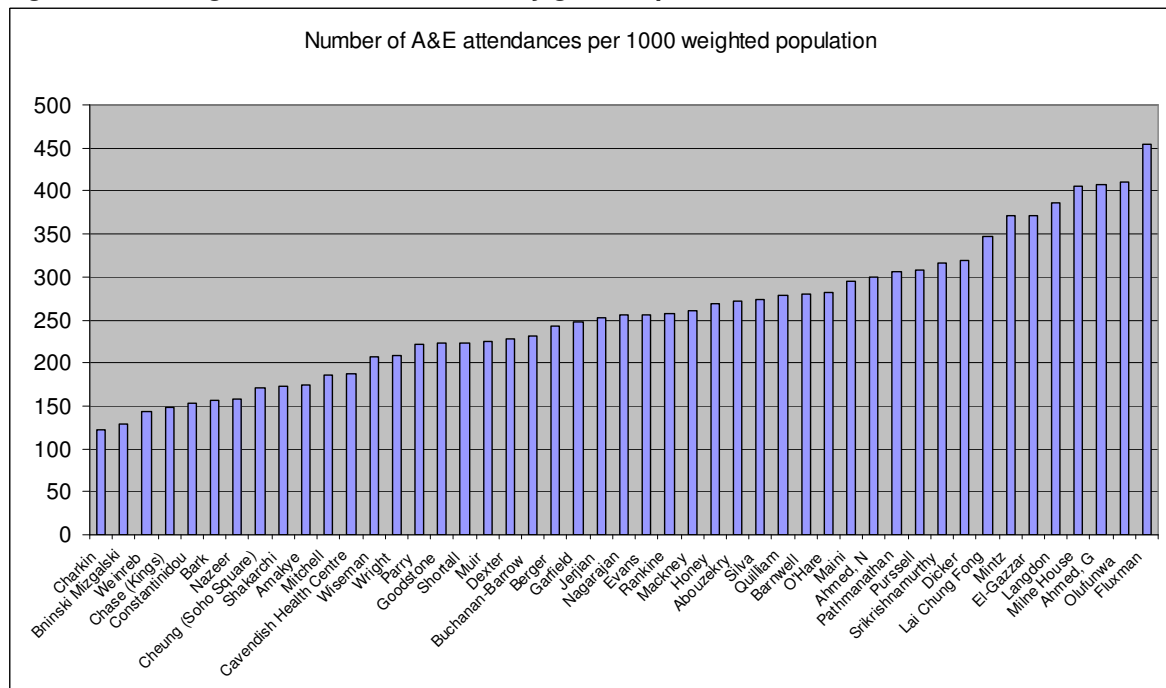
**Figure 3.16: A&E attendances for Westminster residents by discharge destination and HRG category, Jan 09 to Dec 09**



Source: SUS

87% of hospital admissions for Westminster residents come from A&E, compared to 66% nationally. This indicates that A&E services are more readily used by Westminster residents than would be expected.

**Figure 3.17: Weighted A&E attendances by general practitioner**



**Note:** Rates have been weighted for deprivation, age, list turnover, distance from practice and gender.

Source: Exeter

A&E attendances vary significantly amongst Practices (Figure 18). One explanation is the correlation between A&E attendances and proximity of the General Practice service to a hospital.

The reasons for the high numbers of potentially avoidable attendances and admissions to hospital are complex but some have been summarised below:

- If a patient has to wait too long for a GP appointment, or cannot access their GP Practice at the times they wish to, they are more likely to attend A&E instead. There are many acute hospitals within easy reach of Westminster which is likely to increase this activity.
- Many ethnic minority groups and new immigrants to the UK are more aware of hospitals and often are not familiar with the role of primary care. Westminster has a very transient population that is very ethnically diverse making this a particular issue for Westminster.
- Older people can find it easier to access A&E via an ambulance call out than getting to their GP. Westminster has a higher proportion of older people living alone than seen nationally which is likely to be a contributing factor.

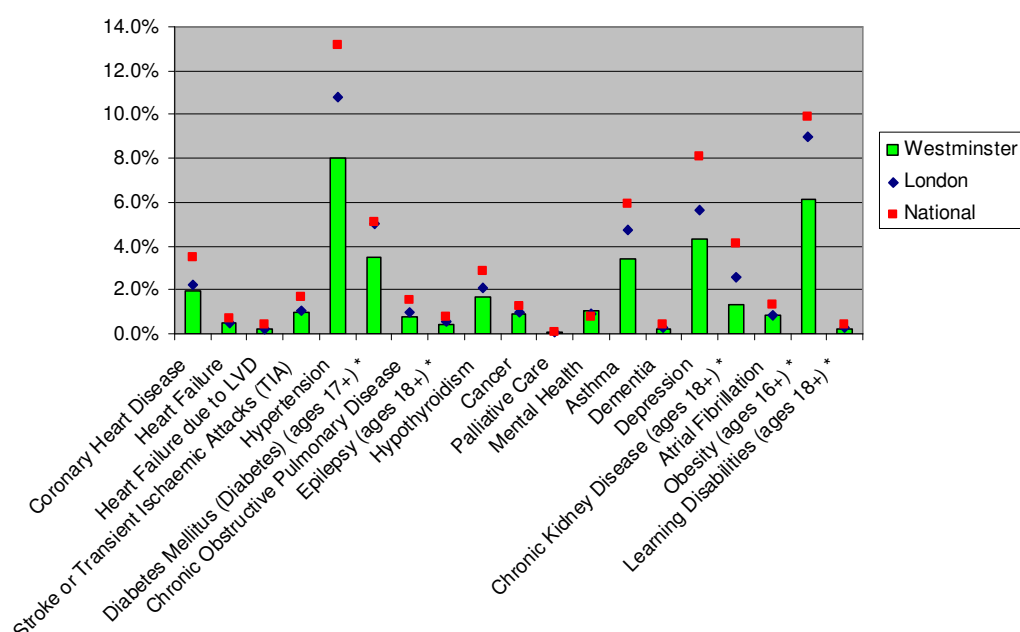
More detailed analysis on hospital admissions and what can be done to improve them can be obtained from the NHS Westminster Public Health Intelligence team. A number of areas where general practice can influence patient health outcomes have been identified, as follows:

- Better identification of patients at risk.
- Development of individualised care plans.
- Provide support for self care and referrals to support services
- Support Urgent Care Centre admission avoidance through services such as the Single Point of Access (SPA) number to redirect to GP
- Health promotion education.

### **3.4 Chronic disease prevalence and long term conditions**

The Quality and Outcomes Framework (QOF) is an annual voluntary scheme for General Practices which is an incentive and reward programme, focusing on a number of areas, but in particular the management of long term conditions. Data obtained from QOF is an important measure of the Trust in the recorded prevalence of the long term conditions in the registered population and how this compares to the expected prevalence. This can indicate unmet health need in the population.

**Figure 3.18: QOF prevalence of clinical conditions, 08/09**



Source: Information Centre (July 2010)

Overall, Westminster is showing a low level of prevalence across most clinical conditions when compared to London or national averages. There is however variation between Practices and in all disease areas. There is also under-reporting on all of these clinical conditions when compared to public health data that indicated the expected prevalence levels which is of concern. This is shown in more detail in Table 5.

Data showing reported versus expected prevalence has been analysed across 6 disease areas at Practice level. The full data sets are shown in Appendix A. This has shown particularly high levels of variation of recording across Practices, and disease areas where the gap between reported and expected prevalence is high – hypertension most notably which shows 28,420 unidentified patients. These differences are summarised in Table 5.

**Table 3.5: Variation in expected vs recorded patients for diseases with the most significant gap**

Disease area	Practice highest (expected recorded) with gap vs	Practice lowest (expected recorded) with gap vs	Total number of patients unreported across Westminster
Coronary heart disease	-140 patients	+42 patients	2,501
Stroke TIA	-52 patients	+2 patients	1,184
COPD	-190 patients	-5 patients	3,752
Diabetes	-172 patients	+103 patients	1,972
Hypertension	-1189 patients	-24 patients	28,420
Heart failure	-58 patients	-2 patients	921

Source: NHS Comparators

### 3.5 Languages spoken in GP Practices

The following Practices advertise languages spoken at their Practice:

**Table 3.6: Languages advertised as being spoken in GP surgeries**

Name of Practice	Are languages spoken in the practice advertised in the practice leaflet	Language
	(Yes/No)	
Dr Chase – Kings College Health Centre	YES	French, Spanish, Hindi, Gujarati
Dr Fluxman – Harrow Road Health Centre	YES	Arabic, Spanish, French and Polish
Dr Purssell & Partners – Paddington Green Health Centre	NO	The practice does have a Bengali speaking interpreter on Monday and Thursday morning and at Tuesday's baby clinic
<i>Dr Shakarchi – Dr Maher Shakarchi's Practice</i>	YES	Chinese, Portuguese, French, Spanish

*Source: Westminster GP Practices*

### 3.6 Patient reported need

In 2008, NHS Westminster commissioned Opinion Leader to undertake focused work to seek public and stakeholders views on what the priorities should be for improving and investing in healthcare services; and to find out what their expectations and aspirations are for local NHS services. Opinion Leader delivered a face to face survey with 1500 Westminster residents and two deliberative events; one with 150 Westminster residents and one with 70 representatives of key voluntary / community sector organisations working in Westminster.

To assess patient reported need for services in primary care, this information has been taken from the final report submitted to NHS Westminster.

During the mapping process, participants at the deliberative events were asked to consider the different ways in which the individual services could meet the “ideal”. Thoughts on GP Practices included:

- GP Practices would be well staffed with well-qualified, experienced doctors and nurses. Reception staff would have good communication skills and be sensitive to the cultural and other needs of patients.
- The practice would offer a comprehensive, flexible service operating longer opening hours (including evenings and weekends) and making more time available for consultations. Waiting times for appointment would be minimal.

- Patients would be able to get an appointment with a named GP as / when required and also be able to make the appointment at any time of the day. There would be an effective “out of hours” service to supplement the work of the GPs.
- Some specialist services would also be provided on site including counselling services and specialist support for specific conditions (e.g. HIV / Aids). Advocacy and interpreting support would be available for second language speakers and residents from other countries / cultures.

In the quantitative survey, respondents were also asked to think about what they would do if they could design a new health service for Westminster or improve the current health services. This was an open ended question and invited individual's views.

Responses focused on the need for more staff, flexibility, quality and reduced waiting times. However, it should also be noted that there was a significant proportion of respondents (26%) that did not give a response.

**Table 3.7: What respondents would do to improve Westminster health services <sup>2</sup>**

	Percentage of total responses	Number of total responses
Don't know	26%	394
More doctors / GPs	8%	125
More flexible / longer opening hours / weekend consultations	6%	91
Reduce waiting times / abolish waiting lists	6%	91
Better quality health services / more efficient / faster services	6%	91
More staff / nurses	5%	81
Better accessibility / make it easier to access GP / register with a GP	5%	72
Educate people more / better health education for children	5%	71
Provide more surgeries / hospitals	5%	69
Improve dental facilities / free dental service / more dentists	4%	57
To have better trained staff / more staff training	4%	61

*Source: Opinion Leader report*

At the deliberative events, location of services was considered to be important although for many the key factor was felt to be ease of access (in terms of transport) rather than being close to home. This was confirmed by the quantitative survey. When prompted with a list of factors that are considered to be important in relation to the location of health services, 70% of respondents felt that the most important factor was the ability of residents to use existing health services easily.

<sup>2</sup> These results were coded from open ended answers to give percentages so percentages are lower than for closed questions

In addition, it should be noted that no correlation between patient reported satisfaction with access and opening hours and actual levels of opening hours of the Practice.

### **3.7 Conclusions and key messages**

- All data sources indicate population growth in Westminster, which will result in a continual need to build the capacity of primary care services. In particular services should expect to see growth in the oldest population groups (particularly 90+ and the 'baby boom' generation around retirement age), and in the middle-aged groups;
- Westminster's population is also expected to become more ethnically diverse and there is a need for services to adapt to ensure they are appropriate and accessible to all groups;
- Levels of diversity vary greatly between wards and neighbourhoods. Services need to be commissioned and performance managed with reference to this to ensure appropriate provision;
- The registered population in Westminster is highly transient (390 per 1,000 population) which presents some very specific challenges for both primary care commissioning and practice management. This highlights the importance of ongoing list maintenance by the commissioning organisation and challenges for providers in meeting the health needs of a changing population and new communities;
- Commissioning of primary care services needs to take into account the daily influx of visitors and workers, and what this means for the commissioning of primary care services for non-registered patients. This needs to be considered particularly in light of Government proposals to remove practice boundaries.
- The impact of the proposed removal of practice geographical boundaries on access to primary care for residents, particularly those with the poorest health, needs to be assessed. This is particularly pertinent in West End and St James's wards which both have areas pockets of higher than average deprivation, a dense daytime population and low levels of service provision;
- It is important to recognise that registration boundaries do not directly correspond with borough boundaries and that a significant number of Practices have portions of their list of patients from other boroughs;
- Registration levels in Westminster vary, with some specific areas showing low levels of registration with a GP. The areas with lowest levels of registration are the more affluent areas of Westminster. The reasons behind this needs further explanation and could indicate higher use of private services or more limited access to NHS GP services;
- Some age-sex groups may be experiencing greater barriers in registering with a general practice. In particular older people aged 65+, men aged 15 to 34 and women aged 25 to 29.
- Two of the wards with the greatest proportion of older people (South West End ward and Abbey Road ward) are also those with the least

primary care provision. It is likely this is a contributing fact to the surprisingly low numbers of older people registered with primary care;

- A&E attendance figures have shown that up to 51% of A&E admissions are for minor conditions that could have potentially been managed more appropriately primary care;
- Chronic disease management varies significantly across both Practices and conditions. Levels of hypertension recording are extremely low, with a gap between expected and actual prevalence of 28,420 patients;
- Patients continue to report access to General Practice as a priority, both in relation to access to a GP of choice and to be able to access their GP in the evenings and at weekends; this is particularly the case of people of working age.



## 4: Primary care services in Westminster

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### 4.1 Overview of current service provision

NHS Westminster commissions with 52 Independent Contractors. These Contracts are varied appropriately to meet the needs of Westminster residents, with the differing features of these Contracts including:

- **Contractual type:** NHS Westminster oversees the delivery of 27 General Medical Service (GMS) Contracts, which are nationally negotiated, 23 Personal Medical Service (PMS) Contracts, which include locally agreed priorities and 2 Alternative Personal Medical Service (APMS) Contracts, which have more detail and locally negotiated performance indicators, can be provided by a wider range of providers and are time limited.
- **Contract size:** The size of Contracts in Westminster varies significantly. Westminster has 3 limited list Practices, with patient list sizes of less than 250 patients, and two Practices with lists of over 10,000 Patients.
- **Patient base:** Two of Westminster's Practices are specifically established to deliver care to homeless people in Westminster
- **Contract value:** The value of Contracts varies significantly both within and across Contract type with the Contract price per patient ranging from £64 per patient to £171 per patient.

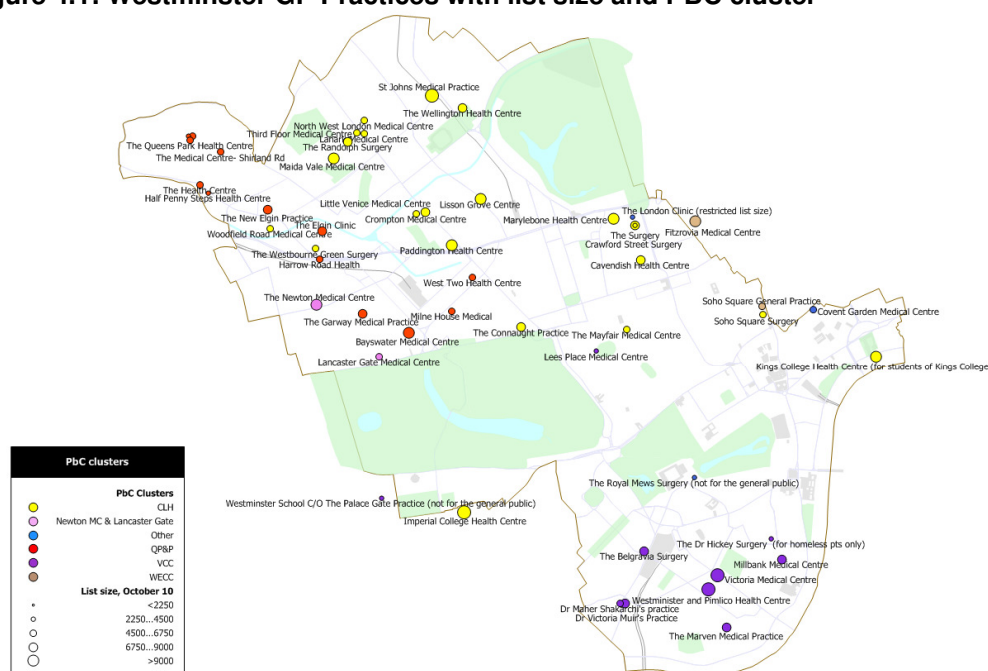
At the time of writing this report, Westminster Practices are organised into 4 Practice Based Commissioning clusters for the purpose of joint working and planning services for a wider population base. These are Queen's Park and Paddington, Victoria Commissioning Consortium, Central London Healthcare and Newton MC & Lancaster Gate.

### 4.2 Assessing primary care capacity

To assess demand, capacity and pressure in Westminster's primary care services, a number of indicators have been considered:

- The number of registered and weighted patients per practice
- The average patient list size per GP
- GP consultation per 1,000 weighted population (where data is available)
- Choice of GP Practice for local people

**Figure 4.1: Westminster GP Practices with list size and PBC cluster**



Source: Exeter

## 4.2.1 List sizes in Westminster

Some information on GP list sizes are detailed in table 4.1 below. Analysis has found that practices with the higher list sizes per GP are found in more affluent areas of Westminster.

**Table 4.1: Information on Westminster GP list sizes**

Average registered patient list size in Westminster	5,297
Range of numbers of registered patients (excluding limited lists)	1,200 to 12,440
Median list size	4,853
National average list size	6,487*
Range in list size per GP in Westminster	904 to 3,189
Average number of patients per GP	2,125
Median number of patients per GP is (data available for 39 Practices)	1,889

Source: \*NHS Information Centre 2007

## 4.2.2 Registration choices for patients

A desert map for GP Practices in Westminster has been produced to assess distance to GP Practice for local residents. It should be noted that this does not indicate the registration boundaries for each of the Practice, but instead ease of access for patients. The shaded areas show 500m distances from GP Practices. National guidance suggests that patients should have access

to 2 or 3 GP Practices to enable effective choice of Practice<sup>3</sup>. The map clearly shows where this is available in Westminster and where the gaps are.

### **4.3 Primary care access arrangements**

Primary care access arrangements are referred to in relation to core and extended hours.

The GMS Contract defines core hours as the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday except Good Friday, Christmas Day or *bank holidays*. This equates to 52.5 hours per week.

The Contract states that the Contractor must provide essential services at such times, within *core hours*, as are appropriate to meet the reasonable needs of its patients, and to have in place arrangements for its patients to access such services.

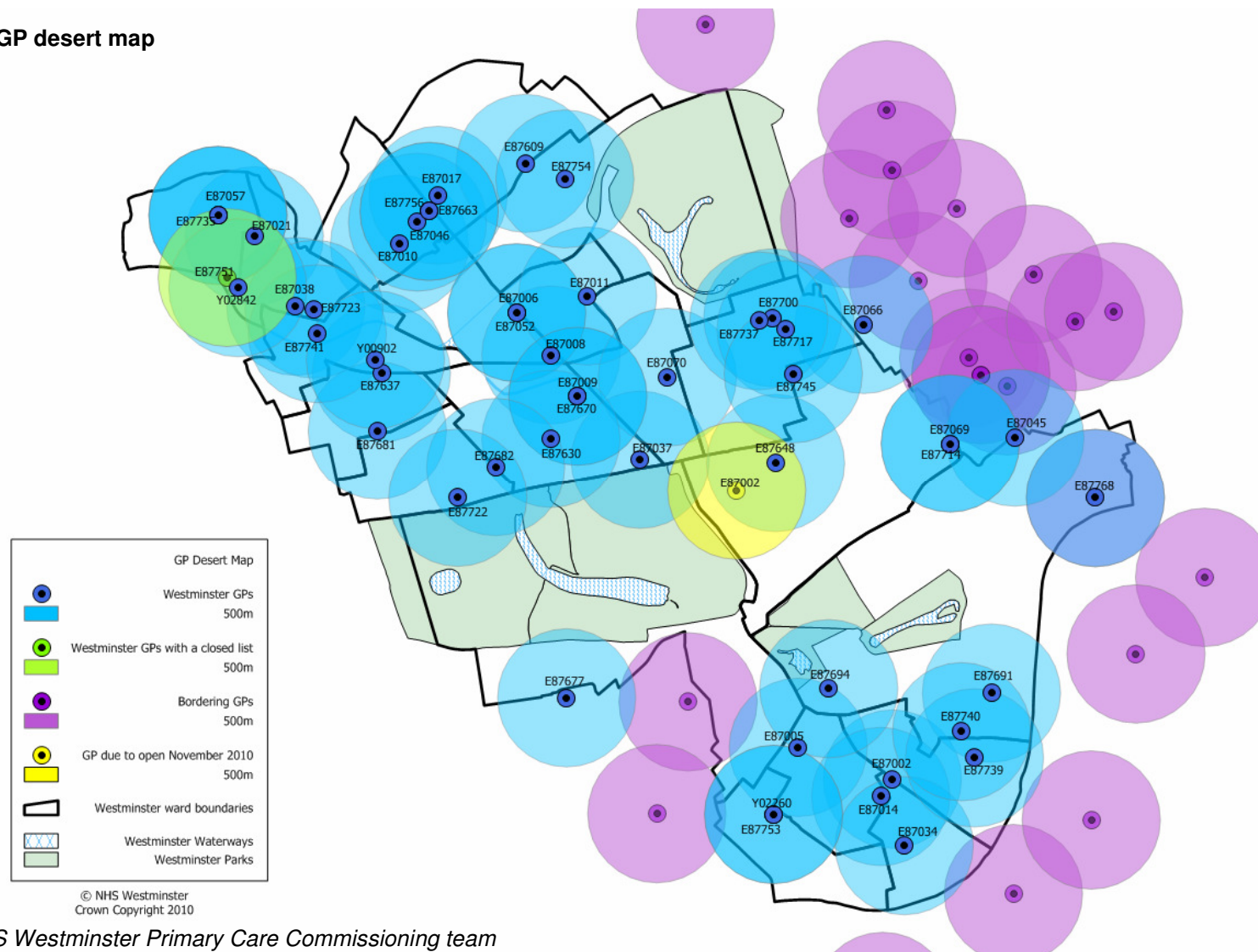
Practices implement local access arrangements to meet the needs of their patients and their Practice. NHS Westminster is aware of two Practices that implement the Stour access model – a GP led telephone triage service.

Other Practices operate systems for walk-in access, same day and pre-booked appointments. Responsibility for triage varies from Practice to Practice between GPs, Nurses and Receptionists.

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<sup>3</sup> World Class Commissioning: Improving GP Services (2009). The guidance states that PCTs should assess the proportion of patients which are located within 2 or 3 practice boundaries. As we have been unable to map practice boundaries, geographical distance has instead been used as a marker.

Figure 4.2: GP desert map



Source: NHS Westminster Primary Care Commissioning team

A snapshot of Practice access models is as follows:

**Table 4.2: Excerpt of GP practice models**

GP Practice	Consultations per 1000 registered patients	Access Models			
		Walk ins	Same Day Appointments	Pre-booked Appointments	telephone triage consultations /
Dr Maher Shakarchi's Practice (Y02260)	5	no	yes	yes	yes
Srikrishnamurthy Harrow Road Surgery (E87751)	-	no	yes	yes	no
Marylebone Health Centre (E87737)	96	no	yes	yes	yes
Newton Medical Centre (E87681)	54	Yes	Yes	Yes	no
The Randolph Surgery (E87046)	53	no	n/a	n/a	Yes / Stour Access Model
Covent Garden Medical Centre (E87045)	57	Yes	Yes	Yes	Yes
Victoria Medical Centre (E87002)	21	no	yes	yes	yes
Great Chapel Street (E87772)	80	Yes / Homeless practice	no	no	no

The practices' patient satisfaction levels for Access for these Practices are below:

**Table 4.3: Patient's satisfaction levels for access to practices**

GP Practice	48 Hour Access	Advanced Access	Satisfaction with Opening Hours
Dr Maher Shakarchi's Practice (Y02260)	90%	86%	84%
Srikrishnamurthy Harrow Road Surgery (E87751)	77%	77%	88%
Marylebone Health Centre (E87737)	72%	82%	79%
Newton Medical Centre (E87681)	80%	67%	77%
The Randolph Surgery (E87046)	60%	61%	69%
Covent Garden Medical Centre (E87045)	68%	90%	85%
Victoria Medical Centre (E87002)	57%	67%	80%

There are no discernable correlations to be drawn between access models offered and patient satisfaction for access. It is important to note however that different groups of patients have different characteristics that will influence their requirements for ease of access. The relative proportions of these groups in any one practice list will have an impact on which is/are the most appropriate(s) model(s) for that practice.

Practice opening hours, by cluster, is detailed as follows<sup>4</sup>:

## Central London Healthcare

**Table 4.4: Practice opening hours for CLH**

Practice	Hours open pw	Clinical hours pw
The Mayfair Medical Centre	20.5	20
Crawford Street Surgery	32	20.5
Maida Vale Medical Centre	40.5	26
Queens Park Health Centre	41	20.5
The Westbourne Green Surgery	41.5	24.5
Crompton Medical Centre	44.5	22
Little Venice Medical Centre	45	45
Imperial College Health Centre	45	21.5
Marylebone Health Centre	45	45.5
Soho Square Surgery	46.5	22.5
Third Floor Medical Centre	46.5	19.5
The Medical Centre	46.75	26.5
North West London Medical Centre	47	25
Lanark Medical Centre	47	30
Fitzrovia Medical Centre	48	48
Soho Square General Practice	48	22.5
Paddington Green Health Centre	49	51.5
Lisson Grove Health Centre	49	34.5
The Randolph Surgery	50	50
The Surgery	51	27
St Johns Wood Medical Practice	51.5	51.5
Cavendish Health Centre	53.5	53.5
The Wellington Health Centre	56.5	39
The Connaught Practice	60	37
Cluster average	46.1	32.6
Westminster average	46.8	35

## Queens Park and Paddington

**Table 4.5: Practice opening hours for QPP**

Practice	Hours open pw	Clinical hours pw
Queens Park Health Centre	23	23
Harrow Road Health Centre	36	20.5
The Elgin Clinic	40	19.75
Milne House Medical Centre	42	31.75
The Health Centre	42	24
The Medical Centre	43	29.75
Queens Park Health Centre	43	24
The New Elgin Practice	47	47
Bayswater Medical Centre	47.5	47.5

<sup>4</sup> Data provided is data NHS Westminster hold from Practices. We have been unable to validate the information for the purpose of the needs assessment and individual Practices may wish to report variation

<b>West Two Health</b>	56.5	29
<b>The Garway Medical Practice</b>	62.5	61
<b>Cluster average</b>	43.9	32.5
<b>Westminster average</b>	46.8	35

## Victoria Commissioning Consortium

**Table 4.6: Practice opening hours for VCC**

<b>Practice</b>	<b>Hours open pw</b>	<b>Clinical hours pw</b>
<b>Westminster and Pimlico Health Centre</b>	47.25	46
<b>Millbank Medical Centre</b>	50	40
<b>Dr Victoria Muir's Practice</b>	51	51
<b>The Marven Medical Practice</b>	51.5	29
<b>Dr Maher Shakarchi's Practice</b>	53	53
<b>Victoria Medical Centre</b>	56.5	56.5
<b>The Belgravia Surgery</b>	63	52.5
<b>Cluster average</b>	53.2	46.9
<b>Westminster average</b>	46.8	35

## Newton Road / Lancaster Gate

**Table 4.7: Practice opening hours for Newton Road / Lancaster Gate**

<b>Practice</b>	<b>Hours open pw</b>	<b>Clinical hours pw</b>
<b>The Newton Medical Centre</b>	46	21.5
<b>Lancaster Gate Medical Centre</b>	48	43
<b>Cluster average</b>	47.0	32.25
<b>Westminster average</b>	46.8	35

(these figures exclude the Half-Penny Steps Health Centre which has longer opening hours as part of different Contractual arrangements)

## 4.4 Primary care performance

A key tool for measuring and supporting primary care performance in Westminster is the Balanced Score Card (BSC). The BSC forms part of NHSW approach to implementing a fair and transparent framework in assessing Practice position across a range of areas. It is anticipated that the participation by GP Contractors in the Balanced Score Card enables GPs to achieve parts of the judgement framework for registration as set by the Care Quality Commission and Department of Health thresholds for a selection of indicators.

The BSC has the overarching functions which are as follows:

- To raise the quality and standard of Primary care in General Practice
- As a information tool for GP Contractors and PBC Clusters
- To enable Patients to make an informed choice of General Practitioner

The Balanced Score Card is designed to enable PCT commissioners to:

- Ensure acceptable standards of care are delivered to every patient receiving general medical services from our contractors as a minimum
- Provide a systematic communication tool which will guide feedback and inform performance discussions with our contractors
- Facilitate a constructive climate and channel for the sharing of 'good practice' and encourage benchmarking which is relevant locally
- Enable the PCT to objectively identify practices that consistently perform within and above expectations and with whom it wishes to commission further services as identified through the PCT investment programme.
- Work with those practices which are below acceptable standards and to agree and monitor plans to improve
- The contractual requirements and monitoring by the PCT will continue. The BSC, while not a contractual requirement will be an additional complementary tool.

All Westminster Practices participated in the Balanced Scorecard for 2008/09, with the outcome as follows:

- 30 Practices achieved an overall Grade A (60%) – 15 GMS and 15 PMS Contractors
- 14 Practices achieving an overall Grade B (28%) – 7 GMS and 7 PMS Contractors
- 6 Practices achieving a Grade C (12%) – 4 GMS and 2 PMS Contractors

Details of individual practice grading and the indicators used can be found at: <http://www.westminster-pct.nhs.uk/English/Pages/default.aspx>

Moving forward, the proposed approach is to focus on individual practice improvement, development and enablement. It is the intention to use the BSC to facilitate this in a fair and consistent manner, whether this function is fulfilled by a National Primary Care Board or GP Consortia. In future years developmental measures could be revised to reflect the continuously improving standards, in consultation with the LMC. The responsible agencies may wish to consider benchmarking so that comparisons can be drawn and lessons shared from the best performing contractors.

#### **4.5 Choice and responsiveness of services**

48 out of 52 practices have signed up to the Choice & Booking Local Enhanced Service, committing to offer patients a choice of secondary care provider and date and time of appointment.

GP Practices fulfil this by using the Choose & Book system which electronically allows GPs to book their patient into the hospital of their choice while still in the consultation room.

In CLH, the cluster has set up a Patient Referral Service which also uses Choose & Book to facilitate patient choice. The service is proving highly responsive, with operatives ensuring that the service provided fully meets



patients' needs. One incident involved finding a hospital which provided services on the ground floor as the patients had a chronic fear of heights.

Overall, patient reported satisfaction of GP services in Westminster remains high (highest scoring surgery = 96%, lowest scoring surgery = 73%).

Areas where Westminster meets or exceeds the England average are:

- Ease of getting into surgery building
- Ease of getting through on the phone
- Ease of speaking to a nurse on the phone
- Able to book ahead for an appointment with a doctor in the past 6 months
- Satisfaction with opening hours
- Ease of getting medicines

Areas where Westminster score 6% or less than the England average are:

- 'Ease of getting test results on the phone'
- 'Impression of waiting time at the surgery (respondents who answered 'I don't normally have to wait too long')
- Rating of nurse listening to you, rating of nurse explaining tests and treatments
- Rating of nurse treating you with care and concern'
- % of respondents stating they know how to contact the out of hours service
- % of respondents who used out of hours and stated it was easy to contact the out-of-hours service

Westminster continues to have a response rate which is significantly lower than the England average; the highest scoring surgeries score 33% while the lowest scoring surgeries score 8%.

There is a significant difference between the percentages of the highest scoring (91%) and lowest scoring (49%) surgery for the following questions "Ease of getting through on the phone"

There is a significant difference between the percentages of the highest scoring (59%) and lowest scoring (5%) surgery for "Ease of speaking to a doctor on the phone". There is a significant difference between the percentages of the highest scoring (95%) and lowest scoring (50%) surgery for "Ability to see a doctor fairly quickly".

## **4.6 Urgent care arrangements in Westminster**

### **4.6.1 Out of Hours Services**

14 out of 52 practices have opted to make their own arrangements for providing Out of Hours Services (provision of urgent primary care services outside of Core Hours). Of these 14 practices, 3 directly deliver Out of Hours

themselves. The remainder have private arrangements with the provider that the PCT commissions for the remaining 38 practices.

The commissioned Out of Hours Services is provided by London, Central and West Urgent Care Collaborative (LCW) which is the organisational name of the local GP Co-op and covers NHS Westminster, NHS Kensington & Chelsea, NHS Hammersmith & Fulham and NHS Brent. The provider provides services between the hours of:

- 6.30 pm and 8.00am every weekday
- 24 hours a day every weekend
- 24 hours a day every public holiday

The service includes:

- Advice on the telephone
- Advice and / or treatment at an appropriate Patient Consultation Centre
- Advice and / or treatment at the patient's home
- Provision of medicines or prescriptions to obtain medicines
- Appropriate onward referral to other services i.e. District Nurse / Mental Health Team

#### 4.6.2 Access to urgent care

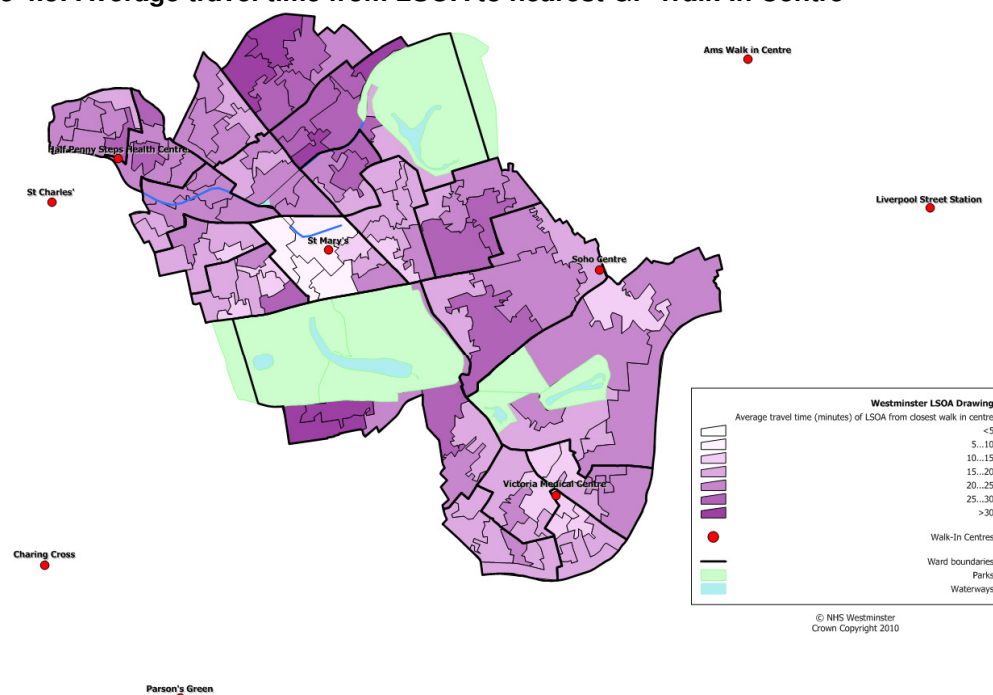
There are 4 facilities in Westminster providing access to walk-in health services, 1 of which provide a nurse-led service:

**Table 4.8: Services and times provided by Westminster walk-in centres**

Soho Walk-in Centre	Mon- Fri 8am – 8pm Sat and Sun 10am – 8pm	Nurse led walk-in centre
Half Penny Steps Health Centre Queens Park	8am – 8pm 7 days per week 365 days per year	Access to non-bookable appointments with GPs and Nurses for registered and unregistered patients.
Urgent Care Centre, St Mary's Hospital	10am – 7pm 7 days per week 365 days per year	GP and nurse non bookable appointments
Victoria Commuter Walk-in Centre	Monday – Friday 7am – 7pm	GP and nurse non bookable appointments

Ease of access for local residents to these health facilities are shown on the map below, which indicates travel time to these urgent care facilities by public transport. The map includes walk-in facilities in neighbouring boroughs to ensure accurate timings are given.

**Figure 4.3: Average travel time from LSOA to nearest GP Walk-In Centre**



Source: HSTAT

## 4.7 Enhanced services in Primary Care

Since 2004, practices in Westminster have provided a range of Direct, National and Local Enhanced Services to their patients. The total investment by NHS Westminster in 2008/09 was £3,400,000. The number and variety of schemes has increased year on year with Local Enhanced Services being developed by different commissioners in various directorates within the PCT.

In 2009/10, a review of enhance services was undertaken, comprising of desk-top research, benchmarking with other PCTs and stakeholder engagement on the future arrangements for enhanced services.

Key findings of the enhanced service review were as follows:

- The introduction of enhanced services does make an impact on existing targets and national priorities. For example, for influenza immunisation, 45 practices participate in the enhanced service and this directly correlates with high levels of achievement against this target for Westminster.
- There is a varying level of participation by practices. This indicates inequitable access to services for patients in Westminster and commissioning of services that are not aligned to health needs and addressing health inequalities.
- Low uptake of particular enhanced services indicates a lack of alignment between strategic priorities and services commissioned. For example, enhanced services with the lowest uptake were Contraceptive Implants and Near Patient Testing. Increasing contraceptive implants are a key deliverable of the Teenage Pregnancy Strategy and Near Patients Testing

is an important diagnostic that can be undertaken in primary care offering better value for money.

- Financial resources allocated to enhanced services vary significantly. Comparison of spend across enhanced services is complicated due to the significant variation of work undertaken under the various tariffs. The service with the highest investment is Counselling and Psychological Therapy which cost £404,676 in 2008/09 (35 participating practices, 1,503 assessments). An enhanced service with a similar number of interventions (1,742) is Enhanced Minor Surgery, the total spend against which was £165,905 in 2008/09.

NHS Westminster is with the top 10% of PCTs for spend on enhanced services. Westminster spends £20.01 per head of population, against a PCT average of £15.21 (NHS PCC Benchmarking). The range of spend per head of population is £4 to £31.16.

As an outcome of the review, enhanced services are being consolidated into 4 delivery frameworks in order to simplify the contractual mechanisms for commissioners and providers, ensure that the portfolio of enhanced services meets the needs of all NHS Westminster commissioners and supports practices with long-term financial security to allow service development. The 4 delivery areas are public health, long-term conditions, care closer to home / clinical services and Practice development. The first of these delivery frameworks, public health, will be launched in January 2011.

#### **4.8 Translation and interpreting services**

There are currently two main providers of interpreting services in NHS Westminster. The preferred provider is the GRIP interpreting service which provides face to face interpreters for patients that require translation of their appointments with GP. The second provider is Language Line which offers an over the phone interpreter for appointments.

- **Activity: GRIP**

During 2009-10 activity was reported for 38 practices in Westminster for a total of 6,215 appointments with GRIP interpreters. The range of appointments is from 2 to 772 appointments in a single practice. The median no. of appointments is 107.

Appointments took place in 54 different languages during 2009-10.

The top 5 languages that GRIP Interpreting appointments took place in during 2009-10 were as follows:

Arabic	2794 appointments
Bengali	505 appointments
Farsi	490 appointments
Portuguese	487 appointments
Spanish	323 appointments

- **Activity: Language Line**

During 2009-10 activity was reported for 15 practices in Westminster for a total of 221 sessions with Language Line interpreters. The range of sessions is from 1 to 44 sessions in a single practice. The median number of sessions is 9.

Appointments took place in 25 different languages during 2009-10

The top 5 languages that Language Line sessions took place in during 2009-10 were as follows:

Arabic	73 sessions
Tigrinya	20 sessions
Portuguese	14 sessions
Spanish	12 sessions
Mandarin	10 sessions

Patient feedback and research undertaken by Westminster's BME Health Forum have indicated that gaps currently exist in the provision of Interpreting services across Westminster. This raises concerns over whether GP Practices and Patients are fully aware of the services available to meet their interpreting needs. This may also result in patients using family members or children as interpreters which raises issues around confidentiality and patient safety.

#### **4.9 Conclusions and key messages**

- The sizes of General Practice Contracts in Westminster vary significantly. As changes to the arrangements for Primary Care Contracting come into effect, it is recommended that the future focus of primary care commissioning focuses on the Practices which represent the highest levels of investment.
- Westminster's average list size is smaller than is found nationally, although some Practices are very large – twice the size of the national average;
- This needs assessment notes that the Practices with the highest list sizes per GP are found in Westminster's most affluent areas. The reasons behind this need to be explored in further detail as to whether they are is a lesser demand on services, fewer NHS GP Practices in these areas or patients accessing private healthcare provision;
- The GP desert map has shown choice and access to General Practice services for Westminster GPs. This shows North West Westminster served well by services, with patients in the main having the choice of 2 or 3 surgeries within 500m of each other (national guidance). The map reveals central and north central Westminster are less well resourced by GP services, while South Westminster has coverage but less choice;
- Flexibility is allowed in the Contract in relation to core hours. Few Practices provide 52.5 hours per week. It is recommended that whilst this does not signal a contractual breach, Contract managers should assure themselves that the reasonable needs of patients are met;

- Variations in access models are difficult to cross-evaluate due to the different needs of different practice lists. Monitoring improvements in access by comparing practices with similar demographics employing different models and by comparing improvements over time within individual practices would be productive in assessing practice management;
- Overall, Westminster patients report high levels of satisfaction with access to services (although there is wide variation between practices), although the response rate to the national patient survey is low year on year. However, cross-analysis of results show that there is significantly less satisfaction with access with people of working age and people from Black Minority Ethnic communities;
- NHS Westminster has made significant investment in enhanced services in primary care which has resulted in increased performance amongst Contractors, although there is currently inequitable access to enhanced services across Westminster Practices;
- Travel time to urgent care and non-bookable appointments is concentrated in North West Westminster, with the North Central area, North East and South West having longer travel times. Practice level data for A&E attendances should continue to be monitored to assess the impact of the current arrangements;
- Patient feedback and research undertaken by Westminster's BME Health Forum have indicated that gaps currently exist in the provision of Interpreting services across Westminster. A guide for interpreting in General Practice has been developed and this should be further publicised amongst Practices;
- The voluntary nature of "opt-in" to some aspects of primary care services, such as enhanced services, creates inequitable access to particular primary care services and to do serve to address health inequalities.

## **5: Infrastructure to support primary care**

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### **5.1 GP Finance and primary care**

The latest GMS Statement of Financial Entitlements (SFE) sets out the baseline payment for GMS contractors which is set at £64.59 per weighted population (2010/11). A London adjustment of £2.18 is added which establishes a baseline payment of £66.77 per patient within the GP Contract.

In addition to this, practices may also receive:

- Growth funding
- Minimum income protection guarantee (MPIG), as a protection of funding from the change to the new contract in 2004

In Primary Care, Contract values vary both within and by Contract type:

- PMS Contractors receive £7 per patient more than their GMS peers on average and £4 per patient more than the PCT average. When Growth funding is included there is a greater gap between PMS and GMS Contractors (£21 per patient).
- The variation of price per patient, with GMS Contractors is £66 per patient to £103 per patient, with a PCT average of £77 per patient (including growth funding).
- The variation of price per patient, with PMS Contractors is £64 per patient to £171 per patient, with a PCT average of £98 per patient (including growth funding).
- The PCT average for GMS and PMS Contractors is £79 per patient excluding growth funding and £88 per patient including growth funding.

#### **5.1.1 Additional PMS Contract payments**

PMS Practices receive funding that is in addition to the GMS global sum. These payments are:

- Premises costs
- Seniority payments
- Delivery of specific objectives to meet the needs of the practice population.

This payment is made up of the following four elements:

- Global sum equivalent
- Growth funding / minimum income protection guarantee (MPIG)
- Out of hours development funding
- Employers pensions contributions

Payment is made through the GP Contract to deliver the following services.

### **5.1.2 Essential Services**

“GMS Essential Services” are:

- The management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable.
- The general management of patients who are terminally ill.
- The management of chronic conditions in the manner determined by the healthcare professional in discussion with the patient.
- Note summarisation (patient records).

### **5.1.3 Additional Services**

Funding for additional services is placed within the Global Sum. Practices do not get extra funds for providing these services, the same way as they do Enhanced Services. Practices lose a percentage of their funding for opting out of these services.

Additional Services as defined by the New GMS Contract (2003) Investing in General Practice are:

- Cervical screening.
- Contraceptive services.
- Vaccinations and immunisations.
- Child health surveillance.
- Maternity services – excluding intra partum care (which will be an Enhanced Service).
- Minor surgery procedures of curettage, cautery, cryocautery of warts and verrucae, and other skin lesions.
- Childhood Vaccs and Imms (separate to DES)

Although not regarded as an additional service, practices will also lose a percentage of their Global Sum funding if they opt-out of out of hours provision.

### **5.1.4 Additional Contract payments**

Practices (GMS and PMS) receive funding that is in addition to the GMS global sum. These payments are:

- Premises costs
- Seniority payments

### **5.1.5 Enhanced Services**

Contractors can be commissioned to deliver a range of enhanced services. Enhanced services are those not provided through essential or additional services or essential and additional services delivered to a higher specified standard.



### 5.1.6 Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results.

The Statement of Financial Entitlements (SFE) states that each QOF point is valued at £126.77 (per average list size of 5,891 patients) a maximum of 1000 QOF points were available to each practice in 2010/11.

## 5.2 Premises

Westminster General Practitioners operate from a range of premises that are owned by GP Partners, owned by NHS Westminster, leased under private arrangements or leased from NHS Westminster. These are arrangements, by cluster are shown in Figure 23:

**Table 5.1: Status of GP premises in Westminster**

	CLH	QPP	VCC	NRLC	Other
Owned by Drs	4	4	4	1	0
Leased (private)	13	7	3	1	1
Leased (PCT)	2	0	0	0	0
Owned by PCT	4	3	0	0	0

In total, there are 13 Practices in Westminster which are owned by GP Partners. Of these, 8 are single handed GP Practices. Commissioners of primary care services should be particularly aware of two of these Practices where the GP Contract holder is aged over 60 years, and therefore should be considered as a priority for future planning purposes. The list sizes of these Practices are 1,645 and 2,441.

The costs of General Practice premises are reimbursed to Principle GPs by NHS Westminster through arrangements detailed in the GMS Primary Medical Services Contract. NHS Westminster employs the District Valuers office to confirm acceptable market rent for reimbursement to Practices and who undertakes rent reviews.

Costs of premises vary significantly in Westminster due to the location of premises and the size of premises required for Practice list sizes. In order to fairly compare the costs of these premises, the costs have been analysed on a price per square metre basis and a cost of the premises per year per patient registered at the Practices.

Disability access in Practices is varied in Westminster, and is largely influenced by the nature of building stock. DisabledGo have been commissioned by NHS Westminster to assess primary medical service

premises and have awarded symbols, which assess disability access across 17 areas.

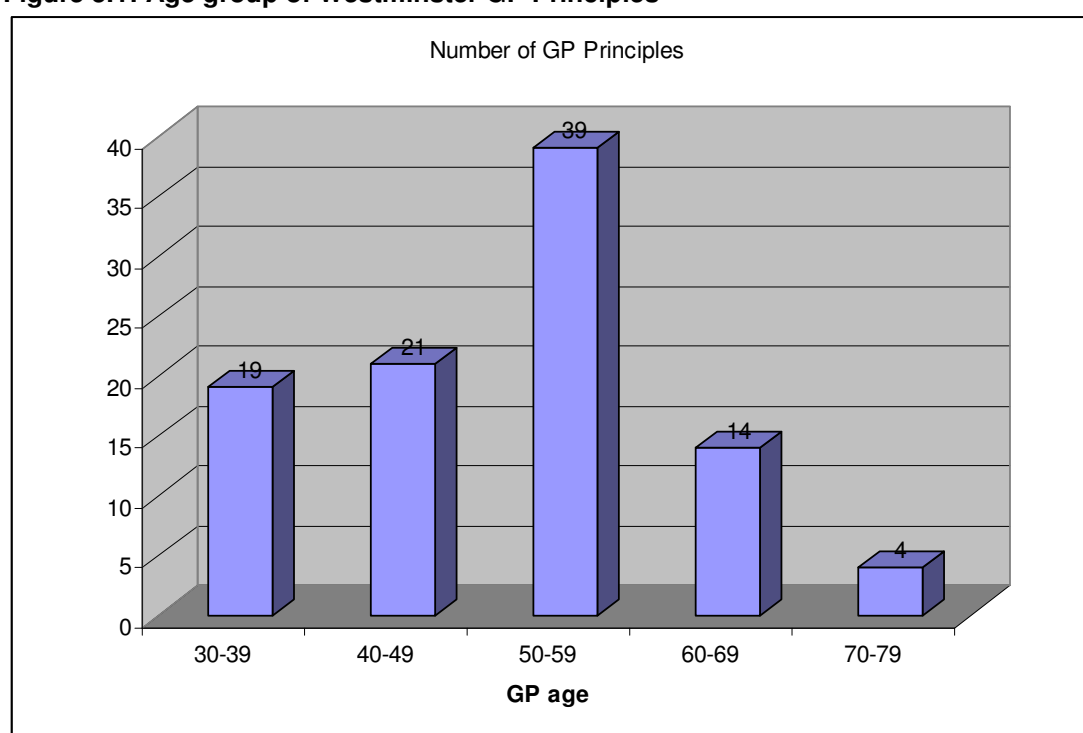
### 5.3 Primary care workforce

NHS Westminster does not hold detailed information regarding the primary care workforce and needs and shift within it – with the exception of GP retirement ages. On this basis, informal feedback has been obtained from a limited number of Practices regarding workforce issues.

In general, we have not received reports of any issues that Practices have with recruitment or retention of General Practitioners. Changes are reported usually as being due to retirement. Practice nurse turnover is reported as being higher by a number of Practices. Many Practices report challenges in obtaining Practice Nurses on a locum basis, and some challenges are reported in the recruitment of permanent staff.

NHS Westminster have reviewed the retirement ages of Principle GPs in Westminster (Contract holders) and these are detailed in the chart below and shown in the table at a Cluster level.

**Figure 5.1: Age group of Westminster GP Principles**



**Table 5.1: Age and number of GP principles by cluster (number of \*\*s denote the number of single handed practices in the age bracket)**

Central London Healthcare	
Age range	Number of GP Principles
30-39	12
40-49	13
50-59	16****

60-69	8*****
70-79	1*

<b>Queens Park and Paddington</b>	
<b>Age range</b>	<b>Number of GP Principles</b>
30-39	1
40-49	1
50-59	10*****
60-69	3**
70-79	1

<b>Victoria Commissioning Consortium</b>	
<b>Age range</b>	<b>Number of GP Principles</b>
30-39	1
40-49	7*
50-59	9**
60-69	1
70-79	0

<b>Newton Rd and Lancaster Gate</b>	
<b>Age range</b>	<b>Number of GP Principles</b>
30-39	0
40-49	0
50-59	3*
60-69	1
70-79	1

It is important to note from this analysis the number of GPs aged 60 and over, particularly those who are sole Contract holders for future service planning. The future of these Contracts should be a point for discussion, particularly within the CLH cluster.

In relation to access to a choice of male and female GP, the profile of Westminster Practices is as follows:

**Table 5.2: Gender of GPs available in Westminster**

Principle GP	Principle GP	Assistant GP	Assistant GP
Male	Female	Male	Female
64	38	18	34

Of the 66 Principle male GPs, there are 12 Practices in which patients do not have access to a female GP, either as a principle, assistant or regular locum doctor.

## 5.4 Conclusions and key messages

- Financially, there is significant variation across Contract price within primary care, that does not show significant correlation to higher service performance;

- There are 13 Practices in Westminster in which the premises are owned by the Contract holders, 8 of which are single handed Practices. In 2 of these Practices, the Contract holder is aged over 60 years. This has important implications for succession planning;
- Levels of rent reimbursement vary significantly across Westminster, as do the size of Practices per list size;
- There are very few primary care premises which are accessible to wheelchair users without assistance;
- Very few practices have services which are accessible for people with a visual impairment. Whilst the findings relating to the infrastructure of the building maybe challenging to address, this finding is not related to the building itself and therefore should be considered as a priority for action;
- A fairly significant proportion of the GP workforce in Westminster is nearing retirement age. This is of particular significance in the Central London Healthcare cluster where a number of these are single handed practitioners;
- 12 Practices in Westminster do not over access to a female GP, either as a principle, assistant or regular locum. This may have implications for access to primary care services for some of the population;
- Contracts can be terminated by GPs with 3 months notice. It is therefore essential that contingency arrangements are in place by the agency with the statutory Duty of ensuring access to primary care services.

## 6: Findings of the report and priorities for the future

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Throughout this document, the primary care landscape has been described and conclusions and key messages drawn from the data that is available. This section of the report summarises the findings and makes some suggestions for future priorities for services.

### 6.1 Findings of the report

This report set out to ascertain the following:

- Are there people not registering with GPs and if not why not? What is the population profile?
- Are there groups of people/areas that are under resourced by GPs?
- Is the quality of services provided through primary care consistent across the borough and between different sub-groups in the population?
- Are there going to be changes to current services which may impact care in the future e.g. GP retirement, end of premise lease?
- What are the population trends for the future and how will they be affected by the changing policy context?

The needs assessment has provided answers to a number of these questions, but has also highlighted areas that require further investigation, as follows:

*Are there people not registering with GPs and if not why not? What is the population profile?*

This report has shown that there are particular areas in Westminster where people are not registered with a GP and that these tend to be in the most affluent areas of Westminster, with the exception of the Abbey Road ward which has some levels of deprivation and lower levels of provision of primary care services. The report has also shown that males in the 15 to 34 age group have lower levels of registration than would be expected, as well as less than expected registration levels for men and women in the 80+ age group, which is of particular concern.

The reasons behind these low levels of registration need further exploration. Possible explanations would be higher levels of private healthcare registration, inadequate service provision (the areas do correspond with the lowest levels of service provision, or barriers in accessing services).

*Are there groups of people/areas that are under resourced by GPs?*

The GP desert map has clearly set out access to General Practice services in Westminster. This has shown North West Westminster well served by services, with patients in the main having the choice of 3 surgeries within

500m. The map reveals central and north central Westminster are less well resourced by GP services while South Westminster has coverage but let choice.

*Is the quality of services provided through primary care consistent across the borough and between different sub-groups in the population?*

Through an analysis of performance data as well as patient feedback the report has demonstrated variation in services across the borough, both in relation to quality and accessibility. A more thorough analysis to understand these differences between sub-groups of the population needs to be undertaken as the second stage of this needs analysis.

*Are there going to be changes to current services which may impact care in the future e.g. GP retirement, end of premise lease?*

This report has demonstrated that there will be changes to current services in the short to medium term future through age profiling of the current GP workforce. It has highlighted particular concerns in relation to this where there is a single handed Contractor holder who owns their own premises.

*What are the population trends for the future and how will they be affected by the changing policy context?*

This report has demonstrated that the population of Westminster is growing and that this is demonstrated by all population figures available, with the greatest growth in the 90+ year old group. The increase in day time population has also been noted and the implication that this may have in the event of a removal of Practice boundaries.

## **6.2 Priorities for the future**

This section of the report seeks to make recommendations based on these findings. In doing this, it is noted that it will be the responsibility of a range of agencies to assess, develop and where there is consensus, take forward the recommendations made.

### **6.2.1 General recommendations**

- Any agency involved in the commissioning and development of Primary Care services in Westminster should base their decisions on review of this primary care needs assessment. In order to ensure it remains relevant, this needs assessment should be a living document and record changes in services, need and demand;
- A long term Primary Care Development Plan should be developed that has capacity and changes to the primary care workforce that can be anticipated as a significant focus. Capacity and equity of access for Westminster's resident population, particularly it's most vulnerable and most marginalised groups, will need to be continually monitored as the

population of Westminster grows and practice boundaries are removed allowing registration of Westminster significant daytime visitors.

### **6.2.2 Developing primary care capacity**

- Primary care capacity should be continually monitored as the population of Westminster grows;
- Capacity in primary care also needs to be reviewed in light of Government proposals to remove Practice boundaries. The daytime population in Westminster is significantly higher in the areas with the fewest primary care services;
- The Medical Director role should consider safety and access issues regarding the number of registered patients per WTE GP, as significant variation already exists in Westminster;

### **6.2.3 Contracts and Contract Management**

- Contract management in the future should be mindful of Practice size and investment in Contract support should be proportional to this;
- Equity in price and return on investment for General Practice services should be considered in line with national variations to the GP Contract.

### **6.2.4 Primary care commissioning**

- Future commissioning opportunities for primary care contracts should take into account the GP desert map and choice of provider in particular areas of Westminster. This would suggest a focus for future commissioning in the South West End ward and North Abbey Road ward.
- New commissioning opportunities should also take into account the demographics of the prospective patient list, appropriately tailoring specifications to reflect need.
- Commissioning of enhanced services in Primary Care should follow the recommendations of the extensive review and align this with the work and commissioning priorities of Practice Based Commissioning clusters to ensure enhanced services are designed to deliver strategic and operational objectives;
- The Balanced Score Card should continue to be applied as a measure to raise and achieve greater equity of performance in primary care and with a focus on supporting Practices to achieving CQC registration standards;
- Service providing access to urgent care or un-bookable primary care services are concentrated in North West Westminster, with low levels of access in the North Central and South Westminster areas. Future commissioning should identify appropriate models for these areas to meet local population health needs. The impact that they have on A&E attendance rates should be closely monitored.

### **6.2.5 Premises and workforce**

- Succession planning should be a priority for single handed Practices where the Contractor is aged 60 years or over. In particular, commissioners need to start discussions where the Contractor owns their premises to identify their future intentions and options of the local population;
- Access to a female GP should be considered an important aspect of primary care service delivery, and opportunities presented in new or existing service changes be maximised to ensure this;
- Contract management should implement a consistent programme across all Contractors to review rent reimbursement based on space used within Practices to delivery services as set out in the GMS Contract. From an assessment of size of clinical space to the size of the Practice list, opportunities to sweat assets should be maximised to support the delivery of community based primary care services. Commissioning clusters should prioritise discussions with member practices to fully utilise space available;
- A robust programme of rent reviews should be established to ensure a fair market rent is reimbursed to Practices in line with the conditions set out in the Contract.

### **6.2.6 Chronic and long term condition management**

- Focused work should be undertaken with Practices to explore and address the gaps between expected and recorded prevalence, particularly in the area of hypertension;
- The gap between expected and actual prevalence should be investigated further to understand if there are trends amongst particular population groups.

## **6.3 Conclusion**

Westminster has a mature, strong and diverse primary care infrastructure to meet the health needs of Westminster's registered population. However, primary care services face a number of challenges in the short, medium and longer term future, as a result of a range of factors including population growth, national policy changes and the growth of the primary care setting in delivery of a wider range of services. It is hoped that this report can provide support to commissioners, providers and other stakeholders who will be taking the development of the services forward.

Lisa Henschen / Bethan Searle  
January 2011