SHAPING A HEALTHIER FUTURE

REPORT TO THE INDEPENDENT HEALTHCARE COMMISSION

EVIDENCE FROM HARROW COUNCIL'S COMMUNITY ENGAGEMENT

June 2015

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Executive Summary

Harrow council recognises the need for change to enable the NHS to respond to the changing needs of our population. There has been increasing evidence recently of the difficulties being experienced as a result of the implementation of Shaping a Healthier Future plans, most specifically, the pressures on A&E at Northwick Park hospital. The Council has focussed its evidence on the implementation of the Out of Hospital Strategy to see how effectively residents are being diverted from hospital care. Our residents feel that:

There is insufficient joint planning and delivery of care in the community.

- It is unclear how decisions are being made, and decisions made in a number of cases do not appear to have been the most practical and logical choices.
- There are a multitude of different management structures planning, delivering and financing health and well being services. This is resulting in fragmentation in the provision and delivery of services and contradictory decision making as the impact of changes in one component of the health and well being economy on another are not anticipated.
- The most important planning document driving the delivery of health and well being services is the Joint Strategic Needs Assessment. It is by no means clear that the JSNA is either informed by, or helping to drive, the planning and implementation of Shaping a Healthier Future.
- Whilst there are examples of excellent service integration these tend to be pilots or have limited coverage and are not integral parts of the overall structures and processes – STARRS, Virtual Ward.
- Poor integration of services has had a devastating effect on a number of Harrow's vulnerable service users.

Planning may not have been sufficiently aspirational

- The NHS is 60 years old, and though widely respected and valued, it is questionable whether the 1945 model of provision is still relevant.
- In the context of the poor performance of out of hospital services, it seems that residents may actually be making informed, conscious decisions about how to access health care – sooner wait 4 hours in A&E than 4 days to see a GP.
- The need for change is acknowledge and a shift to the community is welcome. However, none of the proposals regarding shifting care out of hospital are new, but their implementation has never been successfully completed.
- Tinkering at the margins of service delivery will not resolve the fundamental issues and cannot be afforded. Although challenging, the time may now be right to consider fundamental change to how health services are delivered. Experiments such as those in Manchester, offer opportunities to properly fund, integrate and manage services.
- Significant change of such a valued resource as the NHS will need the full engagement of the population if it is to be successful.

Understanding our Community

- The successful delivery of change to health provision must recognise the rich and varied composition of our population: what works for one group of residents may not work for all. Harrow is not alone in having an increasingly transient, ageing, multi-cultural community who may have differing expectations, requirements and different communications needs.

Performance of General Practice

- There are examples of excellent practice amongst some of Harrow's GPs reflecting the needs of local communities and making access to services as simple as possible for all of our residents.
- Despite the very excellent efforts of Harrow Patient Participation Network, it is proving difficult to share this good practice across the borough.
- GP service delivery is thus inconsistent and dependent on where you live. Despite core contracts, issues such as opening hours vary from practice to practice.
- Even if service were consistent and consistently good across the borough, they would still need to be sensitive to the specific needs of more vulnerable residents for whom a standard service isn't enough – one size cannot fit all.
- Whilst there are clearly failings in general practice from a patient/resident perspective, are the changes in service anticipated in Shaping a Healthier Future and the Out of Hospital strategy placing too great a burden on GPs themselves: Are we expecting too much of GPs?:
    - Increasing specialisms as care provided in the community
    - Is the increased pressure demoralising GPs and making the profession less attractive
    - The service is losing older experienced GPs which places an additional pressure on those less experienced

Harrow has concluded that:

There is still need for change in the healthcare system to ensure structures and processes are fit for purpose. However, the out of hospital strategy is not adequately supporting the delivery of the Shaping a Healthier Future plans despite reassurances given.

- Planning and delivery remain disjointed with limited attention paid to the interconnectivity in the health and well-being environment.
- The challenges are not new. The time is ripe to consider more integrated, radical approaches to the delivery and governance of health and well being services.
- The real characteristics of our population are not being properly taken into account.
- General practice is for many in our borough failing to meet need, with no noticeable improvement since the launch of Shaping a Healthier Future:
    - No consistency of care
    - Single model of GP can never meet all needs – there is a particular lack of understanding of the specific needs of our most vulnerable residents
    - GP system is insufficiently resourced (numerically, financially and professionally) to deliver what is expected

None of this is new, for many years policy makers have talked about and tried to organise the preventative and rehabilitative care of residents in their community. It seems the difficulties remain,

perhaps the time is ripe to consider what the blockage to improvements might be whilst assessing need and developing services to meet these needs.

Leader's Foreword

This report summarises the discussions which have taken place between Harrow Council and the residents of Harrow, following the implementation of the proposals in NW London NHS's Shaping A Healthier Future. It constitutes Harrow Council's submission to the Independent Healthcare Commission chaired by Michael Mansfield QC.

The Council wishes to emphasise from the outset that comments or criticisms gathered during this exercise are of systems and processes and not of any individuals or service providers. The National Health Service is a precious resource for all residents and it is not our intention to undermine its attempts to respond to challenges from an increasingly difficult financial, technical and demographic environment. We hope that our comments can be seen in the spirit of constructive engagement with partners in the health and well-being provider community. The Council is committed to partnership working , so we offer this report to support the delivery of services to our residents, not to undermine our partners. I am also keen that, as a result of this exercise, we might be able to work together with our partners and residents to address some of the difficult issues raised by our residents.

Initially, Harrow Council was generally positive about the proposals which have seen our local hospital, Northwick Park, designated as a major hospital for the area and receive significant investment. During the consultation on the proposals however, we highlighted our concern that downgrading of A&E facilities at NW London Hospitals NHS Trust's Central Middlesex Hospital site could create significant pressure on remaining facilities at Northwick Park Hospital. In response to our comments, we received reassurances specifically with respect to NHS NW London's plans to safeguard Northwick Park including investment in the hospital, the transfer of staff from Central Middlesex Hospital and the urgent implementation of Out of Hospital strategy which would minimise the need for local residents to attend hospital to receive care.

The evidence of the failure of these safeguards is plain:

- Weekending 26th April – only 74% of those attending A&E were seen within 4 hours
- At no time since the implementation of the changes has the hospital met its target for A&E waiting times
- During the second week of April, more than 700 people waited for more than 4 hours to be seen in A&E

Our initial enthusiasm for the changes to our hospital has thus diminished and we have reassessed our initial decision not to participate in the Independent Healthcare Commission. The Council decided it should be bold and take a lead as we witnessed the services to our residents suffer serious decline, and that we should bring the difficult issues facing our residents to the attention of the Commission.

We endorse much of the evidence presented by the other boroughs participating in the commission with regard to how the changes have been implemented and would especially endorse the evidence presented by our neighbouring borough Brent with regard to the capacity of Northwick Park A&E and the impact of the downgrading of services at Central Middlesex and the evidence from the Harrow Patient Participation Network on the financial situation in Harrow. We are also aware that Harrow CCG has submitted evidence on the progress on delivery of the Out of Hospital Strategy.

The main focus of our evidence to the commission was therefore the very specific experience of our residents: whilst the statistical information is important, we feel that it is the real experiences of people trying to access health care at times of need which can really demonstrate our concerns to the Independent Healthcare Commission. In addition to a summary of the issues brought to our attention during the workshops, our report is illustrated throughout with statements and real examples of the experiences of our residents.

Our evidence is presented as follows:

- Methodological approach
- Our findings
- Our conclusions

This has been a revealing and rewarding exercise and I would like to take this opportunity to thank the residents, their representatives, our partners and councillors from the authority for the very valuable evidence which their involvement has elicited.

Cllr David Perry
Leader of Harrow Council

Talking to Our Residents: Our Methodology

Of necessity, this project has been undertaken over a very short time period. At the outset of Harrow's involvement, we determined to bring a real residents' perspective to the commission's attention and in the time available have sought to involve, not just our residents, but also their representatives: the local voluntary and community organisations who so effectively lobby on their behalf, the patient and user groups set up to ensure the voice of those using services is heard, local GPs who have direct experience of the implementation of the changes and our own ward councillors.

This project is not intended as a statistically-based investigation of the experiences of a representative sample of our residents from which generalisations might be derived. Rather, we have attempted to listen to our residents to try to understand their experience of the changes and how this feels from a human perspective: not simply numbers but real peoples' experiences. We recognise that some may feel this limits the application of these findings but we hope that in offering these personal stories and experiences, a greater appreciation of the impact of failings in our services can help service providers to understand and hopefully resolve the problems in the system. The findings are offered in the spirit of the ongoing improvement of local services.

A key indicator of the difficult implementation of the Shaping a Healthier Future proposals has been the significant failures at the A&E department of Northwick Park hospital, these failings have been well documented and as such, are not the focus of this investigation. Instead, our ambition has been to consider the implementation of the Out of Hospital strategy, designed to alleviate potential capacity issues at the hospital by minimising the need for residents to attend. The three key components of this strategy, which we feel can have maximum impact on the experiences of residents are:

- Access to GP services
- Use of alternative emergency services - for example, Urgent Care Centres
- Maintaining residents with long term conditions in the community

In order to discuss their experiences we held six workshops during weeks commencing 18th and 25th May with:

- Harrow Voluntary Sector Partners
- Harrow's Local Medical Committee
- Harrow Patient Participation Network
- Harrow's Local Account Group
- Harrow Health and Wellbeing Board
- Harrow local ward councillors

In independently facilitated sessions, attendees were invited to share their experiences of the key areas for investigation, not simply their opinions. The following section in this document summarises the issues raised at these sessions.

The purpose of the workshops was not to allocate blame or to simply discuss failings, in identifying the issues, it was also hoped that an opportunity might be offered to participants to suggest ways in which some of the failings might be addressed. These findings are also summarised in the following section.

The launch of the project took place on 14th May and was attended by a number of local organisations, service users and councillors. The launch offered the council the opportunity to explain the purpose of the project, how it would be undertaken and encourage as wide a degree of participation as possible. It was also an initial opportunity for those attending to share their experiences.

What Our Residents Have Told Us: Our Findings

In this section we summarise the issues raised with us by our residents. The points raised have been organised under the following headings:

- Integrating the planning and delivery of services
- Aspirational planning
- The nature of Harrow's population
- The performance of General Practice

Integrating the Planning and Delivery of Services

Key to the success of the out of hospital strategy must be the recognition of the need for joint planning and delivery of services: as people are diverted from emergency care/acute care, there must be parallel developments which can pick up those being diverted.

Perhaps the least surprising comment, but also perhaps the most disturbing is the lack of confidence from the majority of those involved in this project in the capacity of the key service providers to plan and deliver services in a co-ordinated way. Whilst there are ambitions to enhance our integration through such means as the Better Care Fund and there are examples of excellent projects to co-ordinate service delivery, residents remain concerned about poor co-ordination as the benefits of new systems remain unclear and there application remains limited.

The Virtual Ward or whole systems integrated care pilot co-ordinates the care of older people in their own homes preventing hospital admission. Care is co-ordinated via the GP and involves any service necessary to maintain the patient in their home.

The lack of co-ordination is evidenced in the opinion of voluntary sector colleagues in the expectation of the enhanced roles for the sector in the context of diminishing funding

There are now partnership bodies in place with a view to ensuring that services are planned and delivered in co-ordination. Comments were made however about the efficacy of these bodies and their capacity for strategic planning, it is felt that the overall approach is one of individual project management rather than strategic oversight.

Participants in the project are unconvinced about the basis upon which decisions are being made. The Joint Strategic Needs Assessment should present a clear analysis of residents' well-being needs. There is little confidence that the changes, particularly with regard to the development of care out of the hospital are being reflected in this analysis.

Lines of accountability are now blurred – for example CNWL now covers 2 boroughs, how can residents hold providers to account if they don't know who is responsible?

There is a plethora of management bodies and structures with separate planning and budgeting processes and lines of financial accountability which are a disincentive to co-ordination. These bodies must be enabled to function collectively to give any hope of success to co-ordinating the planning and delivery of effective health services. How, for example, are the JSNA and coordinated planning bodies such as the Health and Well Being Board able to influence some of the fundamental questions with regard to General Practice. A number of participants made reference to their concerns about the lack of transparency

and control with regard to GP 'planning'. As virtually independent bodies, how can their critical role in such a significant shift of care be properly planned and co-ordinated?

In particular in this regard, participants raised a number of examples of how they feel this fundamental cornerstone of the out of hospital service is outside of the strategic planning function

> ***Lack of evidence-based decision-making***
>
> *Practice mergers are being initiated and led by Patient Participation Groups.*
>
> *Well-articulated, evidenced applications for practice expansions are being turned down with no apparent justification and no explanation.*
>
> *Decisions have been made with regard to the location of expanded practices (polyclinic/walk-in centres) with no clear justification.*

The maintenance of a healthy community is dependent on integration of a number of components: Primary health care – GPs, walk in centres, Emergency health care – UCCs, A&E, Acute health care – hospital beds, Community nursing care – support on discharge, prevention of admission, Social care – support on discharge, prevention of admission, Voluntary sector support, Residents – public health individual responsibilities. A breakdown or imbalance in any single component of this system will inevitably create pressures in other parts of the system. It is the view of those involved in this exercise that this is what has happened, that there has been serious disjoint between proposals to close the A&E at Central Middlesex hospital and the implementation of the out of hospital strategy:

- Insufficient bed space in the acute hospital blocks patients who need to be admitted – step down ward
- Ambulances have been unable to deliver patients to A&E
- Insufficient support from community services prevents patients from being discharged or may mean they are readmitted

> *Can A&E map 'busy' periods, are staffing/process decisions made in the context of this information i.e. if there is an identifiable peak and trough, do staffing numbers follow this?*

Lack of timely access to primary care means residents will access services more immediately via A&E or their conditions deteriorate such that they need more expensive support further down the line, counter intuitive to the ambitions of the Shaping a Healthier Future model of care.

Joining up care, especially for residents with long term conditions

When a patient with a Learning Disability is admitted to Northwick Park hospital, the Learning Disability Liaison Service is required to be notified in order that their specific needs in hospital and in preparation for discharge can be met, thus ensuring a smooth transition and care pathway. There is no logging of admissions of people with Learning Disabilities in the hospital which means the service is not notified and care planning for vulnerable residents is not part of the routine process. Their care whilst in hospital and their supported care on discharge is thus jeopardised.

'Shifting the settings of care' means that for psychiatric patients, their care will be delivered by their GP as they are discharged from CNWL. Unfortunately for many patients this has meant disruption to the drug regime as GPs are unable or unwilling to re-prescribe and they cannot return for drug support from CNWL which has discharged them. Lack of proper drug support places already vulnerable residents at significant risk. Psychiatric patients are further at risk as only half the required number of community psychiatric nurses are in post.

A resident with autism spent a year under mental health services but eventually was told they did not have a mental health issue. They were then referred to learning disability services but again told they didn't have a learning disability but might be on the autistic spectrum. They were referred to a psychologist at Northwick Park but told the service was unsuitable for them. They were referred back to their GP. The mother spent many months liaising with the local authority, GP and mental health service to find out who was responsible for his mental well-being. After many months of phone calls and letters, a social care assessment was undertaken and the GP was asked to make a referral for counselling. After 3 years of negotiation with GP and mental health commissioner the resident received 11 sessions with Improving Access to Psychological Therapies, which helped. They still need continuous support, currently this is unavailable.

Aspirational Planning – Stretching the Boundaries

How far has Shaping a Healthier Future and the Out of Hospital strategy attempted to deliver real change.

> *'It's like an old house…we keep talking about renovations but what we really need to do is knock it all down and build what we really need.'*
>
> *'We need systems leadership, whole systems assessment – an honest collective discussion about need and how to meet it'*

The need for change is understood, our population is significantly different to that of 1945, we live longer, have more complex conditions and our expectations of health are high. A key focus for this change and for the delivery of services such as those incorporated in the Out of Hospital strategy has been on the use, modification or improvement of existing structures: how well we are adapting or modifying the structures, services and staff that we already have. Discussions with participants in this exercise have also however considered whether this constraint on our thinking and planning is helpful or indeed appropriate in the difficult financial circumstances which have precipitated the need for change.

We consider hospitals, walk in clinics/minor injury centres and GPs and a trajectory from the latter to the former to be a given. Participants in all workshops have raised a challenge to this assumption and thus to the fundamental principles on which Shaping a Healthier Future and the Out of Hospital Strategy are based. It is their view that consideration of alternative models should not be outside of the remit for reconfiguration and delivery of services. In particular the question has been raised as to whether the model of NHS set up 70 years ago is still fit for purpose and in fact do some of the precise difficulties Shaping a Healthier Future and the Out of Hours strategy have been set up to address illustrate the need for more fundamental change.

In this context, participants commented that the current structure of health and well-being service delivery is a 'fragmented' and 'broken system'. Whilst the changes envisaged are not new, they have never been successfully implemented and now may be the time for a far more radical approach to service delivery. Services, across both health and social care are experiencing massive resource pressures and tinkering at the margins of service delivery will not resolve this funding crisis. Participants have urged consideration of a radical rethink of resourcing and planning our services, along the lines of the Manchester experiment which is witnessing the aggregation of health, social care and other budgets across the city and the co-ordination of planning and delivery of services.

Participants proposed that it might indeed make smart business sense to develop services in environments which are demonstrably popular. By attending A&E are our residents perhaps expressing a preference for a model of service delivery which should be influencing investment decisions? It was clearly expressed by residents who responded to the public survey that their preferred location of medical support would be somewhere:

- where they can receive care most speedily, and
- where services required could be delivered in one place.

The logic of this is that our residents would prefer to wait for four hours in A&E rather than four days to see a GP. Clearly this begs the question as to whether the right investment in GP services will reduce the delays being experienced by residents, but it also poses an interesting challenge to

service planners: are we investing in the right services, in the right places? Are we effectively just moving the deckchairs around on the ship struggling to stay afloat?

So, is our mind-set unnecessarily and unhelpfully limiting our capacity to successfully reconstruct the delivery of health and well-being services? What prevents us from taking a radical look at what really needs to happen?

Participants have already identified their concerns with regard to the lack of joined up planning, management and delivery of services. Indeed it is possible that there are disincentives in the system which will continue to militate against significant changes unless they are addressed.

But participants also expressed a lack of trust when it comes to changing the NHS. Whilst there are strongly expressed concerns about some of the shortcomings of NHS services, it remains the case that it is one of Britain's most precious resources and one which claims the allegiance of all communities. As such, any attempt at radical change is likely to be met with fierce opposition unless those planning change can engage with service users, allowing them to influence how their care is delivered. Unfortunately, trust appears at an all-time low and as communication of the changes in Shaping a Healthier Future demonstrates, much still needs to be done to take a community with you.

At the end of the day the extent of our ambition will inevitably be tempered by existing constraints, be they powerful lobbies, existing structures, professional opinion, vested interests or public opinion. But this should not prevent planners from approaching the challenging questions and perhaps taking some small steps towards different models of care.

Broadening our horizons

Extend the network of expert patients- supporting people with long term conditions by linking them with people with the same condition. Enabling them to anticipate issues and develop support networks.

GP hubs (in Urgent Care Centres?) to reduce impact on acute services– 4 open 24/7 with 20-30 beds, GP led with nursing support. Satellite surgeries attached to each hub in community

Salaried GPs

Should there be a greater role for citizens in looking out for their neighbours. Could we expect some staff in the care system to take a greater responsibility?

Lifeboats on Land.

The Nature of Harrow's Population

Any recalibration of services must be cognisant of the nature and future development of the population.

Participants in the exercise expressed concern that the planning of health services must reflect the changing nature of our population. In particular, our capacity to divert residents from A&E emergency services to services in the community may be dependent on our understanding of the community and our ability to engage with it.

The public survey demonstrated that for some residents registering with a GP is problematic, particularly if they don't intend to stay in the borough for long, as they will need proof of address or if their hours of work make using GP appointment system difficult. For these residents, using emergency care becomes the main option

Like most London boroughs, the population of Harrow continues to increase: from 206,800 in 2001 to 239,100 in 2011 and is now an estimated 243,400. This population increase is expected to continue as government welfare policy shifts residents from Inner to Outer London and as planned housing developments on sites such as Kodak come to fruition. There are now an estimated 255,000 residents on GP lists but at the same time as this, the number of GPs and GP surgeries is in decline.

Like most London boroughs, Harrow's population is hugely diverse and somewhat transient. Our residents are religiously, culturally, nationally and ethnically diverse which poses some challenges for service providers trying to change how local people access health services. Comments made by participants have included:

- Do people understand our processes – how sure can we be that the complex network of GPs, clinics and hospitals and the appropriate means of accessing this network is clear to people not familiar with our systems. Is it probable that in some of our residents' countries of origin, there is a simpler system which they equate with ours and thus make inappropriate presentations for services?
- Are people able to access information about our services – for those residents unfamiliar with our systems, and for those we wish to advise of changes, do we provide information in a format which is easily accessible and understandable?
- Are the services relevant – for some of our residents, the changes we are attempting to deliver may not be appropriate. For more transient residents, the process of registering with a GP may be irrelevant, particularly those residents with temporary accommodation or employment who are 'only passing through'

Some resident are 'sofa surfing' as they are unable to find independent accommodation, they will also be unable to access a GP as they cannot register without proof of residence

How well informed are we

Information provided about the changes has been poor and of limited usefulness. Something more engaging should be used to sell the changes properly.

Very little information has been made available about where to go with what care need, how are residents expected to 'self-diagnose' and know where to go in the absence of advice?

'Spectrum' has been produced but not circulated widely – is this something the council could do?

People with Learning Difficulties and Mental Health issues are not keeping up with the changes in service delivery – very poor communications for them

Harrow also has a significant and growing elderly population and again, it is possible that their increasingly complex needs and decreasing mobility are placing demands on the system which the reconfigured Out of Hospital service is not able to meet. For the Out of Hospital service to meet the needs of this group and the needs of our residents with long term medical conditions or disabilities the need for integration across the spectrum is critical and increased sensitivity to their vulnerability is essential.

A visit to Northwick Park witnessed a procession of elderly people arriving in A&E by ambulance looking completely dehydrated. How did their conditions deteriorate to such a degree that they needed emergency care?

The experience of finding it difficult to access a local GP and having to wait for hours on end at the local hospital is extremely concerning, especially if you then also include the transport accessibility and excessive parking costs on top

Many residents and service users have also expressed serious concerns regarding the transport accessibility of Northwick Park Hospital in its effectiveness to serve all the residents of our Borough. For the services users who have to drive to Northwick Park find themselves heavily disadvantaged by the excessive cost of car parking. Both vulnerable patients (and their families accompanying them) as well as those on low incomes report that visiting the hospital is a huge worry.

Only if we are really clear about the nature of our community can we properly design services which can meet their needs in a way which reflects their specific circumstances.

Performance of General Practice

The recalibration of services to deliver care outside of the hospital sets the GP as the cornerstone. Without their fully resourced engagement in the process, it will fail.

This is the aspect of the implementation of the out of hospital strategy which has elicited the most comment.

We start by making clear that there are many examples of excellent service across the borough with high standards of care and professionalism from GPs and their surgeries supported by the Patient Participation Groups which work with them to improve their service delivery by championing the needs of local people.

Whilst it is indeed reassuring to hear that there are some excellent aspects of GP provision, it is also quite clearly the case that there is no overall consistency in the delivery of General Practice and that the services available to our residents are thus dependent upon where they live.

Although the core contracted opening hours for GPs are from 8.30 to 6.30 it is clear that there is significant variation on this standard between surgeries.

'My elderly grandma will not attend A&E as she doesn't like hospitals. She regularly waits up to a month for a GP appointment'

Access to appointments also varies dramatically – some surgeries can offer next day appointments, for some there is a wait of a few days and in some a patient can wait significantly longer. If a patient wishes to see a specific doctor, this inevitably increases the delay

Good practice

A number of surgeries now offer a triage service which has led to a speedier response time on contacting the surgery and also resulted in shorter waiting times for appointments.

A number of surgeries have recognised the needs of people with learning disabilities and mental health concerns and will automatically offer double appointments.

Some surgeries will offer appointments in alternative locations (patient's car) to meet with residents

The Harrow Patient Participation Network is actively campaigning on behalf of over 180,000 Harrow residents to improve services.

Where a patient needs to see a doctor urgently, most surgeries have emergency appointment processes:

- patients are asked to ring between certain times to take access an emergency appointment or
- they are asked to attend the surgery to wait.

Neither of these options guarantee a patient will be seen:

- it can be impossible to get through between allotted times
- some more savvy patients take the emergency appointments even though their needs are not urgent rather than waiting for a non-urgent appointment
- attendance does not guarantee an appointment will be available as all time slots are used

It is also of concern to participants, that there do not appear to be consistent sharing of good practice – whilst the Harrow Patient Participation Network's commitment to improvement is patently clear, its ability to influence other surgeries or to require improvements in its own is not apparent. This is a shame, as the opportunity to learn is lost.

Delay in seeing a GP, in what might initially be fairly innocuous circumstances can cause greater pressures further down the line as conditions deteriorate and thus the cost of care increases. This is probably most likely the case amongst our elderly, less mobile population.

'I am the nominated appointment booker in our family as none of the other family members can give up time in the mornings to keep pressing the redial button to get an appointment'

But delays in seeing GPs do not just affect our residents' immediate health and well-being. It is becoming increasingly apparent that some employers are unwilling to offer their staff time away from their employment or paid time off during the working day to attend GP surgeries (during the GPs' normal opening hours) this means that either these people attend A&E to receive medical advice, they ignore their medical conditions or they lose their jobs. Similarly, increasing numbers of people are presenting to the Citizens' Advice Bureau for advice in circumstances where failure to provide medical evidence of their conditions is resulting in loss of benefits, and even in loss of accommodation.

A paid extension to the opening hours of GPs to include late evenings and Saturdays, for which there is already provision, could alleviate this situation. However, even where GP surgeries are offering extended hours, it may not be possible for these to be accessed in emergencies as payments may only cover GP salaries meaning that surgeries have no administrative cover and thus no telephone answering service

However, even if it were the case that our GP services offered a consistently high standard of care across the borough, it is unlikely that the needs of our most vulnerable residents would be met: whilst high quality consistent care must be our ambition, we must also recognise that in many circumstances, these standards will need to be enhanced for some of our residents to enable them to access care. This project has heard from the representatives of vulnerable service users and service users with 'special needs' themselves of the difficulties they face in accessing general practice, not simply for treatment for their conditions but also as residents for the normal ailments of day to day life.

For my children to wait in the waiting room for an unspecific amount of time is extremely difficult. The uncertainty of this causes extreme anxiety which in turn causes certain behaviours. This could be running up and down, trying to escape, trying to climb on things or people, moving furniture, screaming, crying, shouting, hitting.

When you add into the mix the crowds buzzers going off etc. it turns a normal waiting room, into a living nightmare.

Then... add on the looks of staff and patients, the comments of 'control your child'. The fear in other people's eyes that my son might hurt someone is beyond description.

This happens EVERY TIME we visit the GP.

We have included a number of examples to illustrate their experiences but would summarise their concerns as;

'We need to see Dr R as he is the only one, in our very large surgery, that understands the complex needs of my family. Both my sons have Autism.'

- Lack of awareness of their specific condition – autism, mental health
- Lack of sensitivity towards their needs – double appointments, inability to access appointments
- Need for consistency – seeing the same GP

- Inappropriate surgery environment – crowds, noise

All of those who attended our workshops to discuss the issues of access to care for those with 'special needs' talked about the mistakes which are made as inappropriate diagnoses are made by GPs unfamiliar with or untrained about their conditions.

As NHS policy shifts more responsibility for providing care to our vulnerable residents to those who operate in the community, we hesitate to blame GPs for this failing. We would however draw attention to the need for and willingness to ensure that they are fully aware of the specific needs of some of our residents in order that all can be properly supported.

Difficulties for people with autism, which are also acknowledged as difficulties for people with Learning Difficulties and mental health problems and may also be issues for our elderly residents

Cannot get through on the phone so cannot book an appointment. Long waits on the phone can be very stressful
Cannot work an automated phone so just give up
Receptionists are rude and block access to the doctor
Sensory issues:

- *Bright lights*
- *Noisy waiting room*
- *Children running around*
- *Difficult sitting facing people*

Delated appointment, can be too stressful to wait
Some people dislike name being displayed on screen

Participants suggested that considerable difference can be made to more vulnerable residents' experience of health and well-being services with very simple changes to practice. Simple awareness of some of the difficulties experienced and sensitivity in service delivery costs little, if anything, and can result in significant savings as vulnerable residents are able to access services promptly and their conditions are not allowed to deteriorate.

In one instance where training had been offered for GPs about the difficulties which may be experienced by patients with learning disability and how these might be overcome, the question was raised as to whether there would be additional money for GPs to meet these needs. Providing appropriate care to our more vulnerable residents is not necessarily about greater resourcing but about greater awareness, it should not be seen as an additional demand, financial or otherwise on a GP practice's funding.

For the most part of this section of our report, we have focussed on the reported shortcomings of our GP service and the devastating impact these shortcomings have on our residents, especially those with more complex conditions. During our investigations however, considerable sympathy was also expressed for GPs themselves, who, as a result of NHS policy and other influences, find themselves increasingly in situations which stretch their resources to the limit.

I have also had trouble with understanding what GPs have told me and also what I have told GPs. My GP now understands me (when I can get to see her) but some of the others at the surgery become gruff when I want to know a little more and they try to push me out of the door.

When I was first supposed to be diagnosed with Asperger's Syndrome, I was seen by a psychiatrist in the doctor's surgery who said she thought I had depression and she gave me anti - depressants.

Concerns raised are seemingly rooted in the push towards, community care, universal services and shifting the setting of care. All of these also reflect the ambitions of the Out of Hospital strategy to enable people's medical needs to be supported in the community. Participants consistently questioned, not necessarily the logic of this, but the capacity of GPs to deliver some of the specialist services and diagnoses that this shift might expect: For example do our GPs feel confident to deliver some of the psychiatric support offered by the specialist hospitals? The experience of residents with psychiatric needs and their representatives, would suggest the support available to them from general practice is far from what is required and we have already cited a number of examples of the concerns they have raised.

GPs are also becoming increasingly demoralised as pressure on their lists, their time and their skills base increase. Are we expecting too much of our GPs? Do we now expect a 'champagne service at beer prices'?

Their capacity was also queried in terms of numbers and experience: Whilst the Government ambition to recruit 500 GPs is laudable, this cannot compensate for the loss of experience as older doctors retire. Participants have pointed to the tendency of less experienced doctors to 'overcompensate' or to delay diagnosis and prescription seeking further advice. Participants have suggested mentoring or shadowing opportunities in an attempt to support new doctors develop in their roles.

Impact of unfamiliarity with conditions on vulnerable patients

People being sectioned because their autism not recognised

Attempted suicide after diagnosis of 10 different psychiatric conditions

Failure to monitor medication over 12 month period meant patient almost lapsed into a coma

Suicidal patient escorted home after episode in A&E. She committed suicide

Even where confidence and competence can be assured, the fact remains that GP numbers are reducing, with the best will in the world Government Ministers cannot direct 500 students into firstly medicine and then general practice. Our participants felt that the incentives for careers in General Practice are insufficient – Do GPs seek to supplement their earnings in additional roles which detract from their general practitioner roles? Is the pressure being perceived in the profession limiting its attractiveness? Are they sufficiently rewarded?

Some participants questioned whether the pivotal role of GPs as envisaged in the Out of Hospital strategy is a step too far for general practice as it is currently configured. As discussed above, are we simply shifting resources within the existing model of care introduced in 1945 or do we need to take a more fundamental look at health care and how general practice can be properly configured to support a shift of care from the hospital to the community. Whilst there is an accepted logic in the Shaping a Healthier Future proposals and its predecessor 'Healthcare for London' which recognises that recalibration and reorganisation of health provision can allow the most appropriate care in the most appropriate locations, this logic has stopped short of the realm of general practice, where GPs are being expected to pick up much of what can't be dealt with elsewhere. There may be many obstacles in the way of such a rigorous analysis, not least GP contracts and the plethora of management structures, which will need to be considered to deliver real change. But it does seem that an opportunity might have been lost.

Conclusions

Harrow Council acknowledges the need for change in the healthcare system to ensure structures and processes are fit for purpose. However, the out of hospital strategy is not adequately supporting the delivery of the Shaping a Healthier Future plans despite reassurances given.

- Planning and delivery remain disjointed with limited attention paid to the interconnectivity in the health and well-being environment.
- The challenges are not new. The time is ripe to consider more integrated, radical approaches to the delivery and governance of health and well being services.
- The real characteristics of our population are not being properly taken into account.
- General practice is for many in our borough failing to meet need, with no noticeable improvement since the launch of Shaping a Healthier Future:
    - No consistency of care
    - Single model of GP can never meet all needs – there is a particular lack of understanding of the specific needs of our most vulnerable residents
    - GP system is insufficiently resourced (numerically, financially and professionally) to deliver what is expected

None of this is new, for many years policy makers have talked about and tried to organise the preventative and rehabilitative care of residents in their community. It seems the difficulties remain, perhaps the time is ripe to consider what the blockage to improvements might be whilst assessing need and developing services to meet these needs.

APPENDIX ONE: PARTICIPANT ORGANISATIONS

Harrow Citizens Advice Bureau

Harrow Mencap

Harrow MIND

Harrow Healthwatch

Harrow Local Account Group

Harrow Local Medical Committee

Harrow Patient Participation Network

Harrow Councillors

Cllr Anne Whitehead,

Cllr Varsha Parmar

Cllr Simon Brown

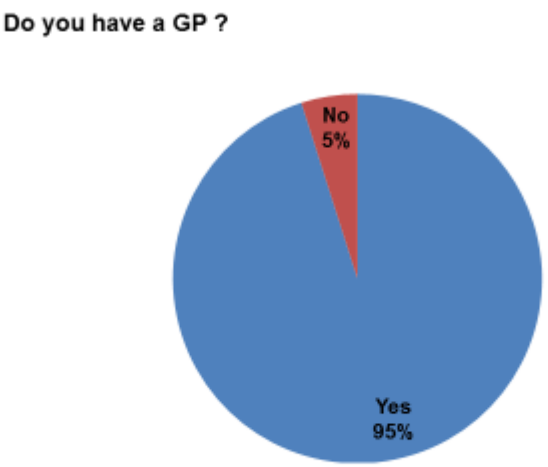
Cllr Rekha Shah

Cllr Chris Mote

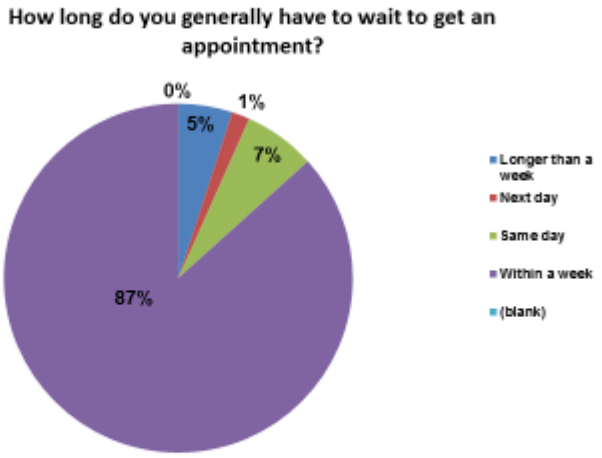
Cllr Janet Mote

Cllr David Perry

APPENDIX TWO: SURVEY RESULTS

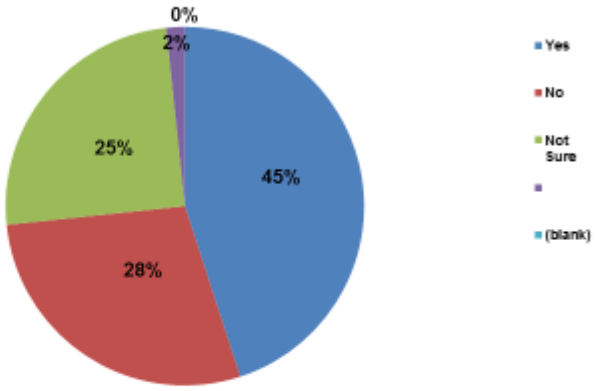


Yes	58
No	3
Grand Total	**61**



Longer than a week	3
Next day	1
Same day	4
Within a week	52
(blank)	
Grand Total	**60**

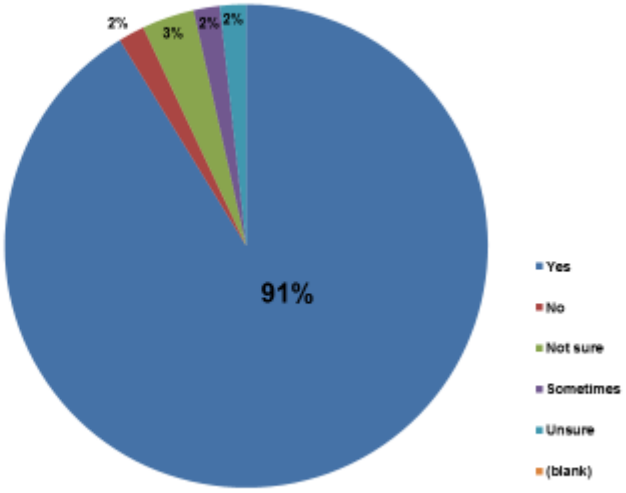
Do you have to wait longer if you want to see the same doctor?



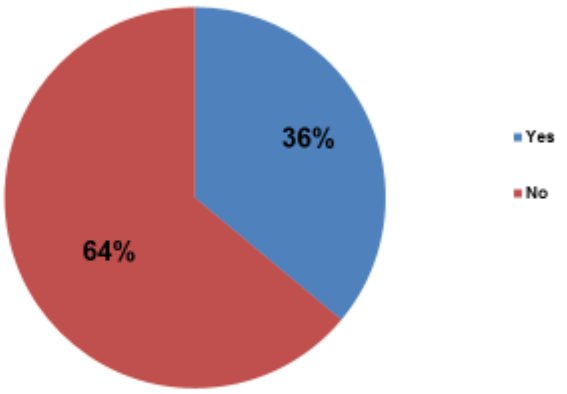
Yes	27
No	17
Not Sure	15
	1
(blank)	
Grand Total	**60**

Yes	4
No	13
Not sure	4
7 days a week	1
9am till 6pm	2
9am till 6pm Just started Saturday	1
Mon/Wed 09:00-20:00 other days 09:00-18:00	1
No	2
No 9am till 6pm	4
No only one day 08:00 to 20:00	1
No usual hours	1
Not sure	1
One day longer hours	1
One day up to 18:30	1
Unsure	2
Yes 08:30-17:30 Thursday 20:00	1
Yes 8am - 1pm	1
Yes 8am - 8pm	2
Yes - Thursday 08:00 - 20:00	1
Yes 09:00-17:00 Saturday 09:00-16:00	1
Yes 09:00-19:00	1
Yes 8:30-18:00 Wed 20:00	1
Yes early morning	1
Yes evenings and Saturday mornings	1
Yes plus Saturdays	2
Yes, 3 practises one open later	1
Yes, 9:30-18:00 and sometimes longer to meet needs + Saturdays	1
Yes, early mornings	1
Yes, Monday evening, Saturday Morning	1
Yes, morning and evenings	1
Yes, offers early morning, late evening and w/end	1
(blank)	
Grand Total	**57**

Does your GP offer extended opening times (early morning, late evening, weekends)?

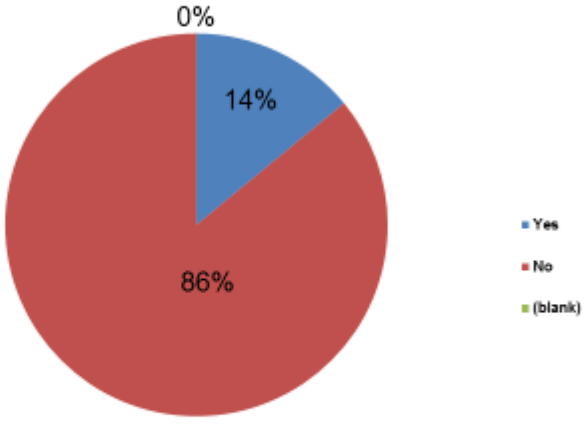


Have you heard about the Urgent Care Centres?



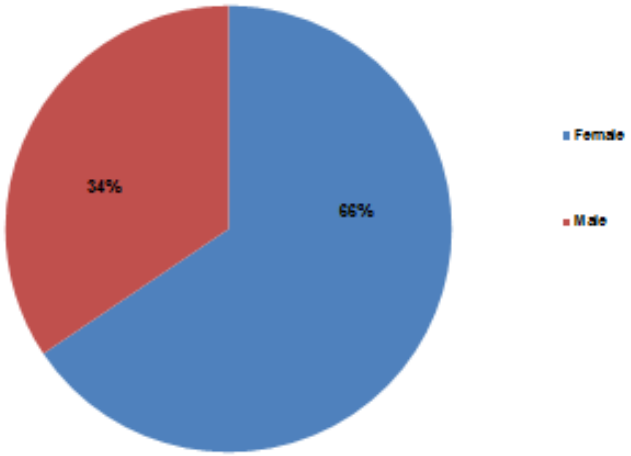
Yes	22
No	39
Grand Total	**61**

Have you used one of the Urgent Care Centres



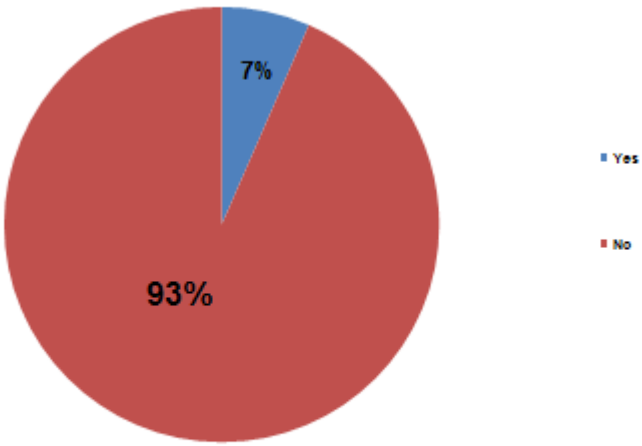
Yes	8
No	49
(blank)	
Grand Total	**57**

Monitoring Diversity - Gender



Female	40
Male	21
Grand Total	61

Monitoring Diversity - Disability



Yes	4
No	57
Grand Total	61

Monitoring Diversity – Ethnic Group

Afghanistan	1
African	1
Arab	1
Arab/Pakistani	1
Caribbean	5
English	17
Human	1
Indian	12
Iraqi	1
Irish	2
Moldova	1
Other Asian	2
Pakistani	1
Polish	2
Romanian	6
Russian	1
Somali	1
Sri Lankan	1
Syrian	1
White and Mixed Caribbean	1
White European	1
Yemen	1
Grand Total	**81**