Health and Wellbeing Board Presentation Documents

Date: **Tuesday 23 March 2021**

7. **Integrated Care System [Consultation and Progress Report]** (Pages 3 - 12)

8. **Adult Social Care Budget [2021/2022]** (Pages 13 - 22)

9. **Covid-19 Update - Infection Rates, Vaccination Plan, Local Outbreak Plan and Test and Trace** (Pages 23 - 42)

10. **Healthwatch Harrow - GP and Dental Service Access Report** (Pages 43 - 86)

Scan this code for the electronic agenda:

This page is intentionally left blank

Harrow Integrated Care Partnership

Next steps on integrating care

3

Consultation and progress on future development of Integrated Care Systems in England

18th March 2021

Harrow Council LONDON

NHS Harrow Clinical Commissioning Group

Harrow Community Action

NHS London North West University Healthcare NHS Trust

St Luke's Hospice

NHS Central London Community Healthcare NHS Trust

HarrowHealth CIC

NHS Central and North West London NHS Foundation Trust

‘Next steps to building strong and effective integrated care systems across England’: Principles

Integrating Care published by NHS England in November 2020 invited discussion on the next steps in the development of Integrated Care Systems in England.

It reflects a number of principles which are strongly supported by and reflected in arrangements in NW London and Harrow ICP including:

- **Stronger partnerships at a place level** between the NHS, local government and the voluntary and community sector (p2).
- **A focus on improving population health and tackling inequalities** (p4) including a “Triple Aim” duty for all NHS providers (p11).
- **The central role for primary care** in providing joined-up care (p2).
- **The role of mutual aid** development of relationships and support during the pandemic (p4) and opportunities to pool funding (p31).
- **The importance of data sharing and digital** alongside a culture of collaboration and agile collective decision-making (p5).
- **The importance of local government and place** (p6-7) in the planning, design and delivery of care (p13).
- **The principle of subsidiarity** – the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places (p13).

The document invited feedback by 8th January 2021.

Whilst proposed legislative changes are unlikely before April 2022 and subject to parliamentary approval, the document sets out an NHS direction of travel including requests for submission of ICS development plans by April 2021 and implementation plans by September 2021.

‘Next steps to building strong and effective integrated care systems across England’: Harrow ICP Feedback

Whilst welcoming these aspects of the proposals, discussions have highlighted the importance of clarity in relation to each area:

- **There is general support for the overall direction of the document but some nervousness across our ICP** around the proposals and the extent to which they reflect the complexity of truly integrating care at a system, place and Primary Care Network level.
- **The success of Harrow as an ICP, as mirrored in experiences in other areas of the country in developing integrated care “on-the-ground”, has been based on the commitment of local leaders** from across council, CCG, acute, community, primary care, mental health, voluntary and community sector and patient / service user representatives; and the strength and the depth of the relationships which have been developed as a result.
- **There is a need to ensure that legislative change has at its core the further development of such relationships and local accountability,** and does nothing in perception or reality that could create new barriers to effective joint working at a local level.
- **Specifically, there is a need to ensure that in promoting the principle of subsidiarity, there is clarity around the role and influence of place, primary care and the voluntary and community sector in the future governance of integrated care systems** which in areas such as London cover multiple, independent, local authorities and a huge and diverse range of PCNs and VCSEs.
- **Mutual aid has been a key component of our pandemic response:** there is a need to understand how the establishment of the ICS as a statutory organisation and the parallel development of formal provider collaboratives will help support mutuality, as oppose to simply centralising planning and accountability. Specifically, local trusts have highlighted that co-terminosity with ICSs may not be the best driver for collaboration at scale.
- **Finally in addressing inequality there is a need to ensure that the distribution of resources across an ICS footprint is considered** in relation to how future plans and funding will be developed, governed and assured at a local level.

Department of Health & Social Care White Paper
'Integration and innovation: working together to improve health and social care for all'

- DHSC White Paper **published February 2021.**
- **Builds on the 'NHS Long Term Plan' (January 2019) and NHS England's consultation on integrated care (November 2020).**
- **Proposes that new arrangements should begin to be implemented in 2022.**
- **Includes a greater role for Integrated Care Systems in helping different parts of the NHS in joining up better** and in becoming statutorily accountable for overall system performance, focussed around the 'Triple Aim'.
- **Within this, the proposals suggest a 'dynamic partnership' between the NHS and local government with a focus on population health, using collective resources to improve the health of local areas:** preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience.
- **There will be increased accountability from NHS England to the Department of Health & Social Care** replacing the NHS's annual mandate with the flexibility to change the mandate in-year; and with new powers for the Secretary of State, for example to intervene at any point in reconfiguration processes.
- **There is a commitment to the 'Primacy of Place' in the joining-up of services to support people to live well** and accompanying flexibility around local arrangements, to be based 'frequently' around local authority boundaries.
- **There are further measures to establish an independent Health Services Safety Investigations Body** and remove the statutory basis for local education training boards.
- **Further proposals on Adult Social Care, Mental Health and Public Health to be brought forward** later in the year including an enhanced assurance framework for social care.

Integrated Care Systems (ICSs) will become statutory bodies.

e.g. NW London Integrated Care System		e.g. Harrow Integrated Care Partnership
ICS NHS Body responsible for the day to day running of the ICS.	**ICS Health & Care Partnership** with health, social care, public health and other partners.	**Place-based joint working** between the NHS, local government, community health services, and other partners such as the voluntary and community sector.
Merging of functions of STPs/ICSs with functions of a CCG to bring together strategic planning and allocation of resources.	**Supporting integration and developing a plan to address a system's health, public health and social care needs.**	**Joining up of services to support people to live well, arranging care around people, prevention and supporting people with multiple health & care needs.**
• **Developing a plan to meet the health needs of the population** within their defined geography. • **Developing a capital plan for the NHS providers** within their health geography. • **Securing the provision of health services** to meet the needs of the system population.	• **Improving population health.** • **Tackling inequalities.** • **Potential forum for NHS and Local Authority partners** to agree co-ordinated action and alignment of funding on key issues.	• ***Frequently, place level commissioning within an integrated care system will align geographically*** *to a local authority boundary.* • **The Better Care Fund (BCF) plan will provide a tool** for agreeing priorities.
• **A statutory duty to meet the system financial objectives which require financial balance to be delivered.**	• **The NHS and local authorities will be given a duty to collaborate with each other.**	• **ICS legislation will complement and reinvigorate place-based structures for integration** such as Health & Wellbeing Boards, the Better Care Fund and pooled budget arrangements.
• **The ICS NHS body will have a unitary board directly accountable for NHS spend and performance**. • **The Chief Executive will be the Accounting Officer for NHS money** allocated to the NHS ICS Body. • **The board will include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities** and others determined locally e.g. community health services (CHS) trusts and Mental Health Trusts, and non-executives. • **ICSs will also need to ensure they have appropriate clinical advice** when making decisions. • **NHSE will publish further guidance on how Boards should be constituted**, including how chairs and representatives should be appointed.	• **Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards within the system, partner organisations with an interest in health and care** (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). • **The intention is to specify that an ICS should set up a Partnership and invite participants, but we do not intend to specify membership or detail functions for the ICS Health and Care Partnership** – local areas can appoint members and delegate functions to it as they think appropriate.	• **Place-based arrangements between local authorities, the NHS and between providers of health and care services should be left to local organisations to arrange.** 'We expect local areas to develop models to best meet their local circumstances.' • **NHS England and other bodies expected to provide support and guidance**, building on the insights already gained from the early wave ICSs. • **The statutory ICS will also work to support places** within its boundaries to integrate services and improve outcomes. • **NHSE to work with ICS NHS bodies on different models** for place-based arrangements.

'Together referred to as the ICS'

'Place'

'Joined up care for everyone in England'

The 'triple aim': better health and wellbeing for everyone; better quality of health services for all individuals; sustainable use of NHS resources.

New statutory duties

Membership

- **Defined ICS NHS Body** optional additional members.
- **Health & Care Partnership** determined by each system.
- **Place-based working** defined locally.
- **Clinical advice** to be incorporated in decision-making.

'We will implement NHS England's recommendations to remove barriers to integration through joint committees, collaborative commissioning approaches and joint appointments, as well as their recommendation to preserve and strengthen the right to patient choice within systems.'

8

- **The powers to remove commissioning of NHS and public health services** from the scope of Public Contracts Regulations 2015, including repealing Section 75 of the Health & Social Care Act 2012 and Procurement, Patient Choice & Competition Regulations 2013.
- **The NHS should be free to make decisions on how it organises itself** without the involvement of the Competition and Markets Authority (CMA).
- **Removes NHS Improvement's specific competition functions** and its general duty to prevent anti-competitive behaviour.
- **Where procurement processes can add value they will continue** but that will be a decision that the NHS will be able to make for itself.
- **For social care, a new legal power to make payments directly to social care providers** to remove barriers in making future payments to the sector.
- **A new standalone legal basis for the Better Care Fund** and a legal framework for a 'Discharge to Assess' model.
- **Place level commissioning will 'frequently' align geographically** to a local authority boundary.
- **The ICS will have to work closely with local Health and Wellbeing Boards (HWB)** as 'place-based' planners. The ICS NHS Body will be required to have regard to the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies that are being produced at HWB level and vice-versa.
- **This will be further supported by other measures** including improvements in data sharing and enshrining a 'triple aim' for NHS organisations to support better health and wellbeing, quality of health services, and sustainable use of resources.

'There are, then, 2 forms of integration which will be underpinned by the legislation: integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.'

Department for Health & Social Care

Ensure the Secretary of State for Health and Social Care has appropriate intervention powers with respect to relevant functions of NHS England

NHS England

Giving NHS England the ability to joint commission its direct commissioning functions with one or more ICS Board: allowing services to be arranged for their combined populations; to delegate or transfer the commissioning of certain specialised services to ICSs, singly or jointly; and allowing ICSs to enter into collaborative arrangements for the exercise of functions that are delegated to them, enabling a 'double-delegation'.

Measures that will enable ICSs to apply to the Secretary of State to create a new trust for example for the purposes of providing integrated care.

Increasing the ease with which providers and commissioners could establish joint working arrangements and support the effective implementation of integrated care (including establishing joint ICS provider committees).

Allowing NHS providers to form their own joint committees. Both types of joint committees could include representation from other bodies such as primary care networks, GP practices, community health providers, local authorities or the voluntary sector.

ICS NHS Body

NHS Trusts

- **NHS Trusts and Foundation Trusts (FTs) will remain separate statutory bodies** with their functions and duties broadly as they are in the current legislation.
- **NHS providers within the ICS will retain their current organisational financial statutory duties.** The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain.

A reserve power to set a capital spending limit on Foundation Trusts.

A new duty to have regard to the system financial objectives so both providers and ICS NHS Bodies are mutually invested in achieving financial control at system level.

'A statutory ICS will be formed in each ICS area. These will be made up of a statutory ICS NHS body and a separate statutory ICS Health and Care Partnership, bringing together the NHS, local Government and partners – for example, community health providers.'

NHS England

NHS England and other bodies are expected to provide support and guidance, building on the insights already gained from the early wave ICSs.

Health & Wellbeing Board

Health and Wellbeing Boards will remain in place and will continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy which both HWBs and ICSs will have to have regard to.

ICS NHS Body

10

The ICS NHS Body will be allowed to delegate significantly to place level and to provider collaboratives.

ICS Health & Care Partnership

The statutory ICS will work to support places within its boundaries to integrate services and improve outcomes.

Place-Based Partnership

Place-based arrangements between local authorities, the NHS and providers of health and care services.

Provider Collaboratives

ICSs will want to think about how they can align their allocation functions with Place for example through joint committees, though this is being left to local determination.

Primary Care Networks

Joint committees including primary care networks, GP practices, community health providers, local authorities or the voluntary sector, enabled by a greater range of delegation options for section 7A public health services and the ability for delegation for example via section 75 partnership arrangements.

Joint appointments of executive directors will be used to foster joint decision making, enhance local leadership and improve the delivery of integrated care.

Next steps for Harrow

- **Further formal guidance is expected in relation to the proposals in the White Paper** including from NHS England.
- **Final proposals are unlikely until the Bill has been published** and the legislation passes through all parliamentary stages.
- **Even once the proposals are finalised there is likely to be significant flexibility** in relation to local place-based arrangements.
- **The overall direction of travel is consistent** with developments in NW London and nationally.
- **The role of the Health & Wellbeing Board, NHS Foundation Trusts, and arrangements such as the Better Care Fund are broadly preserved** even whilst many of the changes introduced in the last major Health & Social Care Act (2012) are amended.
- **It is therefore critical that partners in Harrow continue to build local structures and responses** to the immediate and future needs of the local population, and the priorities in areas such as health inequalities both highlighted and, in many cases exacerbated, by the pandemic.
- **Further proposals are promised on Adult Social Care, Mental Health and Public Health** later this year.

This page is intentionally left blank

Adult Services Budget 2021-22

Health & Wellbeing Board

23rd March 2021

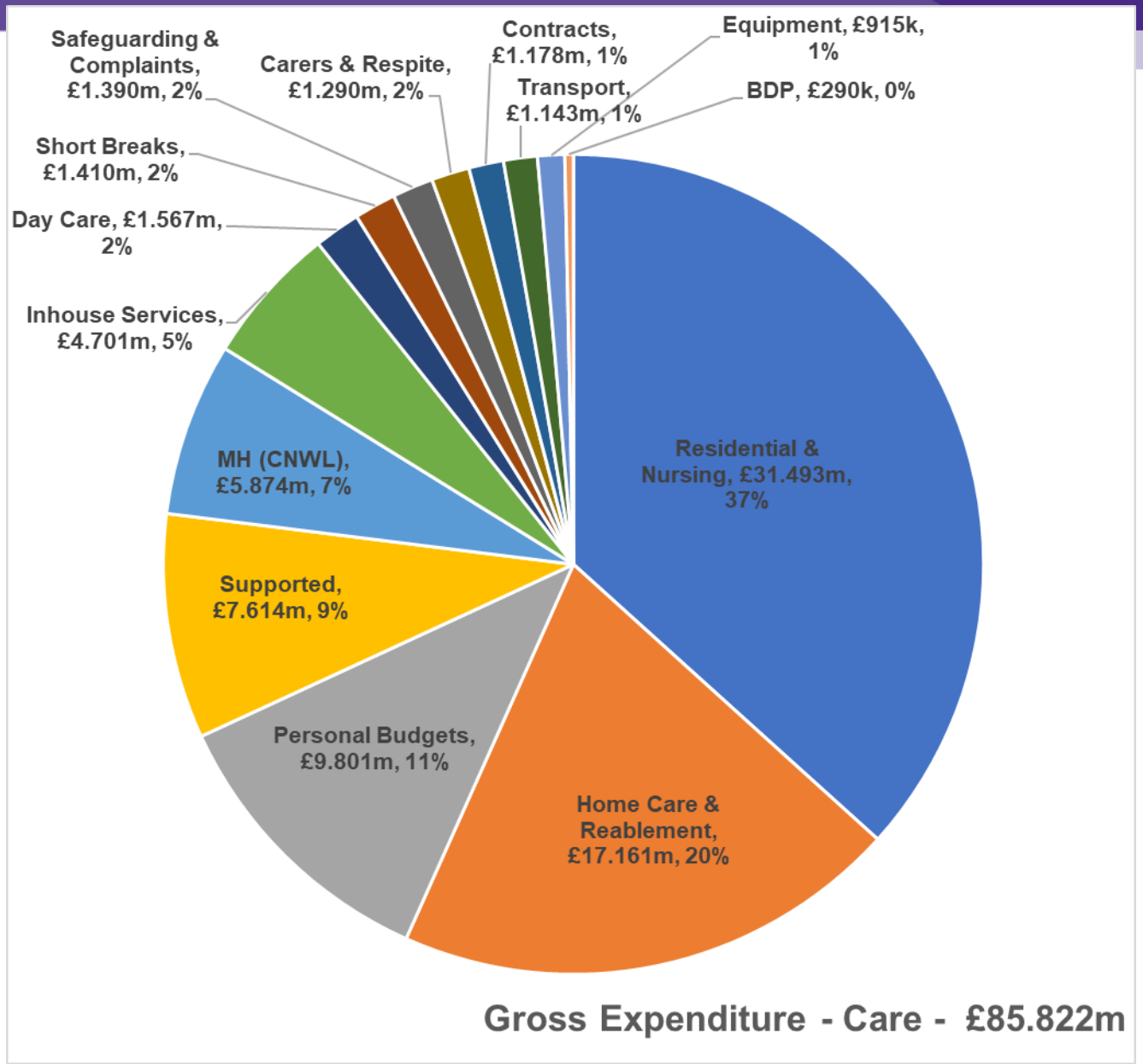
Strategic Context

- Pre pandemic, local Government financially challenged
- Councils required to set a balanced budget annually
- Reduced funding against a backdrop of increasing population and increased need for social care services
- Over the period 2013/14 to 2021/22
  - Reduction in revenue support grant of £50.5m (£52.1m reduced to £1.6m in 2021/22)
  - Demand led growth of £77.4m & technical growth of £19.4m
  - Savings of £147.3m to be achieved to deliver a balanced budget
  - 2020/21 required use of reserves to balance the budget
- Net budget requirement to support service delivery just £179m
- Harrow one of the lowest funded councils in London and nationally

Budget 2021-22 & Future Years

- Balanced budget for 2021-22
- Council tax increase proposed at 1.99%
- Full use of social care precept at 3%
- £300m nationally for additional social care funding (£326k for Harrow assumed ongoing)
- £1.55bn nationally to meet additional covid expenditure pressures (£4.6m one-off for Harrow)
- Public Health grant increase by £160k, of which £84k specifically allocated to PrEP
- Budget gap 2022-23 - £24.651m
- Budget gap 2023-24 - £5.098m

Gross Adults Expenditure Budget 2021-22



Adult Social Care Budget 2021-22 - £77.282m

Service Type	£	Service Type	£	Service Type	£
Residential & Nursing	£31,492,724	Assessed Contributions	-£9,486,168	Care Management	£8,991,307
Home Care & Reablement	£17,161,650	BCF / Grants	-£14,712,128	Corporate Costs	£6,666,466
Personal Budgets	£9,801,390				
Supported	£7,613,980				
MH (CNWL)	£5,873,855				
Inhouse Services	£4,701,334				
Day Care	£1,566,720				
Short Breaks	£1,409,850				
Safeguarding & Complaints	£1,390,036				
Carers & Respite	£1,285,000				
Contracts	£1,178,275				
Transport	£1,143,464				
Equipment	£914,700				
BDP	£290,000				
Gross Expenditure - Care	**£85,822,978**	**Gross Income**	**-£24,198,296**	**Other Costs**	**£15,657,773**

Total Adults Budget 2021-22 - £77,282,455

Current Activity (Feb 2021)

- **3,064** citizens currently supported by the Council across all groups and settings including;
  - 611 citizens in receipt of residential and nursing care
  - 134 citizens in supported accommodation settings
  - 1,273 citizens receiving domiciliary care services
  - 622 citizens arranging their own care using a direct payment
  - 438 citizens under the age of 65 in receipt of mental health services managed by CNWL on behalf of the Council

- **511** carers supported by the Council (including CNWL) in the year to date

NB: some citizens may receive more than one service hence the breakdown by setting reflects a total of 3,078

Social Care 2021-22

- Adult social care forecast placement growth of £6.239m after
  - £300k commissioning savings
  - £200k increased income from updating charging policy
- Pressure on Council finances resulted in reduced growth of £4.318m being funded on an ongoing basis, includes provision for provider inflation of £1.046m
- The balance of the forecast growth of £1.921m to be funded by reserves on a one-off basis if required in 2021-22
- Should the full social care pressures of £6.239m materialise, the ongoing budget funding of £1.921m will need to be identified by the Council for 2022-23 onwards and / or require Adult social care to deliver savings at this level
- Better Care Funding at 2020-21 level of £6.436m, expected to increase by 5.3% in line with NHS Long Term Settlement Plan

Risks 2021-22

- **Social care narrative** - fluid and challenging, post covid operating model uncertain and potential of increased demand from those in the community who have resisted social care support over the last year as a result of fear of infection from care providers
- **Hospital discharges** – higher levels than evidenced pre covid, further increases likely once elective surgeries resumed
- **Lifetime costs** – higher cost of care of discharges adding increased cost
- **Provider impact** – market affected significantly by pandemic, now being required to work differently moving forward, higher inflationary requests anticipated
- **Social work practice** – supported with additional funding during pandemic, however ongoing community support and potential increasing requirement for Care Act assessments post covid is unfunded

Risks 2021-22

- **Citizen expectation** – during the pandemic the lines between NHS services and chargeable social care services were blurred. Likely increased level of challenge for assessed contributions towards care which could affect assumed income
- **Service specific areas** ie; mental health, domestic abuse already seeing increased assessed care support needs.
- **NWL** - initial observations post pandemic across have identified service inequalities arising from the historic financially challenged health & care economy locally in Harrow

This page is intentionally left blank

The North West London
health and care partnership

NWL Vaccination Programme

Harrow Borough based plan

Agenda Item 9
Pages 23 to 42

26th February 2021

Vaccination coverage in cohorts 1-9

Cohort	Target	Current Harrow position
1. Care home staff and residents	90%	
2. 80 years and over	90%	
3. 75-79 years	90%	
4. 70 – 74 years	90%	
4. CEV	90%	
5. 65 – 69 years	100%	
6. Under 65 years with UHC	100%	
7. 60 – 69 years	100%	
8. 55-59 years	100%	
9. 50 – 54 years	100%	

Most up to date data to be provided at the meeting

Vaccination coverage in cohorts 1-9

Key actions to move to target coverage rates

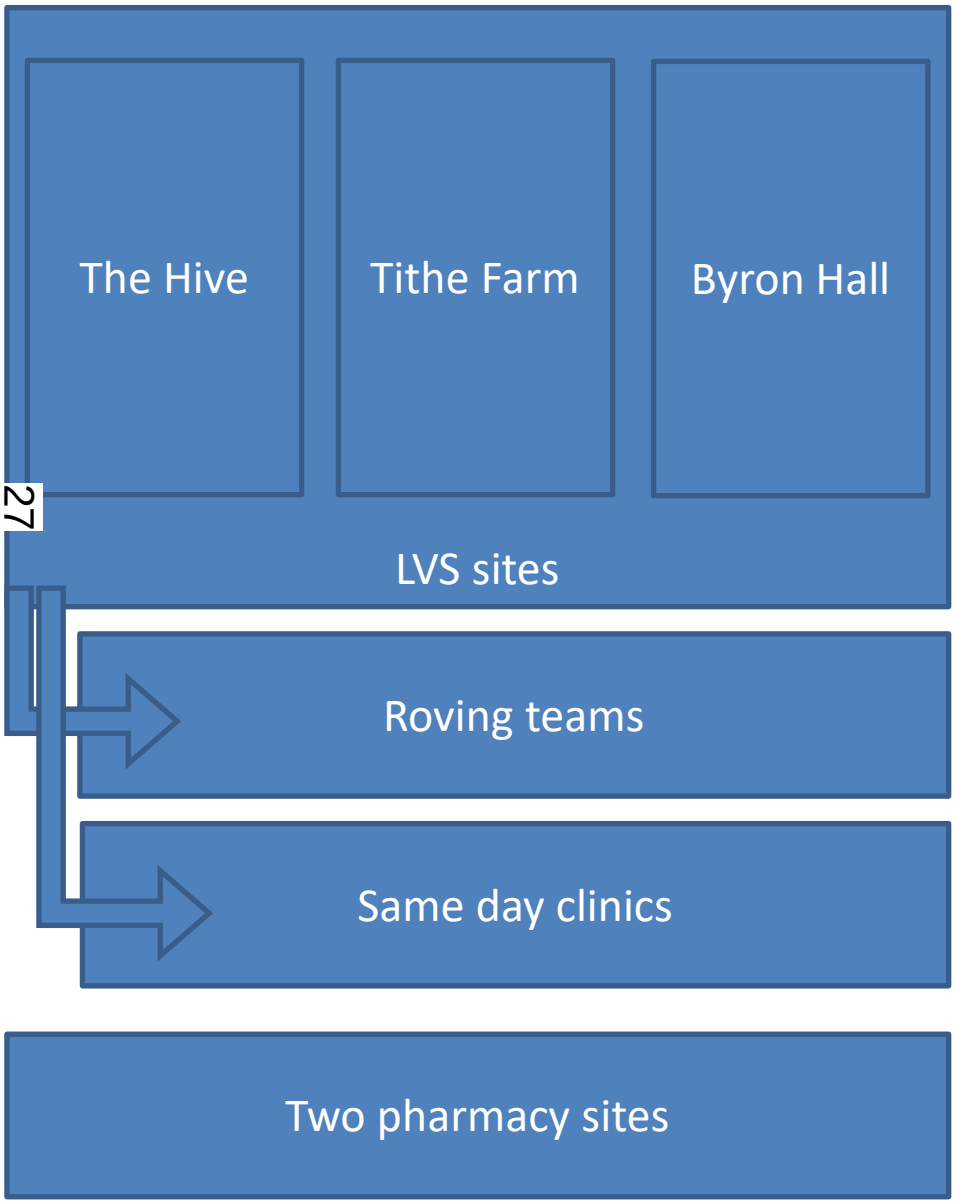
- Ongoing partnership activity with our local authority to address low vaccination uptake amongst specific groups in our community.
- Targeted action at individual Practice level. Each Practice to be provided with a list of patients outstanding, in cohorts 1-4 initially for active follow up where there has not been an active decline of the vaccine. Individual intervention to lead to one of the following outcomes:
  - Book into a vaccination centre (with transport arranged where needed). Priority booking given for those patients in cohorts 1-4
  - Same day clinics to be arranged for this cohort group with PCN / Practice
  - Home visit for vaccine arranged by roving team
- Rearrangement with care homes to confirm if there are new residents requiring vaccination
- Process to be replicated with cohorts 5-9

Vaccination coverage in cohorts 1-9

Current inequalities in vaccination uptake

- Whilst our overall uptake of vaccination to date has been high, these large percentage mask inequalities in uptake that we seeing amongst our population.
- Our WSIC dashboard shows take-up as high amongst White and Asian or Asian British populations (85-90%), uptake upmost Black or Black British population is 57%, and Mixed ethnicity is 72%.
- Detailed analysis amongst our CEV population provided details of the number of patients who have actively declined the vaccines are disproportionality high in our Black and Black British population, mixed population and those with ethnicity not recorded.
- Joint action across the Local Authority, local Practices and CCG is being take to understand the concerns about vaccination amongst these population, through engagement with community leaders, faith groups and promotion of vaccination through trusted local clinicians.
- We will seek to continue to strengthen our position over the coming months.

Current delivery model for vaccination



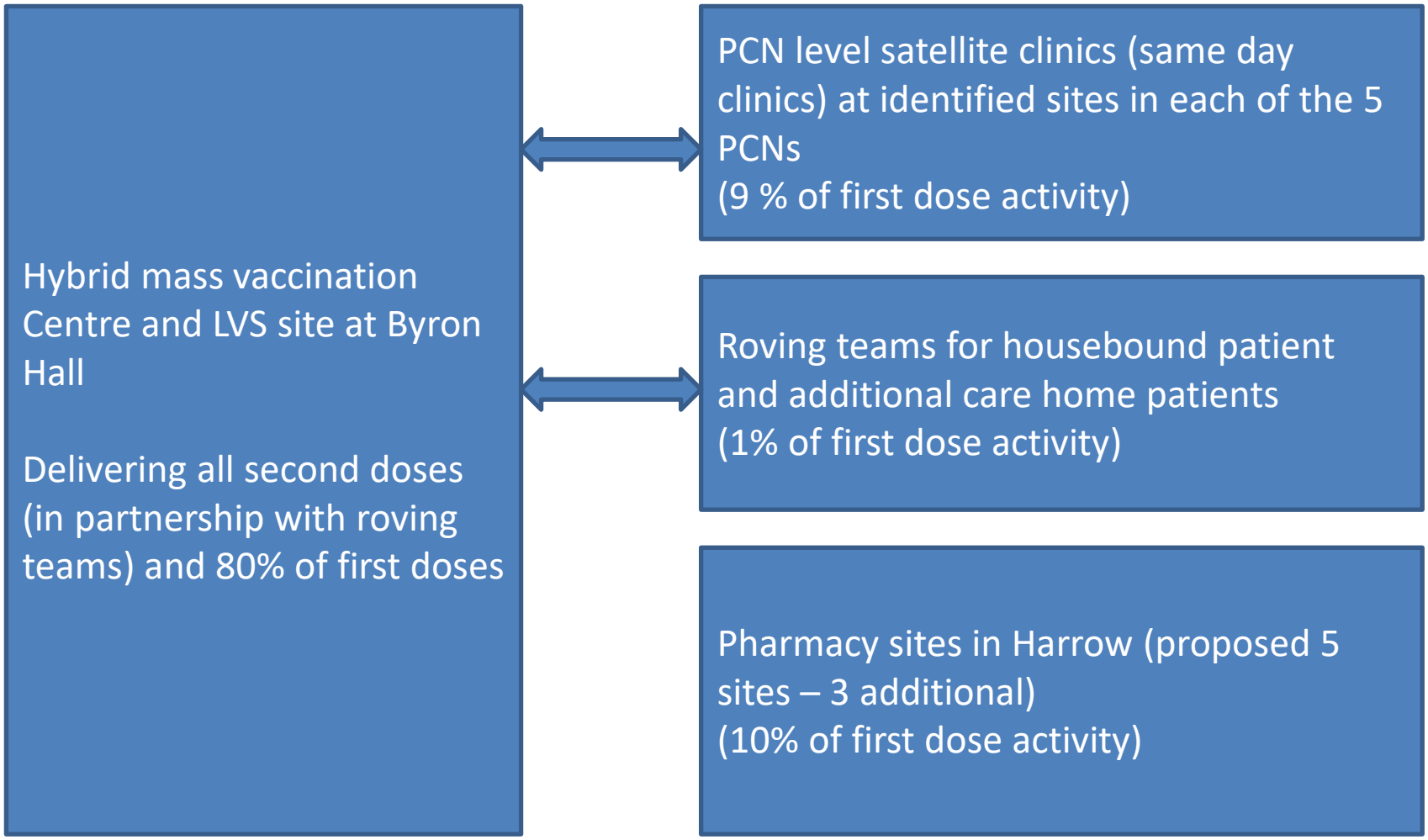
c.95% of activity through the three LVS sites

Care home and housebound vaccination teams

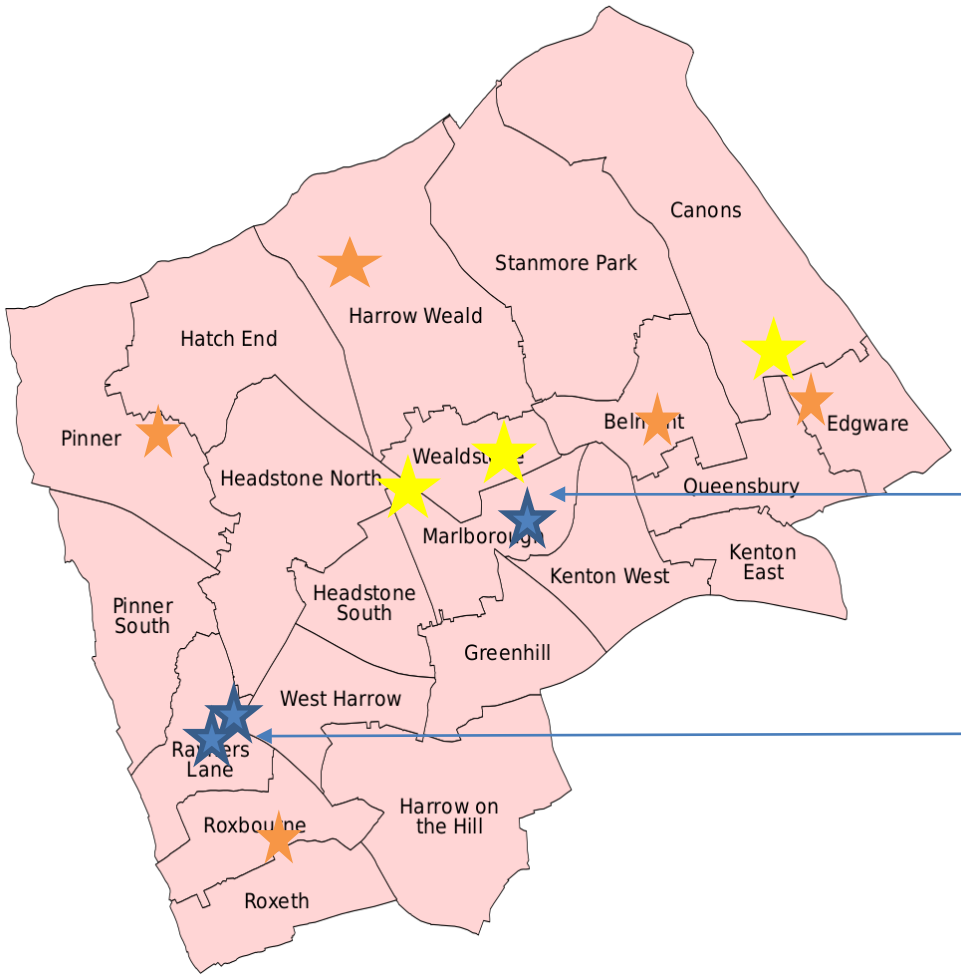
Limited deployment in Harrow to date: 150 vaccinations delivered through this model

Current delivery volumes unknown

Proposed delivery model from May 2020: overview



Proposed delivery model from May 2020: geographical overview



Potential locations for additional pharmacy sites

Potential locations for PCN satellite clinics

Byron Hall

Existing pharmacy sites

Principles driving our proposed delivery model

- Harrow is very proud of their success to date in vaccination uptake and the protection it has provided our local population from COVID-19. Key to this has been close working between the PCN leads, local Practices, CLCH, Local Authority, Harrow Health CIC and the CCG in delivery of the programme.
- Achieving a 60% uptake amongst our population group is relatively straightforward with patients actively responding and taking up vaccination. Achieving 60%-70% requires more work in following up non-responders and moving above 70% is the most challenging, requiring innovation in our delivery models, strong engagement with our communities and one to one conversations between the registered Practice and their patients. In our model going forward, we need to ensure that the strength of this partnership approach is not lost.
- There is wide acknowledgement of the need for General Practice to resume usual services, as well as our clinical leaders within the PCNs to engage with the broader agenda of the development of our local Integrated Care Partnership, and their role as part of the NWL ICS.
- The model we are proposing we believe can meet both objectives. We will consolidate from three sites to one, releasing our workforce back to General Practice and freeing up our clinical leads to engage in broader work programme.
- Operating Byron Hall as a hybrid model enables the partnership engagement to continue and grow, particularly in reaching all of the Harrow community through vaccination.

Harrow Proposed delivery model: detail

Hybrid mass vaccination site

Proposal is that starting from March 2021, a hybrid model is developed at Byron Hall, combining the PCN operations and a mass vaccination site. The site will be operating first and second dose vaccines for the whole of Harrow.

Operationally, the site will operate 4 days a week (Friday – Monday) as a PCN site, delivering all second dose vaccines for Harrow residents, in addition to up to 6,800 (average) first doses per week. The mass vaccination site will operate from Tuesday to Thursday, providing 7,000 vaccines per week. In the event that a Pfizer delivery means that the PCN site needs to deliver second doses on a Tuesday, Wednesday or Thursday, provision of an additional 8 vaccination stations will available (these will be unused at other times). This model will be kept under review, and the number of days each centre is operating will be under regular review, particularly when vaccination moves to the under 50 year old population.

The centre will operate in a partnership model, aligned with the principles of our local ICP and further strengthening this model:

- Clinical leadership provided through the Harrow PCNs and CLCH (for their retrospective operational days)
- Vaccination teams source through the PCN bank, CLCH and the Chelsea and Westminster staff bank
- Strategic support provided through the CCG and Local Authority

The maximum capacity of the site will be 2,400 vaccines per day (16,800 per week) on an 8-8 model, although it could operate until 12pm if needed. One way traffic flow will need to be addressed as capacity increases, in collaboration with our Local Authority. Modelling and phasing of this approach is shown on the following slides.

Harrow population in cohorts 1-9

Cohort	Vaccinations	HARROW COLLABORATIVE PCN	HARROW EAST PCN	HEALTH ALLIANCE PCN	HEALTH-SENSE PCN	SPHERE PCN	Total
All cohorts	Vaccinated	8,697	6,123	10,544	18,571	13,023	56,958
	Not Vaccinated	5,860	3,236	6,351	9,722	7,860	33,029
All cohorts as at 21/02/2021		14,557	9,359	16,895	28,293	20,883	89,987

Harrow Proposed delivery model: phasing

March	April	May	June
Three LVS sites operating in Harrow and second doses commence (capacity for 19,320 vaccinations per week) Mass vaccination site to start to operationalise from mid March increasing capacity by additional 7,000 per week Additional pharmacy sites identified	Three LVS sites operate through April. Just under 50% of this available capacity will for second doses. Mass vaccination centre operating in the hybrid model. A more structured and planned approach taken to Practice satellite clinics, to address areas of low uptake. Total vaccination weekly capacity in Harrow 27,730. Based on averages, 9746 of these will be for second doses – hence 17,000 available for first doses per week.	Tithe Farm and the Hive close on 30th April. All vaccination provision consolidated to Byron Hall with satellite same day clinics operating at PCN level. PCN site operating from Byron Friday – Monday, Mass Vaccination site operating Tuesday – Thursday. Second dose and first dose operating. Average of 10,500 first dose appointments available per week.	Cohorts 1-9 completed. National invitation system becomes operational as we move to patients aged 49 years and under. PCN operation continue at Byron Hall for second doses and to act as a base for satellite clinics to continue to achieve 100% uptake in cohorts 1-9

Joint working with our Local Authority

- The strength of the partnership across health services and the Local Authority has been key to success to date. In taking forward our plan, we will build on this strong foundation to deliver the programme, which is coordinated through our joint operational delivery group.
- Harrow Council play a central role in the vaccination programme in a number of areas, including:
  - Leading the work on vaccination hesitancy and providing strategic advice based on community engagement work to the operational running of the programme. As this work develops we will be ensuring full alignment to Primary Care Networks and our GP community;
  - Communication to our local community through a range of media channels;
  - Incorporating the provision vaccine advice and signposting into the Council's contact centre. This information access point is promoted through our local Practices and Council services. There is option to build clinical resource into this in future, or more specific GP led interventions, if needed – based on a service review;
  - Tactical and logistical support to the vaccination sites in a range of areas including traffic control, Member engagement and estates support. This will continue and grow as service develop further from Byron Hall.

Summary of proposed activity levels from May 2021 for cohorts -1-9

Mode of delivery	Total capacity	Percentage of delivery	TOTAL actual numbers for 1st doses to achieve 1-9 population coverage
Hybrid mass vaccination and PCN site	16,800 per week 10,500 per week for first doses (7,000 of which to be carried out by mass vaccination site)	80% of first doses 95% of second doses	26,400
PCN level satellite sites	As needed	9% of first dose activity (second doses where needed)	2,970
Roving teams	As needed	1% of activity (second doses where needed)	330
Pharmacy sites	Unknown	10% of activity (second doses where needed)	3,300

Note these figures are based on figures at 26/2. Many of these patients will have been vaccinated in advance of this model operating.

Site Plan: The Hive

The Hive														
	1st Dose - wc	07/12/2020	14/12/2020	21/12/2020	28/12/2020		04/01/2021	11/01/2021	18/01/2021	25/01/2021	01/02/2021	08/02/2021	15/02/2021	22/02/2021
1st Dose administered	AZ	0	0	0	0		449	482	772	1,597	2,113	2,452	1,087	0
	Pfizer	0	2,574	423	606		1,059	2,069	2,322	2,268	1,137	1,156	1,167	0
	Total	**0**	**2,574**	**423**	**606**		**1,508**	**2,551**	**3,094**	**3,865**	**3,250**	**3,608**	**2,254**	**0**
Days between Dose		21	21	70	70		77	77	77	77	77	77	77	77
	2nd Dose - wc	**28/12/2020**	**04/01/2021**	**01/03/2021**	**08/03/2021**	**15/03/2021**	**22/03/2021**	**29/03/2021**	**05/04/2021**	**12/04/2021**	**19/04/2021**	**26/04/2021**	**03/05/2021**	**10/05/2021**
2nd Dose administered	**AZ**	**0**	**0**	**1**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Pfizer	**0**	**2,352**	**506**	**7**		**3**	**4**	**6**	**3**	**0**	**0**	**0**	**0**
2nd Doses to deliver	AZ	0	0	0	0		449	482	772	1,597	2,113	2,452	0	0
	Pfizer	0	222	-83	599		1,056	2,065	2,316	2,265	1,137	1,156	0	0
Total		0	222	-83	599		1,505	2,547	3,088	3,862	3,250	3,608	0	0
Weekly Capacity								**6,020**	**6,020**	**6,020**	**6,020**	**6,020**	**0**	**0**
Spare Weekly Capacity								**3,473**	**2,932**	**2,158**	**2,770**	**2,412**	**0**	**0**

36. The Hive will continue administrating first and second doses until the end of April 2021. Around 40% of their total capacity will still be available for administrating first doses.

Vaccine stock to all be targeted towards roving teams and same day clinics to improve vaccination coverage.

After the end of April, also second dose activity will be undertaken in the consolidated site Byron Hall

Site Plan: Tithe Farm

Tithe Farm

	1st Dose - wc	07/12/2020	14/12/2020	21/12/2020	28/12/2020		04/01/2021	11/01/2021	18/01/2021	25/01/2021	01/02/2021	08/02/2021	15/02/2021	22/02/2021
1st Dose administered	AZ	0	0	0	0		247	234	1,073	3,203	1,700	2,701	839	0
	Pfizer	0	1	0	0		803	1,341	2,266	0	1,161	1,161	1,155	0
	Total	0	1	0	0		1,050	1,575	3,339	3,203	2,861	3,862	1,994	0
Days between Dose		21	21	70	70		77	77	77	77	77	77	77	77
	2nd Dose - wc	**28/12/2020**	**04/01/2021**	**01/03/2021**	**08/03/2021**	**15/03/2021**	**22/03/2021**	**29/03/2021**	**05/04/2021**	**12/04/2021**	**19/04/2021**	**26/04/2021**	**03/05/2021**	**10/05/2021**
2nd Dose administered	**AZ**	0	0	0	0		0	0	2	0	0	0	0	**0**
	Pfizer	0	3	3	3		0	4	5	3	0	0	0	**0**
2nd Dose to be delivered	AZ	0	0	0	0		247	234	1,071	3,203	1,700	2,701	0	0
	Pfizer	0	-2	-3	-3		803	1,337	2,261	-3	1,161	1,161	0	0
	Total	0	-2	-3	-3		1,050	1,571	3,332	3,200	2,861	3,862	0	0
Weekly Capacity								**4,900**	**4,900**	**4,900**	**4,900**	**4,900**	**0**	**0**
are Weekly Capacity								**3,329**	**1,568**	**1,700**	**2,039**	**1,038**	**0**	**0**

37

Tithe Farm will continues to provide first and second doses until the end of April 2021.

Around 75% of their capacity will be for administrating second doses, the remaining capacity will be for first doses.

Site Plan: Byron

	1st Dose - wc	07/12/2020	14/12/2020	21/12/2020	28/12/2020		04/01/2021	11/01/2021	18/01/2021	25/01/2021	01/02/2021	08/02/2021	15/02/2021	22/02/2021
1st Dose administered	AZ	0	0	0	0		1	292	1,079	1,683	3,157	1,444	604	0
	Pfizer	0	0	0	0		0	1,146	2,272	1,148	0	1,158	1,155	0
	Total	0	0	0	0		1	1,438	3,351	2,831	3,157	2,602	1,759	0
Days between Dose		21	21	70	70		77	77	77	77	77	77	77	77
	2nd Dose - wc	**28/12/2020**	**04/01/2021**	**01/03/2021**	**08/03/2021**	**15/03/2021**	**22/03/2021**	**29/03/2021**	**05/04/2021**	**12/04/2021**	**19/04/2021**	**26/04/2021**	**03/05/2021**	**10/05/2021**
2nd Doses to deliver	**AZ**	0	0	0	0		1	292	1,078	1,682	3,157	1,444	**2,530**	0
	Pfizer	0	0	-5	-2		-6	1,146	2,259	1,143	0	1,158	**3,477**	0
	Total	0	0	-5	-2		-5	1,438	3,337	2,825	3,157	2,602	6,007	0
Weekly Capacity PCN site (at 4 days per week)								**9,600**	**9,600**	**9,600**	**9,600**	**9,600**	**9,600**	**9,600**
Weekly Capacity mass vacs site (at 3 days per week)								**7,200**	**7,200**	**7,200**	**7,200**	**7,200**	**7,200**	**7,200**
Spare Weekly Capacity after second doses given								**15,362**	**13,463**	**13,975**	**13,643**	**14,198**	**10,793**	**16,800**
	At PCN site							**8,162**	**6,263**	**6,775**	**6,443**	**6,998**	**3,593**	**9,600**
At Mass Vaccs site								**7,200**	**7,200**	**7,200**	**7,200**	**7,200**	**7,200**	**7,200**

Assuming The Hive closes at the end of April - 381 AZ and 737 Pfizer patients will be redirected to Byron Hall on Week Commencing 3rd May.
Assumes mass vaccination sute operational from 29/3

Daily capacity at Byron Hall is currently 1,200 appointments as a PCN site only. This will be extended to 2,400 per day through the additional vaccination stations. This will extend provision to 9,600 vaccines per week.

The above modelling is completed on this basis on the mass vaccination centre operating 3 days per week and PCN site operating 4 days per week – at the same levels of daily capacity. Figures are based on the Hive and Tithe Farm closing and all second doses being delivered from Byron from the first week of May.

Delivery risks

- There is agreement between parties for the proposed operational model at Byron Hall. Operational detail is currently being worked through.
- The additional pharmacy sites to be secured to ensure good geographical access for the Harrow population.
- We need to ensure that pharmacy sites become part of our local partnership arrangements so that all modes of delivery in Harrow are focused on vaccination for our entire population, not just the low hanging fruit.

Ensuring equity of uptake (1)

Comprehensive borough plan in development and being implemented concurrently. Key elements include:

- **Use of Robust Links with Communities and Local Knowledge** – The early phase of the Covid-19 pandemic and the engagement work carried out by the council has further strengthened strong community links with numerous target groups in the borough. Future vaccine-related community engagement is well-placed to use these intensified links to ensure that key messages are transmitted in community languages, through the appropriate channels specific to the needs of each community group.
- **Targeted approach –**community engagement work highly targeted, reaching the most vulnerable groups as a priority, including those with language barriers. This will ensure that resources are used optimally, delivering the greatest public health impact. Communities that have less economic and social vulnerability and have higher resilience and inbuilt capacity (social capital), frees up the council to work with them through universal communications to produce the same outcomes as some of the more vulnerable groups. The use of Covid related funds from sources like MHCLG could be used to deliver targeted work with at risk BAME community groups in the form of a Covid-19 Awareness Fund. This will leverage community infrastructure, use existing trusted networks, and allow multiple projects with numerous community groups to progress efficiently.

Ensuring equity of uptake (2)

- **Combating vaccine hesitancy -** It is undoubted that the key thrust of the community engagement in this phase should be around combating the misinformation and distrust that is prevalent in relation to the Covid-19 vaccines. As studies from the World Bank have shown in relation to the Ebola vaccine, "knowledge does not equal trust".. Combating this will involve specialised work which can address the issues raised by newer research and polling showing higher rates of vaccine hesitancy among Black and Asian groups.
- **Identifying and creating local advocacy -** The involvement of leaders from local communities, trusted professionals, community members etc is critical to producing trust and community buy-in. An important strand of this work will be to work with faith communities to debunk some of the myths such as the products used in Covid vaccines containing substances like porcine gelatine, as is common in some flu vaccinations.
- **Vaccine Webinar followed by intensive engagement –**Because of the urgency of reaching out to community groups, Harrow has organised a large-scale Covid-19 vaccine webinar to reach out to as many members of the community as possible in the first instance. From this, the council will be commencing subsequent targeted work with communities that have higher linguistic and socio-economic needs.

This page is intentionally left blank

GP and Dental Service Access in Harrow

A report by Healthwatch Harrow

January 2021

healthwatch Harrow

“I was satisfied when I used the online form for a known condition and the doctor called me back.

However, I need to speak to/see a doctor about a new condition and can’t book an appointment online and can’t get through on the phone.”

Local GP Patient

Contents

		Page
1.	Executive Summary	5
2.	Background	8
3.	Methodology	10
4.	Factors to Consider	10
5.	GP Services	12
6.	Dentists	22
7.	Glossary of Terms	30
8.	Distribution and Comment	30

Demographics Appendix 1

This page is intentionally blank.

1. Executive Summary

Healthwatch Harrow has been the residents local voice and consumer champion for health and social care across the London Borough of Harrow since 2013. We remain totally independent and engage with the residents of Harrow and work with various organisations. Our role is to gather intelligence / evidence, to check and challenge service delivery, identify where services need to change and make recommendations to the CCG, Council and other health and social care providers.

Access to General Practice's (GP's) and Dental Services is an issue that we are increasing hearing about, which resulted in our undertaking further investigation, the findings of which are included in this report. Section 3 provides the details of our methodology. In summary the findings are based on our survey, mystery shopper exercise, trend analysis reports and feedback from residents through our outreach.

This last year has been an extremely difficult year for everyone as a result of the pandemic, particularly those people working within the NHS. We fully recognise the hard work that is being undertaken as we write this report. The purpose of our report is to share what Harrow residents are saying to us. There is general awareness of the issues that need to be addressed. This report is written in the spirit of collaborative working, knowing how hard people are working but also recognising that patients have the right to access services and to clearly understand how they can do this.

Due to our limited resources this report is not presented as research, but as a snapshot of our findings, what people are saying to us, particularly those from the Black, Asian and Minority Ethnic (BAME) Communities, which is the area we are commissioned to focus on. We also would like the thank all the residents who engaged in this work and our Healthwatch Volunteers for their dedication, hard work and support.

Key Findings: Themes

100 people completed the survey during November and December 2020. This is a summary of key themes and issues and our recommendations.

GPs

- Just 16% of respondents have found it 'easy' to obtain an appointment, with 43% finding it 'difficult'.
- Of those experiencing problems, over half (58%) cite telephone, and 42% state online related issues. Around half (48%) could not obtain an appointment at their own practice.
- On contact, the telephone is significantly the most popular method (82%).
- While 70% of respondents are comfortable with telephone booking, just 54% are comfortable with telephone consultations.

- While 51% of respondents are comfortable with online booking, just 34% are comfortable with online (video) consultations.
- 64% of respondents are satisfied with services overall.
- Those with Mental Health conditions, Carers, Black, Asian and Minority Ethnic (BAME) respondents and those of working age are disproportionally impacted, in terms of access, confidence across platforms and overall satisfaction.

Dentists

- A third of respondents (33%) have found it 'easy' to obtain an appointment, with a larger number (44%) finding it 'difficult'.
- 27% have experienced difficulty in obtaining an emergency appointment.
- 63% of respondents are registered with an NHS dentist, however some have recently been de-registered or advised to go private.
- On contact, the telephone is by far the most popular method (95%).
- 86% of respondents are satisfied with services overall.
- Those of working age are least satisfied, or able to access services.
- Local dentists reported that Harrow do not have enough Units of Dental Activity, so run out of their allocation for NHS treatment which means they have to offer treatment at private fees.

Equality Check

When compared with White/White British respondents, we find that those from BAME backgrounds are more likely to:

- Find it difficult to obtain a GP appointment.
- Be registered with an NHS dentist.

And less likely to:

- Be satisfied with the outcome of GP or Dental Services.
- Feel confident to use telephone or online services for GP access.
- Struggle to access a dentist with pain or problems.

Key issues and recommendations

In summarising the key issues recommendations we would like to highlight the general concerns raised do not relate to the quality of care that people receive, the issues that need to be addressed relate to accessing services.

In addition, there are general concerns around what provision is being made for the increase in populatuion in Central Harrow for exampe with the Kodak development, it is unclear what provision is being made to support these emerging communities, which must present a challenge to the current providers.

Our findings show that even during a pandemic, the impact of people's experiences when they need to access health and social care can have a worrying effect on confidence in the system. This can cause mental anguish.

Feedback varies between different GP practices ranging for example from basic customer service standards seeming to slip at GP practices, telephone receptionists being inflexible and not passing messages on whilst others report getting a great service.

It is important to note that our recommendations are Harrow wide and may not relate to all GP practices. For example, there has been some excellent joint working between Healthwatch Harrow, Ridgeway Surgery, CCG and the Romanian community in producing some key information in Romanian, to enable better understanding and access.

Digital access is a known issue across Harrow, we have not included this as a recommendation as there is already a programme of activity to address. However, it would be prudent to monitor the success of this work.

Key Issues:

- GP Telephone systems and online booking systems are not efficient to meet the demands / needs of patients needing to contact the surgery.

- Commissioning of NHS Dental Care is not meeting current demand.

- The Black, Asian and Minority Ethnic (BAME) communities are disproportionately affected in accessing services.

- Accessibility is particularly an issue for those patients with language, mental health and learning disabilities.

Recommendations:

1. CCG to work with the Primary Care Networks and Harrow GP surgeries to put in place more improved, quicker and easier accessible phone and online appointment booking systems to reduce patient waiting times and cancelling appointments, and to review the effectiveness of their GP texting service in reducing missed appointments.

2. NHS England to review the commissioning of NHS Dental Care in Harrow, to ensure commiussioning is kept up to date with demand and that the dental contract is fit for purpose. For example, one element is the Units of Dental Activity (UDA'S), as each dental practice is commissioned for a set number of UDA's and in Harrow this is not meeting the current demand. Please see Healthatch England report for further information:

https://www.healthwatch.co.uk/report/2016-11-23/access-nhs-dental-services-what-people-told-local-healthwatch

3. Primary Care Networks, GP practices and Dental Surgeries to work collaboratively with the Black, Asian and Minority Ethnic (BAME) communities to further understand the issues which are affecting these communities in accessing services e.g. language barriers, lack of digital access etc. and to put a plan of action in place to address these issues.

4. CCG to work with the Primary Care Networks and Harrow GP surgeries to improve accessibility particularly for those patients with language, mental health and learning disabilities.

This report will be shared with all key stakeholders, particularly those who commission the services and also with the Harrow Health & Care Executive, Health & Wellbeing Board and the Health & Social Care Scrutiny Sub Committee and NHS England. Healthwatch Harrow will work collaboratively to ensure appropriate action is taken.

2. Background

In 2017 Healthwatch Harrow produced a GP Access report to see this, click the following link: Healthwatch Harrow GP Access Report June 2017

In this report the following recommendations were made:

1. Ensure Harrow GP surgeries are able to put in place more improved, quicker and easier accessible phone and online appointment booking systems to reduce patient waiting times and cancelling appointments, and to review the effectiveness of their GP texting service in reducing missed appointments.

2. Improve GP accessibility particularly for those patients with language, mental health and learning disabilities.

3. Provide clearly displayed and easy to understand updated information in their surgeries and websites information on translation services, local advocacy services, booking an online appointment, registration and how patients can make a complaint and Healthwatch Harrow information to explain how people can share confidential feedback on their experience, whether good or bad.

4. Create and provide increase public awareness of how to appropriately access and use A&E, Urgent Care, Walk in Centres, NHS 111, 999 information, pharmacy and Harrow Health Help App Now by advertising and providing clear and consistent signposting updated information to patients on GP websites, their out of hours telephone messaging, developing public awareness leaflets and through community outreach awareness workshops to reach all sectors of the Harrow community.

5. Develop and adopt better sharing of good internal standard models of practice and policies at both governance, operational and online levels working practices to ensure consistent and good standard of practice around accessibility and recognising that one size does not fit all, and ensure the services are responsive to meet the needs of its different communities of Harrow.

With the onset of lockdown in March 2020 due to Covid 19 there was a shift in how people access their GPs. Feedback from the community prior to Covid 19 showed peoples experiences were varied with some unable to get through to their GP surgeries, since then the level of dissatisfaction has greatly increased, as evidenced through our Trend Analysis Reports.

It is disappointing to see that some of our previous recommendations have not been addressed, please click the following link for our Trend Analysis Report:

GP Patient Experience, 01.01.20 - 31.12.20.

For more of our reports please visit:

https://www.healthwatchharrow.co.uk/insight-and-reports.

There has understandably been a shift in how we access GP Surgeries such as using online platforms for booking appointments and for requesting repeat prescriptions. However, this has exposed the inequalities in Harrow not all families can afford digital resources. Some patients can only access services by telephone or mail and these are the issues that have been fed back to us.

In addition, we have been increasing getting more issues raised with us around the difficulties in getting NHS dental appointments, as most dentists had to reduce what was on offer to patients because of the risk of infection and some dentists struggled to find adequate PPE during the first phase of the pandemic.

To gain an insight into the extent of the problem we did some investigative work between November and December to ascertain the extent of these issues, so that we would have evidence to share with stakeholders who influence and commission GP and dental contracts. The findings of this work form this report.

3. Methodology

1. We produced a survey, seeking feedback on GP and Dental access to services, which was shared with all our stakeholders in Harrow. This reached up to 500 people within Harrow by email, through our newsletter and our social media channels. The survey ran for 8 weeks till early January 2021.

2. Our volunteers engaged in a Mystery patient exercise targetted at all 32 GP surgeries in Harrow to identify how easy it was to access the surgery by phone to make an appointment.

3. We held a focus group on dental care held in Q3 which was attended by 20 people. The feedback from this engagement session is included within this report in section 6.

4. We specifically forcussed on the harder to reach BAME communities, who traditionally have not got engaged in our online surveys so we could capture their opinions and share their stories.

5. Through our regular outreach sessions with the Somalian and Romanian communities we engaged to share our survey with their members. This included Harrow College who kept it on their intranet for 6 weeks.

6. We also captured intelligence we have recieved through the direct contact we receive through emails and phone calls from the public.

4. Factors to consider

When working on this report, the following factors influenced the findings:

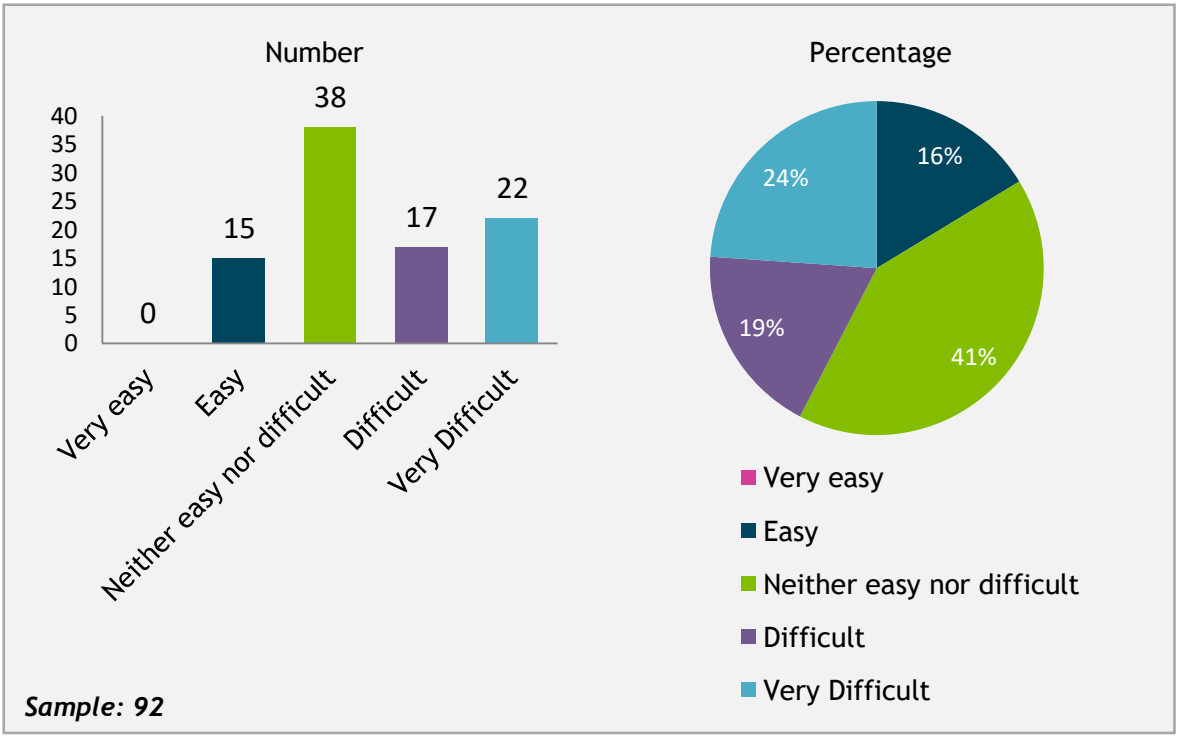
- Face to face sessions could not be held and so the reach of our target audience was limited. Our outreach sessions were accessed through zoom and Microsoft Teams.
- IT literacy meant that some people were unable to feedback and had to rely on others to feedback to us.
- Paper based surveys were discouraged as it was felt during phase 1 of the lockdown that paper could spread the virus.
- Inequalities within the population of Harrow reflected in poverty and IT literacy.

- Diversity of Harrow residents resulted in language barriers and some of the communities were busy supporting the needy and had in some cases also to juggle home schooling.
- Pandemic has meant that everyone is working under pressure and prioritising with limited resources.
- Since GP practices and dentists are private businesses, there is inconsistency in the approach to messaging their patients which impacted on the feedback against specific GP surgeries.

5.GP Services

In this section we evaluate feedback around GP access, including ability to get appointments, contact methods and confidence in their use, and overall satisfaction with the experience. We have also included the findings from our mystery shopper exercise.

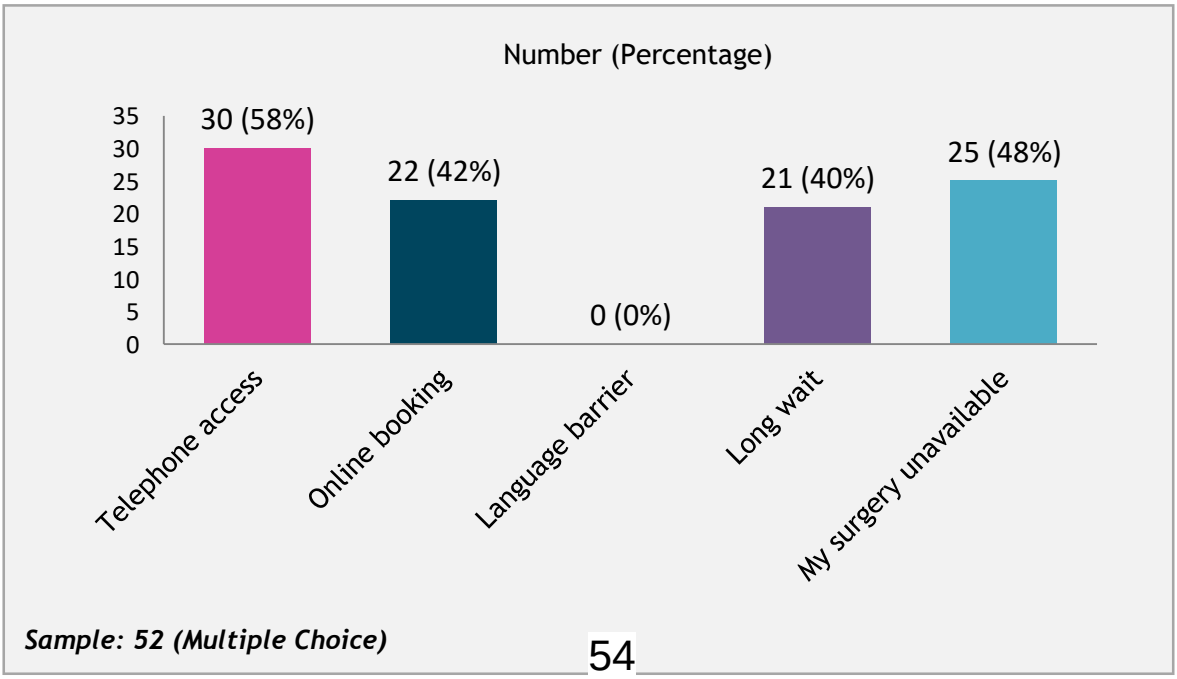
5.1 How easy is it to get an appointment with a GP - since the pandemic (March 2020)?



Sample: 92

43% of respondents have found it either 'difficult or very difficult' to obtain an appointment since the pandemic started in March 2020. While 16% found it easy, it is notable that nobody said the experience was 'very easy'.

5.2 If difficult what was the issue?



Sample: 52 (Multiple Choice)

For those experiencing difficulty with access, over half (58%) cite telephone related issues, while over a third (42%) suggest a problem with online booking.
Around half (48%) said appointments were not available at their practice, and 40% experienced long waiting times. Nobody said language has been an issue.

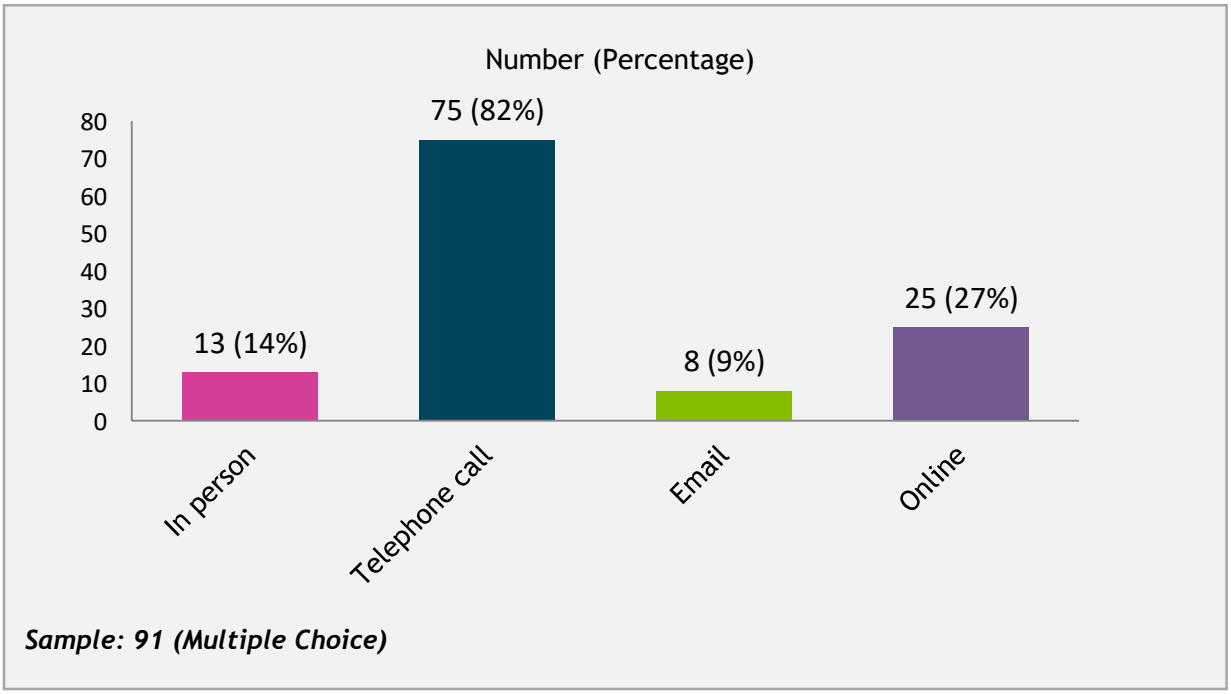
We hear that some patients have experienced difficulty with both the telephone and online systems. It is also reported that online booking does not cover all situations, and may be more difficult to use when feeling ill. One person has not been able to access their GP at all in 2020, resulting in difficulties with referrals.

Selected Comments

"I was satisfied when I used the online form for a known condition and the doctor called me back, however I need to speak to/see a doctor about a new condition and can't book an appointment online and can't get through on the phone."

"I had acute stomach pains and continuous vomiting. Phoned my GP practice - recorded message saying go online and fill in loads of forms. Impossible to do when you feel so ill plus the forms did not reflect my symptoms. Phoned again and waited until receptionist answered. Was told that someone would phone me back later that day. Nurse telephoned me and when hearing my symptoms said that I needed to see a doctor (I know, that is why I'm trying to contact you)! Only problem, no appointments. She booked me into the Pinn Medical Centre where I saw a GP who was able to diagnose and prescribe medication. As he was not my GP however, he was unable to refer on for exploratory scans. Said if it got worse, I should go to A&E. As I am shielding this is not a good idea. I have not seen a doctor from my surgery this YEAR. Last time I was also sent to the Pinn Medical Centre. If I could move to that practice I would as mine is shambolic."

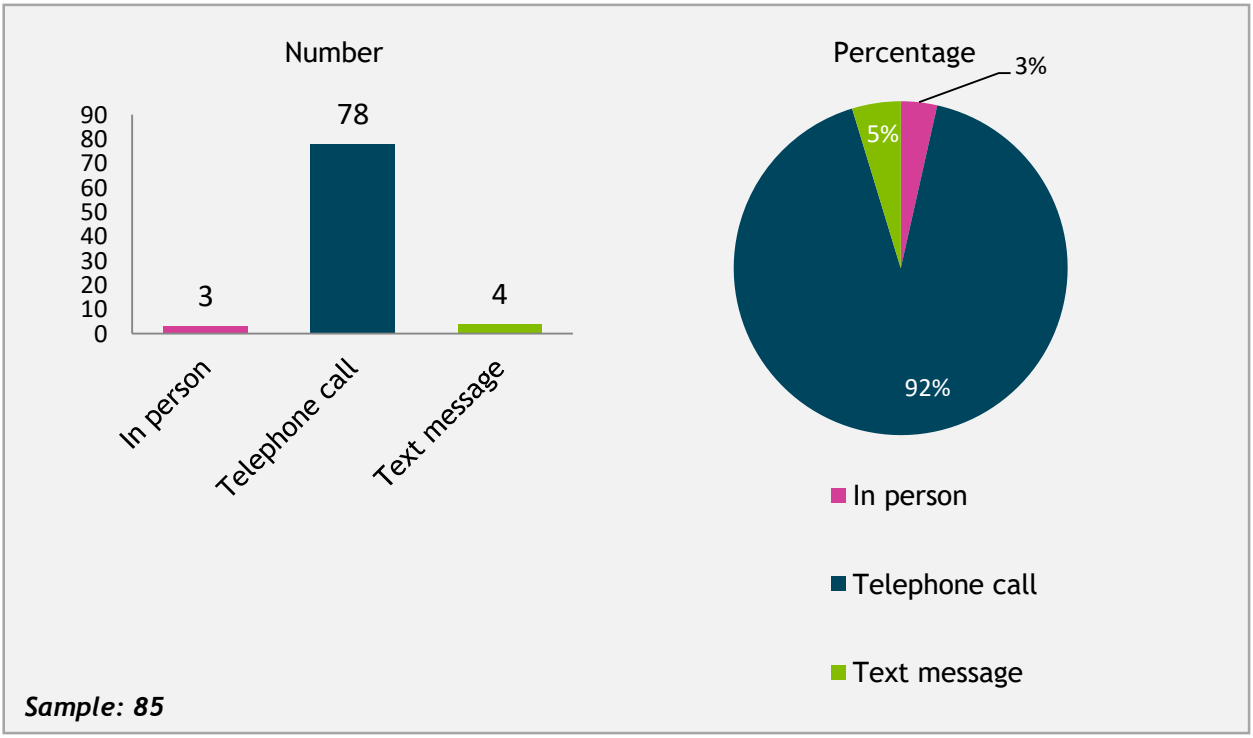
5.3 How did you contact your GP Practice during the pandemic (from March 2020)?



Sample: 91 (Multiple Choice)

At 82%, the telephone is clearly the most popular method of contact.

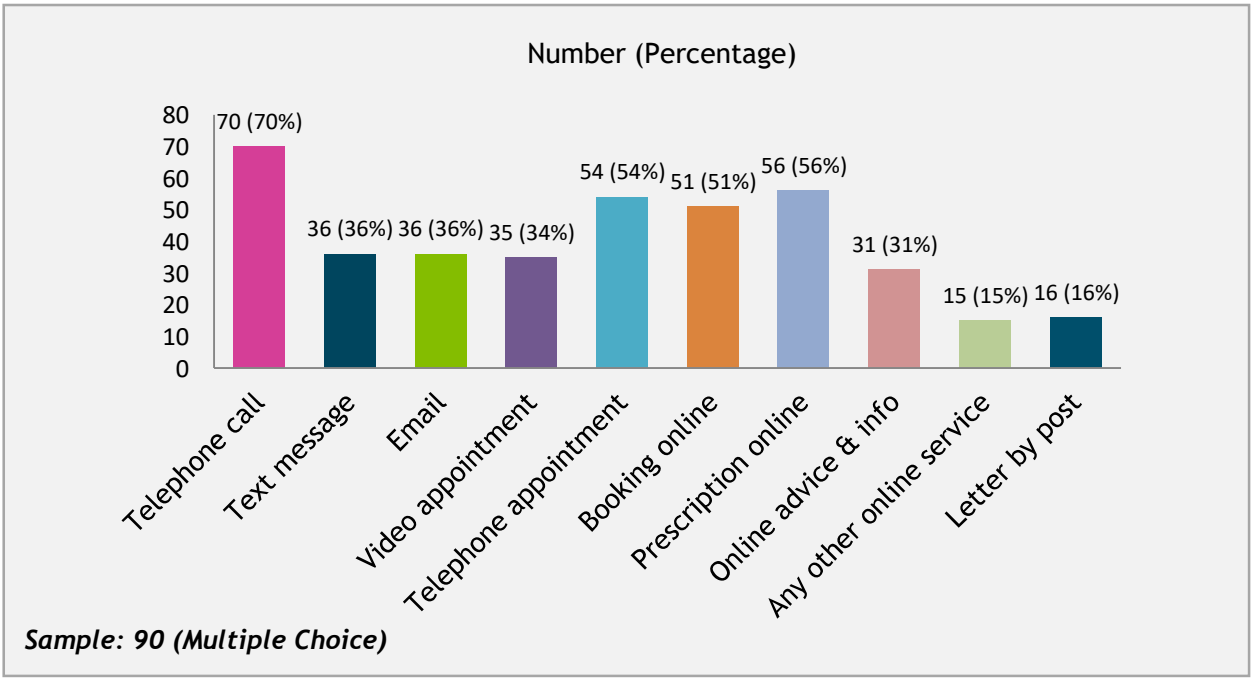
5.4 If the GP contacted, you - how did they do this?



Sample: 85

The vast majority of those contacted by the GP (92%) received a telephone call.

5.5 Do you feel confident accessing services at your GP by the following methods?



Sample: 90 (Multiple Choice)

While 70% of respondents are confident with telephone access generally, a lower proportion (54%) are comfortable with telephone consultations/appointments.

56% of respondents feel comfortable with ordering repeat prescriptions online, and 51% are confident to book their appointments electronically. On other online methods including email, video appointments or access to information and advice, confidence is somewhat lower - generally at the 30% level. It is interesting that just 16% of respondents express confidence in postal letters.

When reviewing feedback, we find that some respondents would prefer a video consultation if the GP does not know them. One person who requested this says it is 'generally not available' at their practice and does not suit all platforms (such as desktop computers).

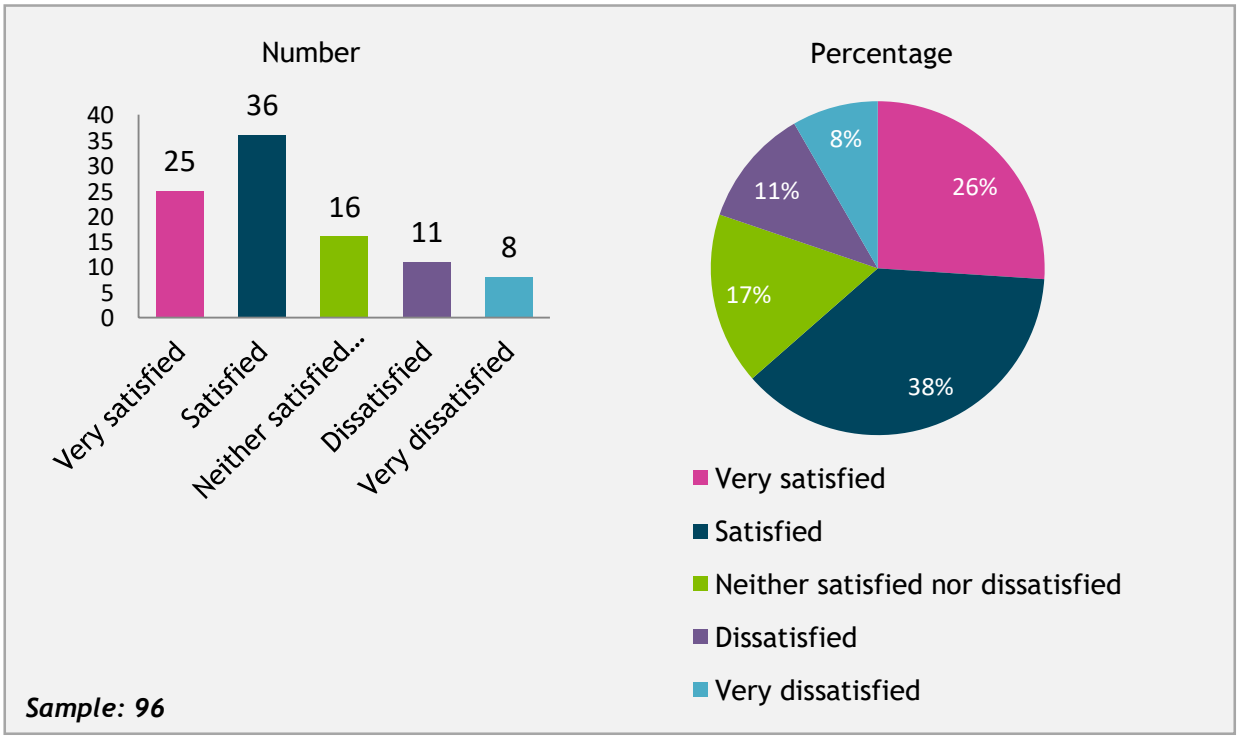
Selected Comments

"Where a face-to-face appointment is not justified in the present circumstances, I think that a video call would feel more personal if I don't already know the particular GP."

"I would like to do video calls with the doctor, but they are generally not available. Last doctor spoken to said they did have a system although she was not familiar with using it and it is only available for smartphones and not desktop PCs, so not possible for us. Reception didn't know any details about the video call system and said it was up to the doctor to arrange."

"Not sure how the online registration system works, too busy to find out - would be good if it could be set up automatically."

5.6 How satisfied were you with the outcome of your contact with the GP practice?



Sample: 96

64% of respondents are either 'satisfied or very satisfied' with the outcome of contact with the GP. Around a fifth (19%) are not satisfied.
We receive accounts of good levels of support, with consultations, prescriptions and referrals accommodated for some patients. Others express frustration at not being able to secure appointments (in one case after four attempts), routine tests or results.

Selected Comments

Positives

"When eventually getting an appointment with the GP I managed to get a personal consultation and additional referrals to clinicians and Northwick Park Hospital."

"The surgery triaged the info I'd entered & then called to say doctor would call. Spoke to GP & prescription sent to pharmacy. Was impressed with the process & happy."

Negatives

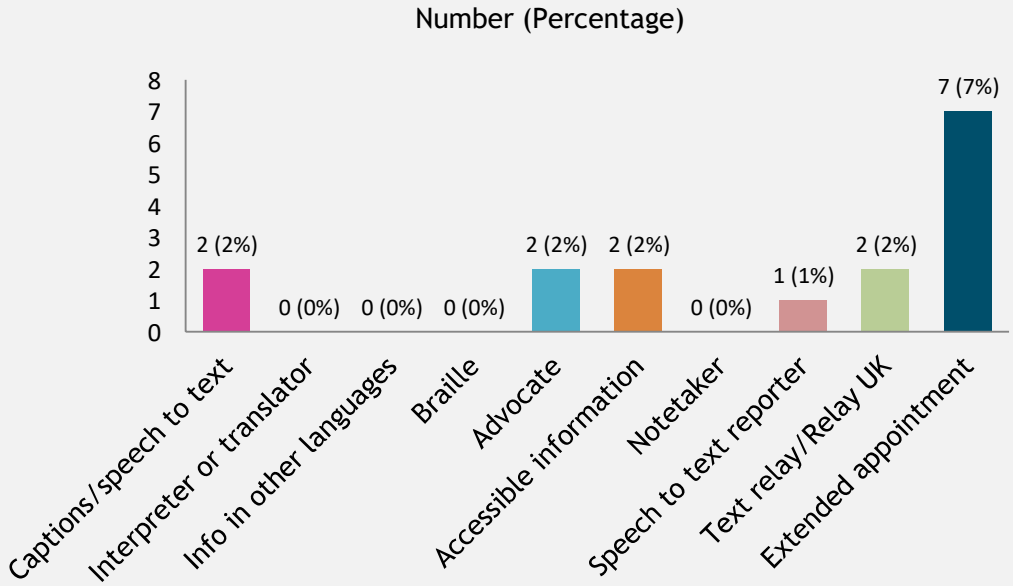
"The surgery has phoned me four times in the last few weeks and told me the doctor would like to see me. I replied that I would like to see a doctor. I was told to wait a moment while she checked the appointments and then I was told there were no appointments. This happened four times and I have to tell someone because it's becoming ridiculous!"

"Not able to talk to GP - receptionist fielding all calls."

"I have undergone a test, but my GP has not contacted me to inform me of my results."

"Have not had a diabetic check since March 2019."

5.7 Do you have access to the following?



Sample: 15 (Multiple Choice)

Extended appointments are the most common method of providing additional support.

5.8 Impact on Specific Groups

We look closely at age, gender, ethnic background and existing conditions, to establish any findings that may be especially relevant to certain groups.

The following 'impact scale' tables highlight all groups which exceed the average (baseline) figure, for key questions.

5.8.1 Found it 'difficult or very difficult' to obtain an appointment since the pandemic:

All respondents (baseline)	43%
Carers	44%
Aged 45 – 64 years	45%
Disability/Long Term Conditions	46%
BAME respondents	47%
Mental Health Conditions	50%

5.8.2 'Satisfied or very satisfied' with the outcome of contact:

All respondents (baseline)	64%
Carers	63%
Aged 25 – 44 years	57%
BAME respondents	57%
Aged 45 – 64 years	55%
Mental Health Conditions	25%

We find that those with mental health conditions are least able to successfully obtain appointments and are also least satisfied overall.

Carers, Black, Asian and Minority Ethnic (BAME) respondents and those of working age are also disproportionally impacted, findings suggest.

5.8.3 Feel confident to book appointments by phone:

All respondents (baseline)	70%
Aged 45 – 64 years	67%
Carers	63%
BAME respondents	60%
Mental Health Conditions	25%

5.8.4 Feel confident to book appointments online:

All respondents (baseline)	51%
BAME respondents	50%
Aged 45 – 64 years	45%
Disability/Long Term Conditions	43%
Carers	31%
Mental Health Conditions	25%

5.8.5 Feel confident with a telephone appointment/consultation:

All respondents (baseline)	54%
BAME respondents	50%
Aged 45 – 64 years	45%
Carers	44%
Aged 25 – 44 years	43%
Mental Health Conditions	25%

5.8.6 Feel confident with a video appointment/consultation:

All respondents (baseline)	34%
Aged 45 – 64 years	33%
BAME respondents	30%
Disability/Long Term Conditions	25%
Mental Health Conditions	25%

Carers, BAME respondents and those of working age are least confident in using both telephone and online systems. It is interesting that those aged 65+ are more confident with both methods, compared with younger peers.

When looking at online specifically, those with disabilities/long term conditions are significantly disadvantaged, compared with others.

Those with mental health conditions are notably least confident of all - in both telephone or online access.

5.8.7 Comparison of ethnic groupings:

	BAME %	W/WB %
Found it 'difficult or very difficult' to obtain an appointment	47%	37%
'Satisfied or very satisfied' with the outcome of contact	57%	65%
Feel confident to book appointments by phone	60%	76%
Feel confident to book appointments online	50%	53%
Feel confident with a telephone appointment/consultation	50%	58%
Feel confident with a video appointment/consultation	30%	38%

Compared with White/White British (W/WB) respondents, we find that those from BAME communities are notably less successful in obtaining appointments, and not as satisfied with the outcome of contact.

BAME respondents are also not as confident in using both telephone and online systems.

Mystery Shopping Exercise

As part of our work looking at access to GP surgeries, we wanted to understand how easy it was for a patient to get through to their GP surgery particularly as due to the pandemic many services have moved online, which does put those patients who do not have digital access at a disadvantage.

We reviewed the websites of all GP surgeries and then our team of volunteers telephoned each of our 32 practices, to assess how easy it was to get though. The intelligence collated related to the following questions:

Q1 How was the telephone call answered initially?

Q2 How long before you spoke to someone?

Q3 Can you book an appointment by telephone?

Q4: Which online booking system is used?

The key findings from this exercise are:

The greater majority of the GP surgeries – 79% operate using a recorded message, which led to a receptionist then answering to speak to the patient.

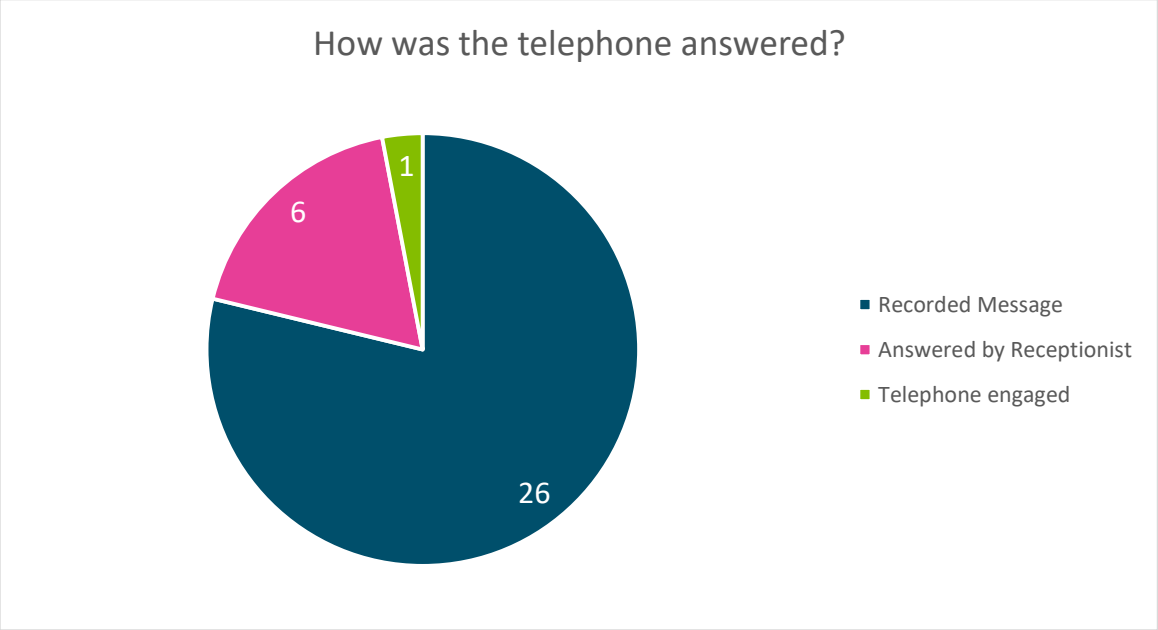
When ringing at a time to get through to a receptionist the majority of calls were picked up within 1 – 5 minutes. It is worth noting that our mystery patient exercise was undertaken by our volunteers who were testing the system to measure ease of reaching a GP through phoning, but they did not have the added pressure or frustration of doing this whilst also potentially feeling particularly unwell.

Q1 How was the telephone call answered initially?

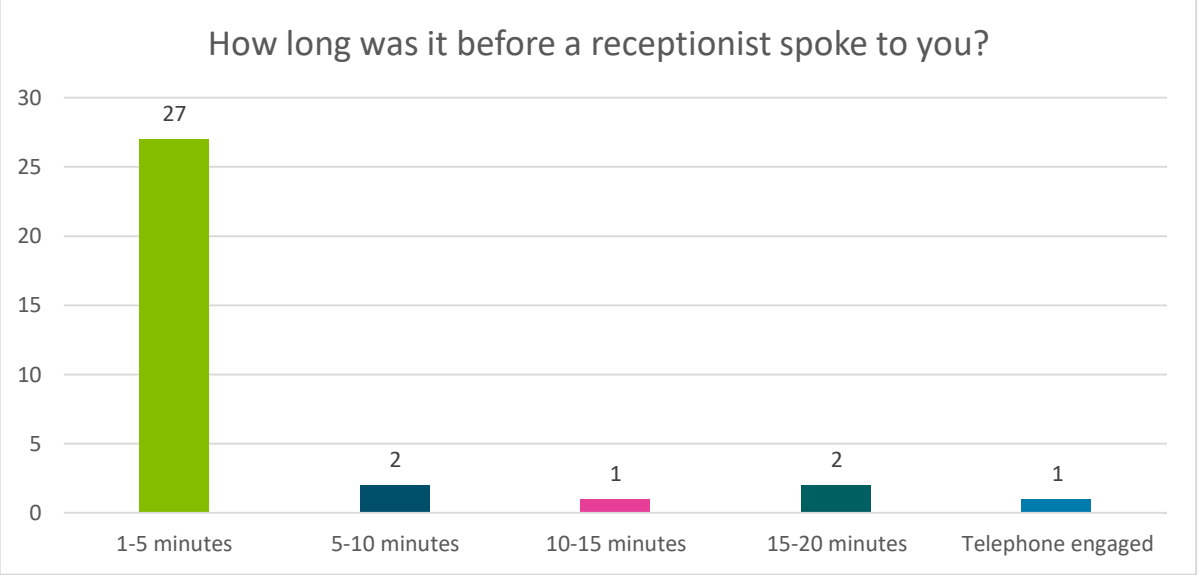
Answerphone/Recorded Message then answered: 26

No Answerphone – straight to receptionist: 6

Engaged and busy lines – 1



Q2. How long before you spoke to someone?



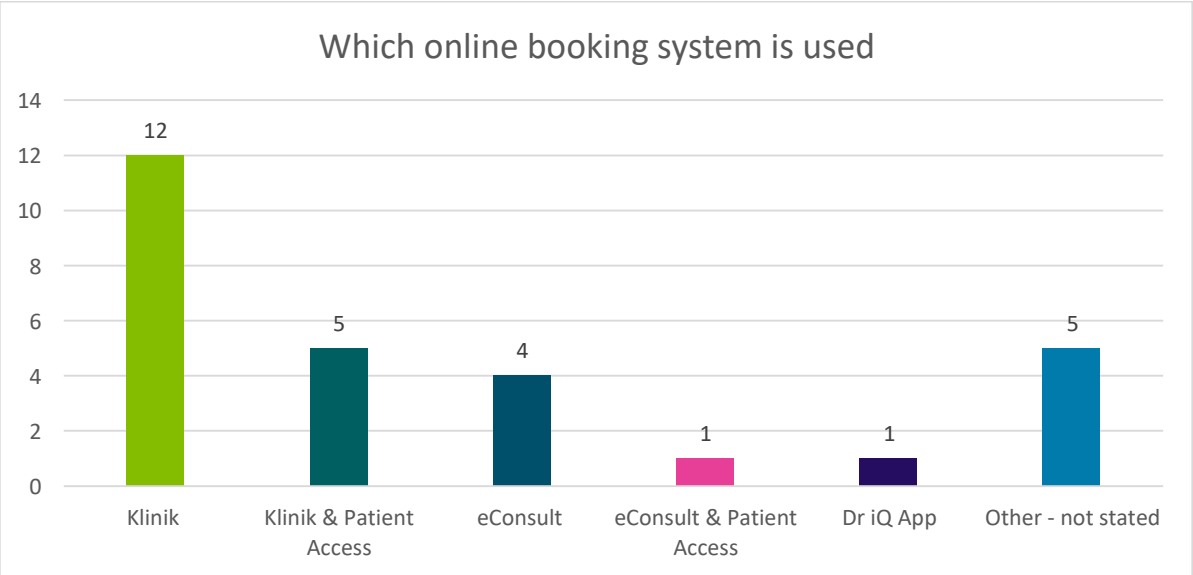
Q3: Can you book an appointment by telephone?

Generally, the majority of surgeries will take telephone bookings – some offer this just for the day's appointments, so if full, patients would need to call back the next day, also the receptionist may book the appointment for you online over the phone.

In some cases, there might not be a telephone booking system, but you book through the receptionist. 25 surgeries confirmed that you can book an appointment by telephone.

Q4: Which online booking system is used?

We found out of the surgeries that we asked, the following confirmed:

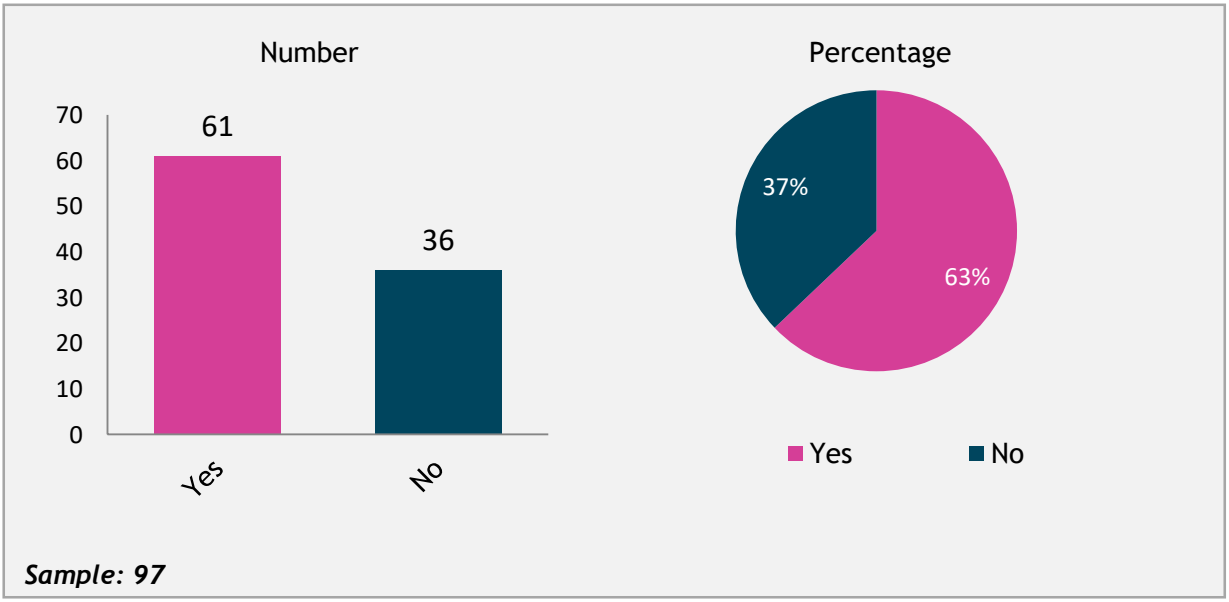


One surgery stated from March 2020 all appointment booking facilities were disabled with telephone booking as the only option.

6. Dentists

In this section we evaluate feedback around dental service access, including registration, ability to get appointments, contact methods and overall satisfaction with the experience.

6.1 Are you registered with an NHS Dentist?



Sample: 97

Around two thirds of respondents (63%) are registered with an NHS dentist. Of the 37% who are not, many are registered with private practices.

We hear that some patients have been either de-registered, or advised by their practices to seek private treatment.

Selected Comments

"My usual dentist has said I am no longer registered with them and cannot register as an NHS patient at this time."

"NHS practice has now told me that I have to go private."

"My dentist tells me that they cannot operate to an acceptable standard within the cash limited services they would have to provide on the NHS."

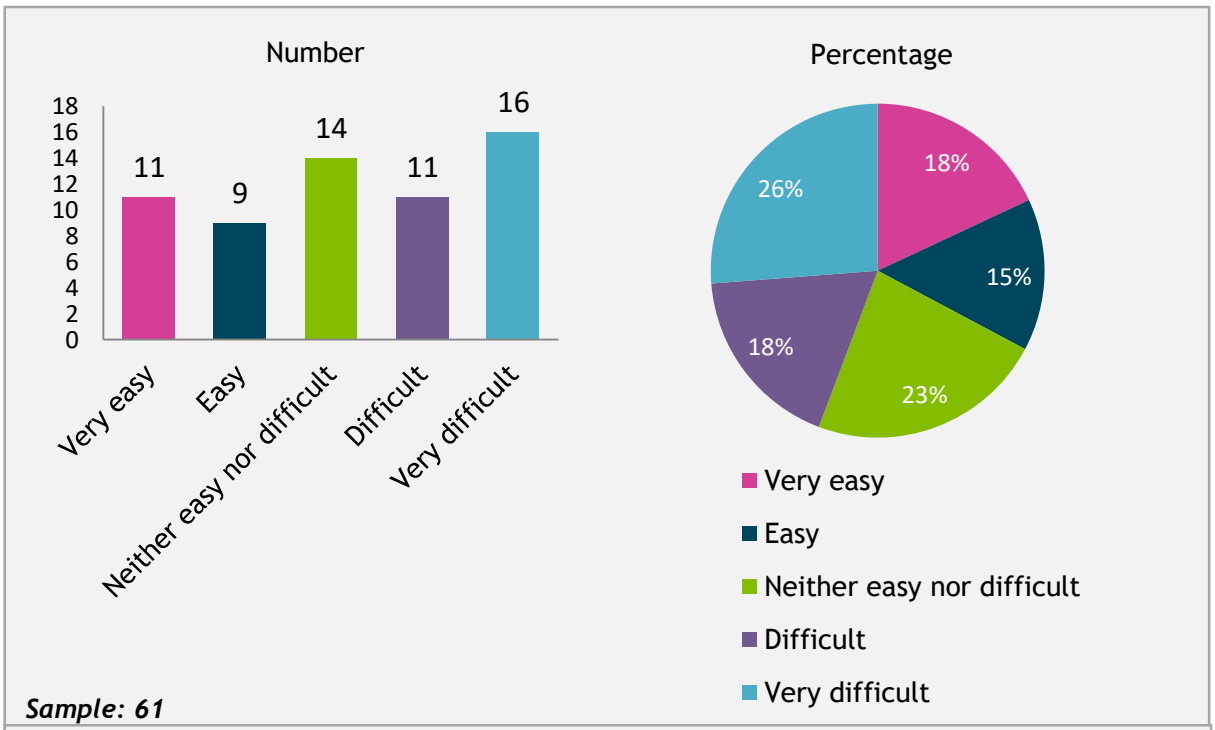
"Difficult to get appointments, they send one letter for check-ups, but no reminders then take you off of their NHS list."

"Trying to get my 2-year-old registered."

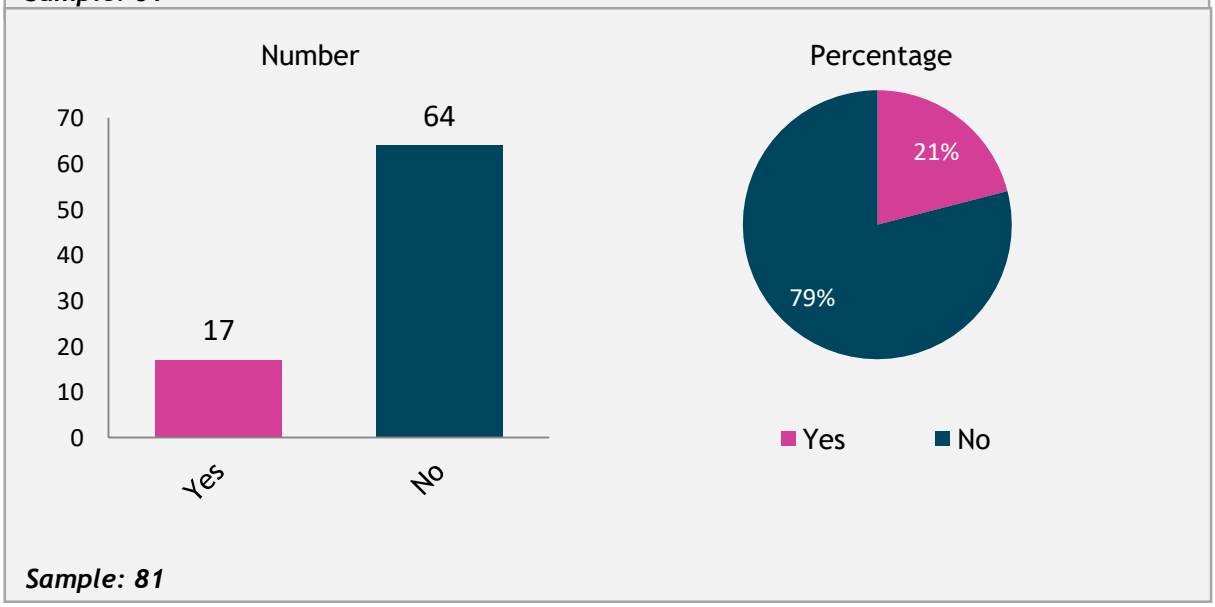
"None available, certainly not at convenient times."

"When we moved to this area many years ago, we were unable to find an NHS dentist. I am now happy with the private dentist I go to, so I don't want to change to another practice."

6.2 How easy is it to get an appointment with a Dentist - during the pandemic (from March 2020)?



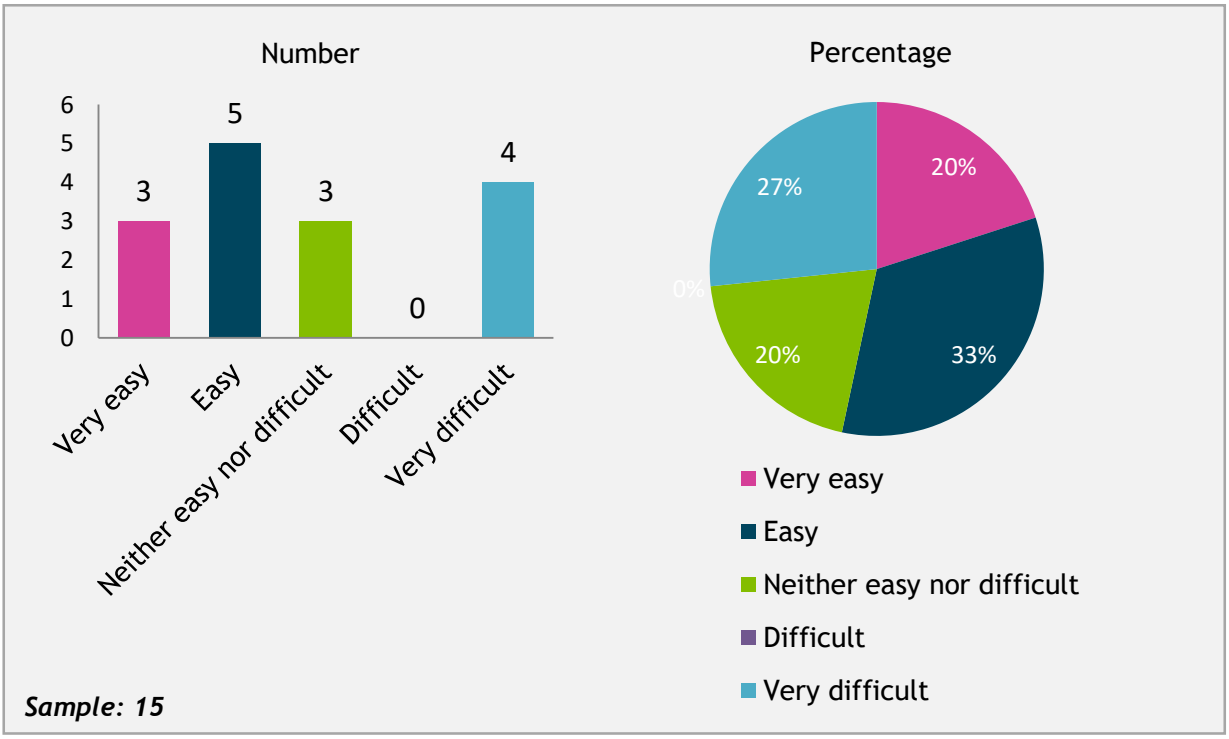
Sample: 61



Sample: 81

Around a fifth of appointments (21%) were for an emergency.

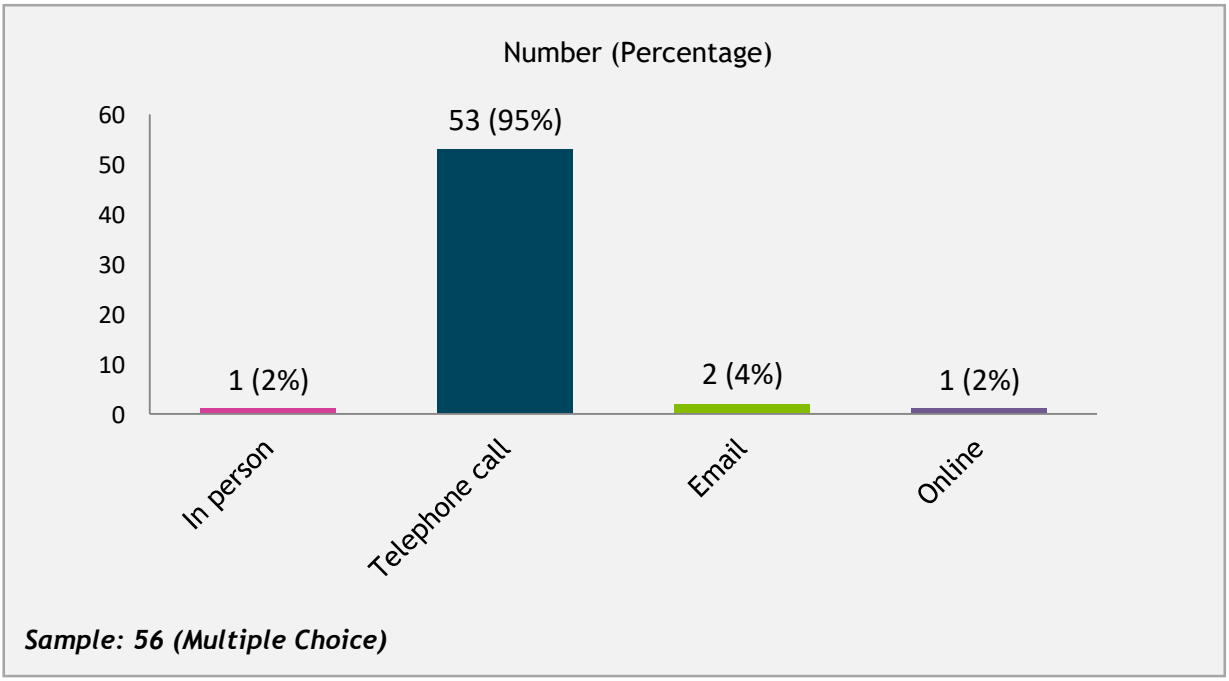
6.3 If yes, how easy was it to get an emergency appointment with the Dentist?



Sample: 15

For those with an emergency, over half (53%) found it easy to get an appointment while a sizeable minority (27%) have experienced difficulty.

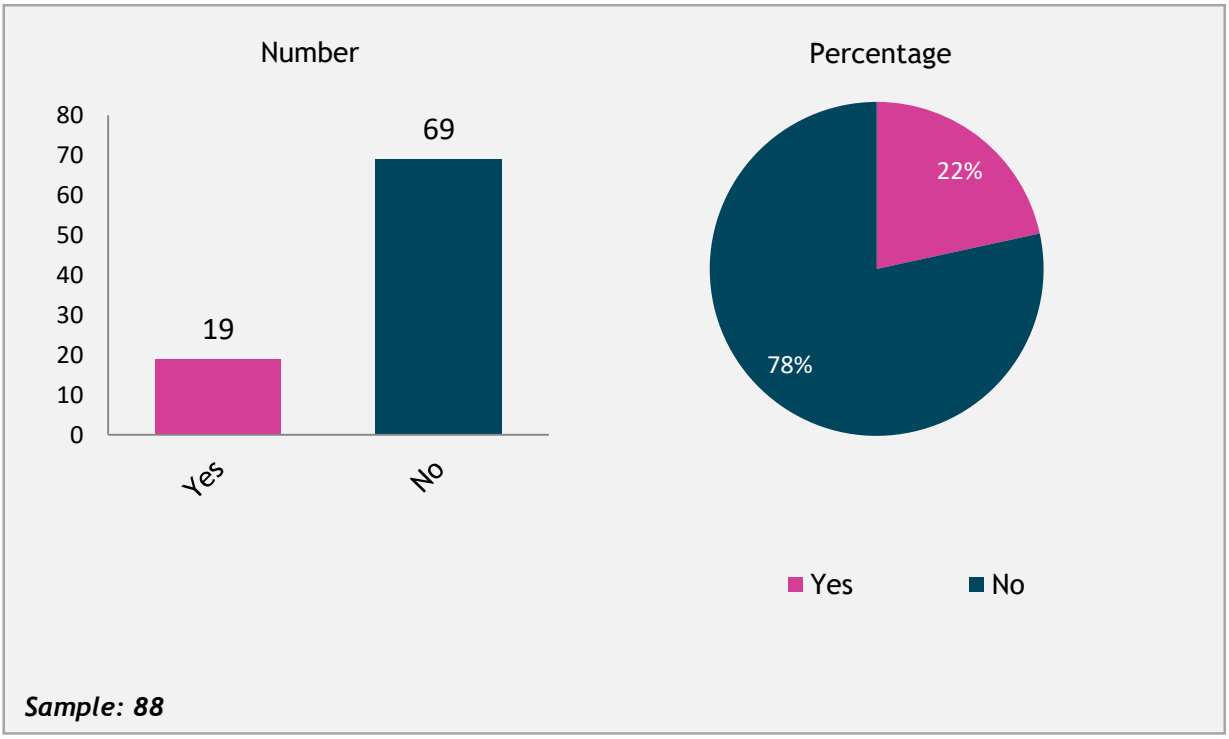
6.4 How did you make an appointment with your Dentist during the pandemic (from March 2020)?



Sample: 56 (Multiple Choice)

On booking, the most popular method by far is the telephone.

6.5 Have you struggled to access a dental service with pain or problems in the last 12 months?



Sample: 88

Over three quarters of respondents (78%) have not struggled to access services with problems or while in pain. A notable minority (22%) have expressed difficulty.

Experiences highlight waiting times (in one case two months for urgent treatment) and difficulty in obtaining access.

Selected Comments

"In July when I had dental pain there were no appointments available until September."

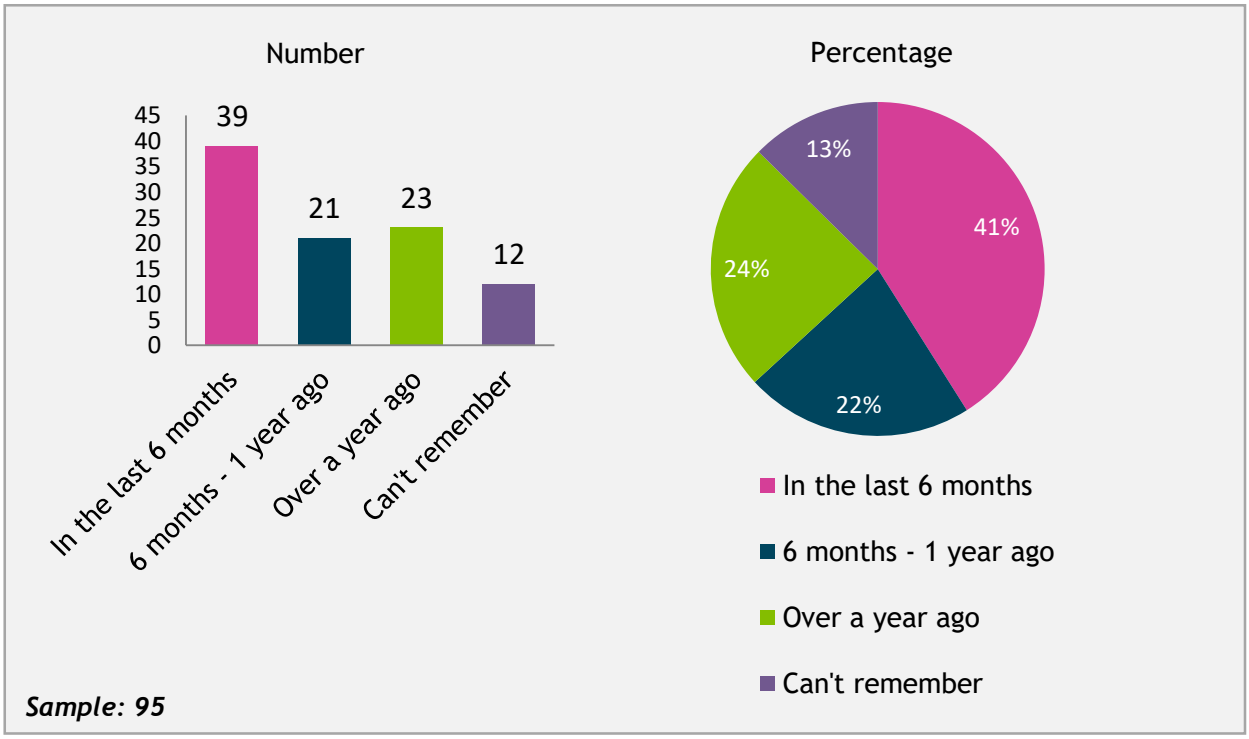
"During pandemic, no appointments available unless established infection."

"I used to go to an orthodontist, but my treatment finished and I am unable to get access to an NHS dentist."

"We do not have our dentist because of Covid."

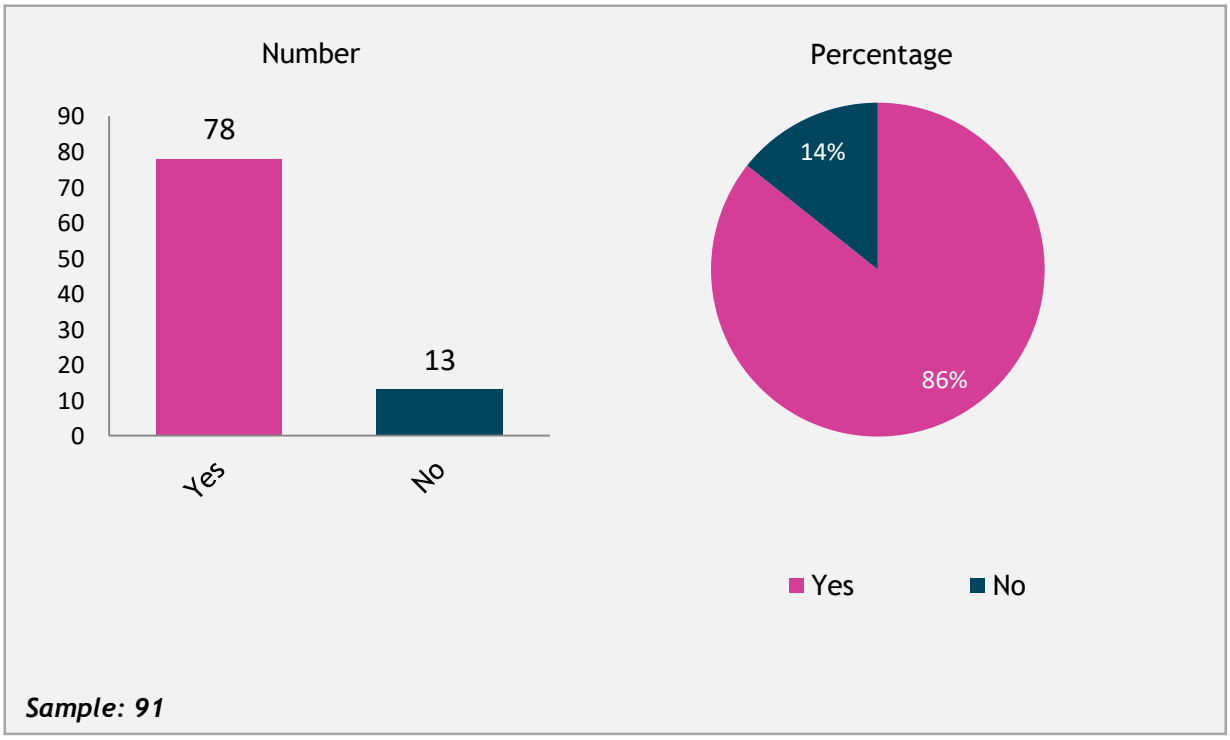
"There were problems for emergency access to dentists because that was the government's request, getting an emergency appointment was either being given antibiotics/tooth out or wait. There were very few dentists confident enough to see patients in the first five months or so since they did not want a patient with the virus and did not want to be in trouble with the department of health. There should have been MORE good dentists available being allowed to see patients."

6.6 When did you last visit the service?



63% of respondents have visited a dentist within the last year, while a quarter (24%) last visited over a year ago.

6.7 Are you pleased with the overall treatment you receive from your dental practice?



The vast majority of respondents (86%) are pleased with the overall treatment received.

We hear that treatment and check-ups have been delayed as a result of the pandemic, a 'cause of concern' for some patients. Waiting times and cost are also cited as issues.

Selected Comments

Positives

"Always able to get an appointment."

"The practice I go to is very helpful and I understand why check-ups were cancelled."

"They provide good advice on dental hygiene and do not appear to do any unnecessary work."

"Because my family paid for me, I'm lucky."

Negatives

"I needed a check-up prior to a hospital appointment. However, during the initial phase of the pandemic, I would not have been able to have treatment as dentists could not use drills. Also, no hygienists were able to give appointments and that is a cause of concern."

"Happy to see a dentist but only an assessment appointment so no treatment could be done. Waiting for the new year to be treated."

"Unable to have a basic check-up."

"They did minimum work and said they would contact me when they are able to do more and have never contacted me."

"Emergency App made by 111. The lady dentist was not confident to pull/remove a dental root! We have to wait 3 months for an app with specialist!!!"

"But it is expensive."

"I had to pay private charges for extraction and treatment."

6.8 Impact on Specific Groups

We look closely at age, gender, ethnic background and existing conditions, to establish any findings that may be especially relevant to certain groups.

The following 'impact scale' tables highlight all groups which exceed the average (baseline) figure, for key questions.

6.8.1 Registered with an NHS Dentist:

All respondents (baseline)	63%
Aged 25 – 44 years	57%
White/White British respondents	56%
Aged 65 and over	48%

Those of retirement age, early working age or from a White/White British background are least likely to be registered with an NHS dentist.

6.8.2 Have struggled to access a dental service with pain or problems in the last 12 months:

All respondents (baseline)	22%
Mental Health Conditions	25%
Aged 25 – 44 years	36%

Working aged respondents are most likely to experience difficulty in obtaining appointments for pain or problems.

6.8.3 Pleased with the overall treatment received:

All respondents (baseline)	86%
White/White British respondents	83%
Aged 45 – 64 years	79%
BAME respondents	70%
Aged 25 – 44 years	57%

Those of working age are significantly least pleased with the overall treatment received. BAME respondents are also disproportionately impacted.

6.8.4 Comparison of ethnic groupings:

	BAME %	W/WB %
Registered with an NHS Dentist	73%	56%
Have struggled to access a dental service with pain or problems	17%	20%
Pleased with the overall treatment received	70%	83%

Compared with White/White British (W/WB) respondents, we find that those from BAME communities are significantly more likely to be registered for NHS treatment, and also notably less pleased with the overall service received.

7. Glossary of Terms

BAME	Black, Asian and Minority Ethnic
W/WB	White/White British

8. Distribution and Comment

This report is available to the general public and is shared with our statutory and community partners. Accessible formats are available.

If you have any comments on this report or wish to share your views and experiences, please contact us.

Healthwatch Harrow, 3 Jardine House, Harrovian Business Village, Bessborough Road, Harrow, HA1 3EX

Contact us

020 3432 2889

info@healthwatchharrow.co.uk

www.healthwatchharrow.co.uk

@HealthwatchHarr

healthwatchharrow

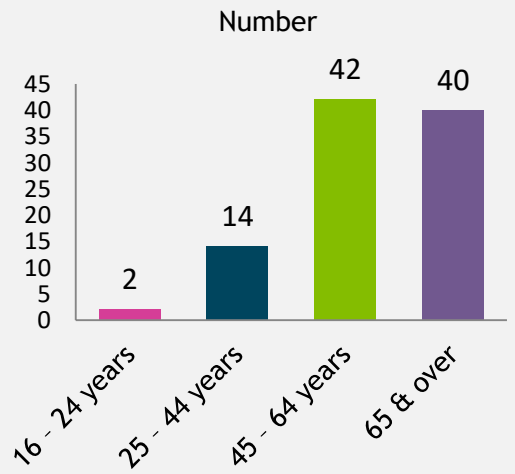
@HWHarrow

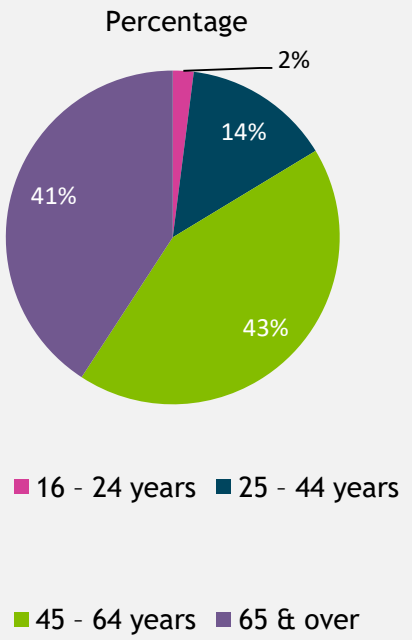
Healthwatch Harrow

Appendix 1 - Demographics

The demographics of participants are stated as follows.

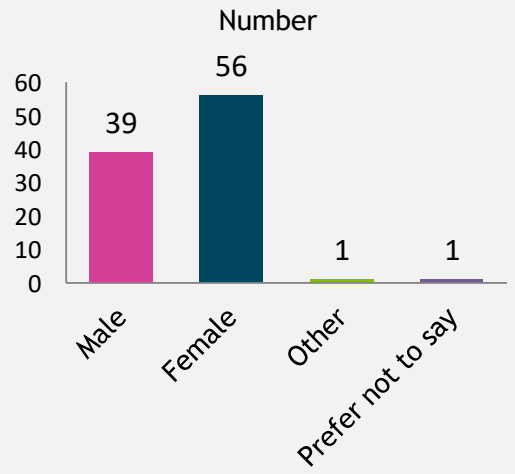
What is your age group?

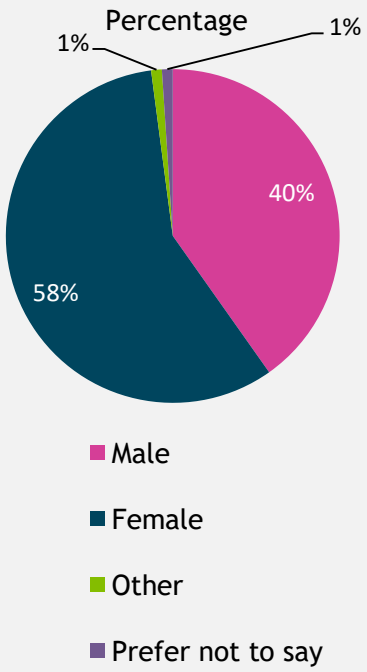




Sample: 98

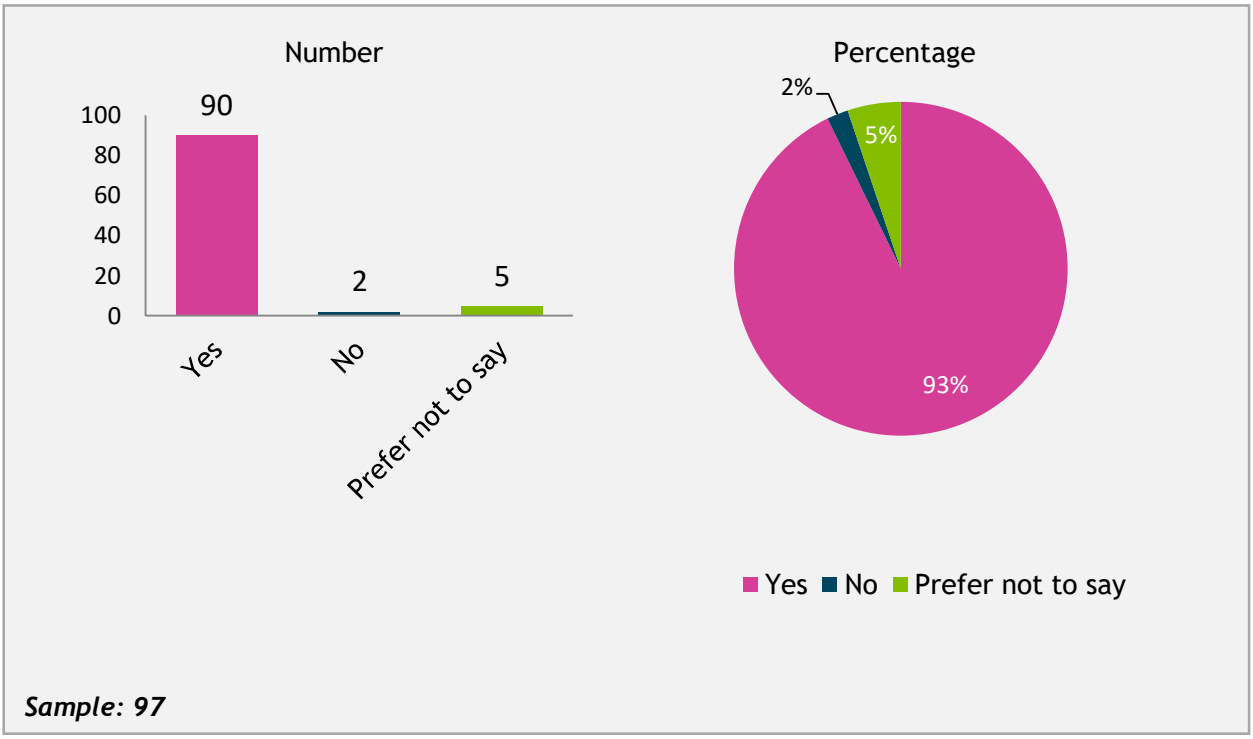
What is your gender?





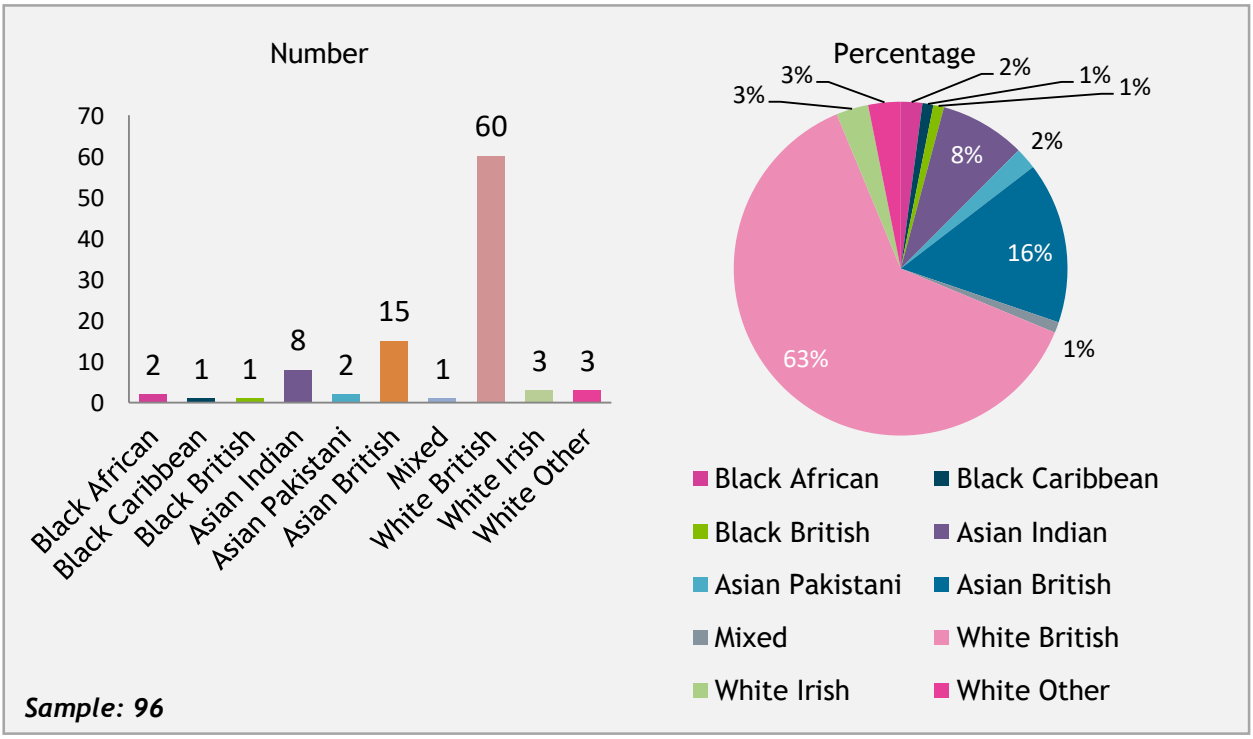
Sample: 97

Is your gender identity the same as assigned at birth?



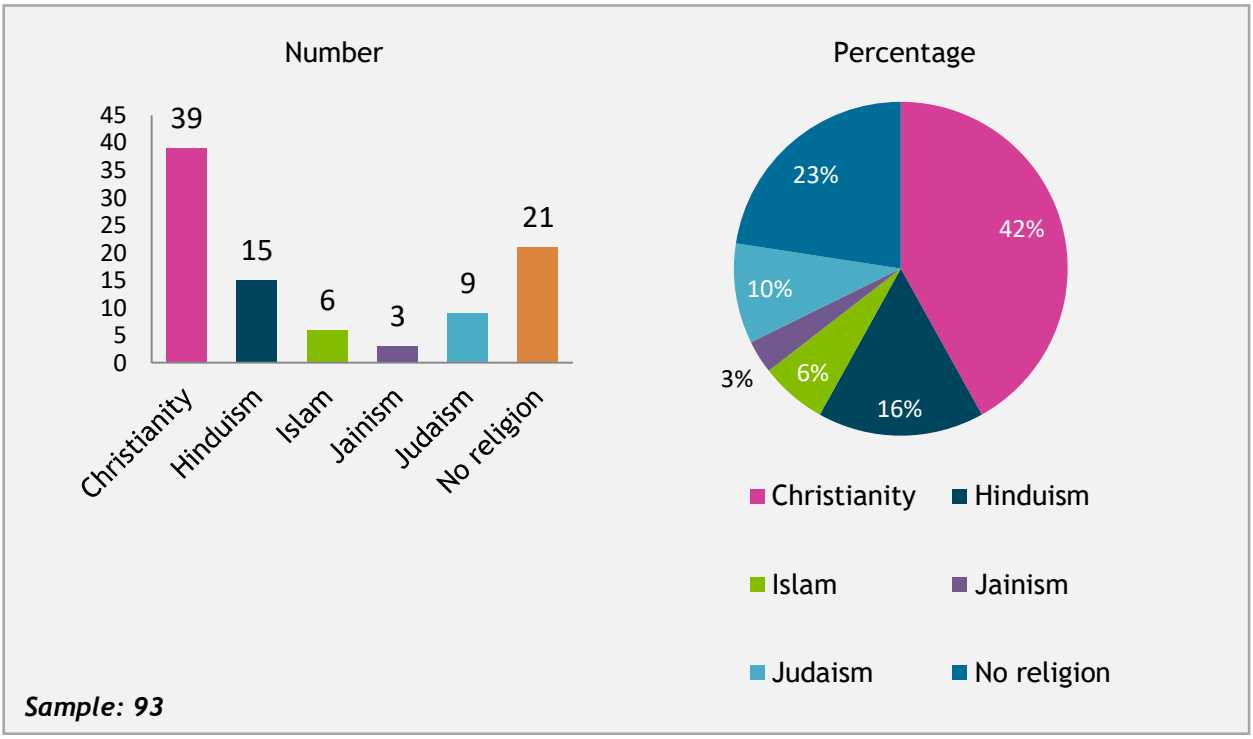
Sample: 97

What is your ethnic origin?



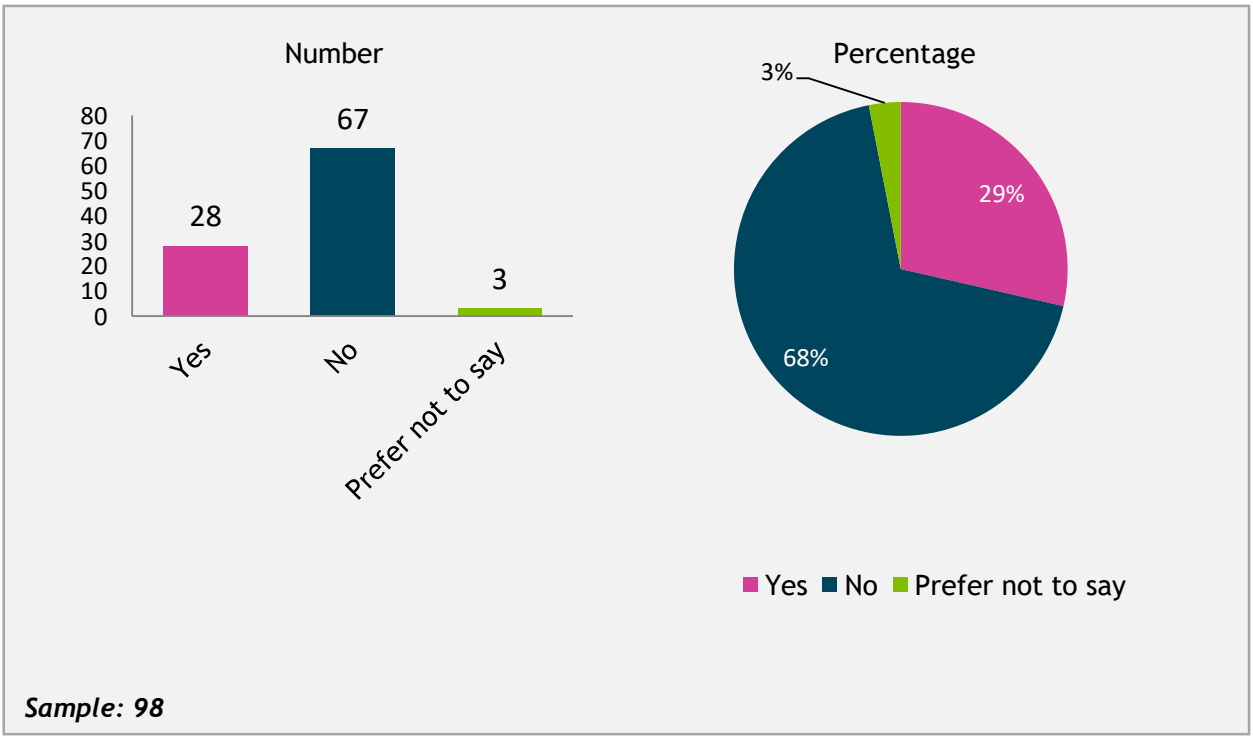
Sample: 96

What is your religion?



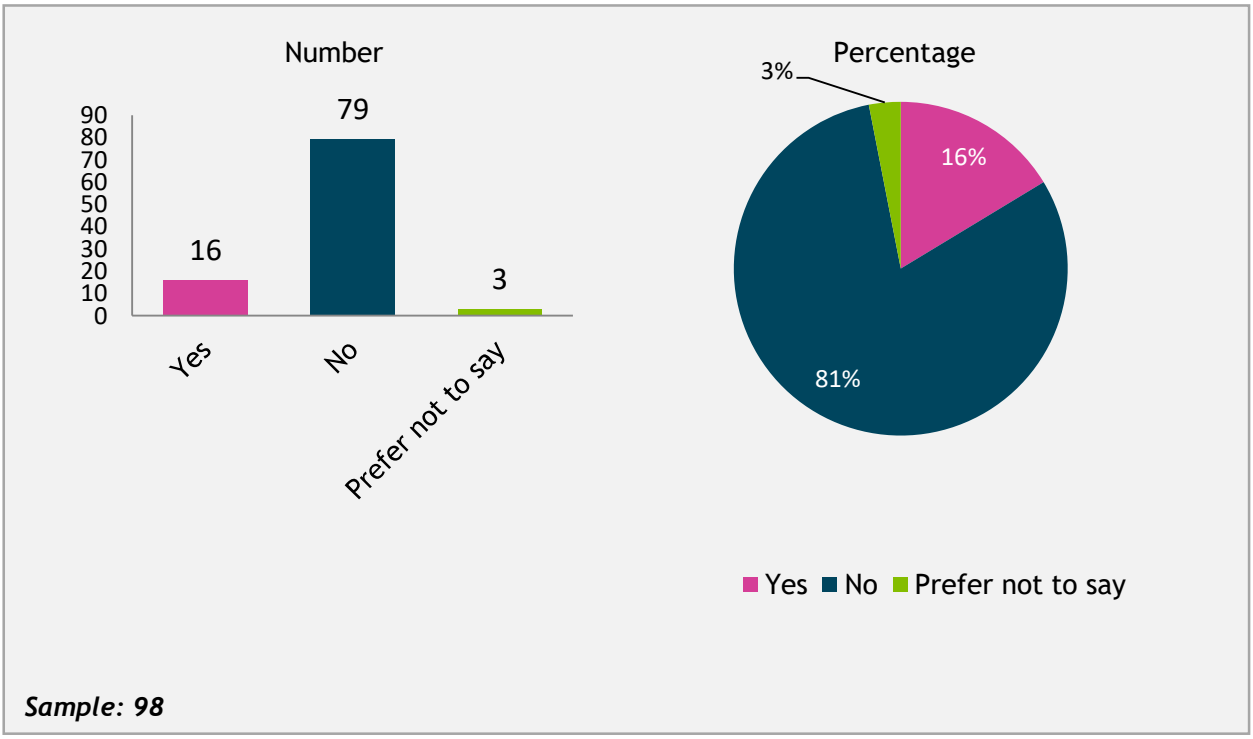
Sample: 93

Do you consider yourself to have a disability or long-term condition?



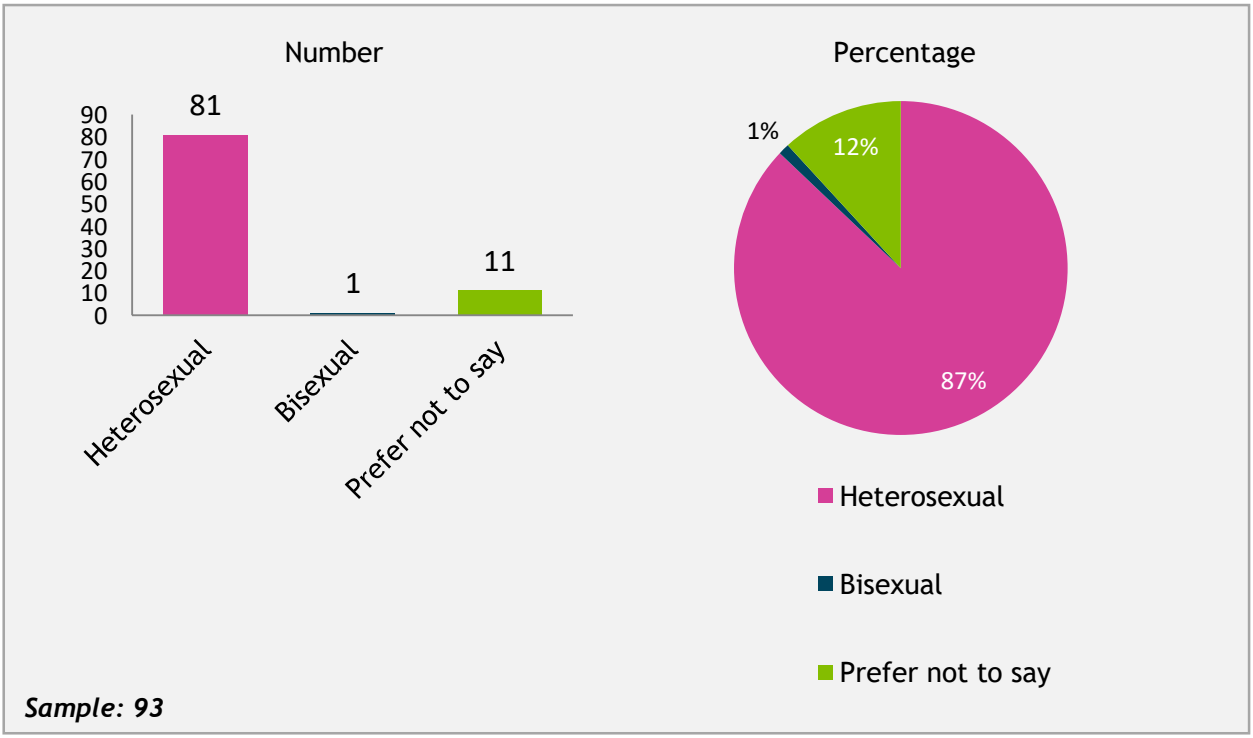
Sample: 98

Are you a carer for a vulnerable person?



Sample: 98

Sexual orientation - are you?



Sample: 93

“The practice I go to is very helpful and I understand why check-ups were cancelled.”

Local Dental Patient

This page is intentionally left blank

GP & Dental Access in Harrow

Marie Pate, Operational Manager
March 2021

Background

- The role of Healthwatch is to gather intelligence / evidence, to check and challenge service delivery, identify where services need to change and to make recommendations to the Clinical Commissioning Group (CCG), Council and other health and social care providers

- Access to General Practice's (GP's) and Dental Services is an issue that we are increasingly hearing about, please see our recent report: https://www.healthwatchharrow.co.uk/insight-and-reports

- There is general awareness of the issues that need to be addressed. Our report was written in the spirit of collaborative working, knowing how hard people are working due to the pandemic but also recognising that patients have the right to access services

- In summarising the key issues and recommendations we would like to highlight the general concerns raised do not relate to the quality of care that people receive, the issues that need to be addressed relate to accessing services.

Key issues

- GP Telephone systems and online booking systems are not efficient and do not meet the demands / needs of patients needing to contact the surgery. For those experiencing difficulty with access, over half (58%) cite telephone related issues, while over a third (42%) suggest a problem with online booking. ***" I dread needing to make an appointment to see my doctor".***
- Commissioning of NHS Dental Care is not meeting current demand. ***"My usual dentist has said I am no longer registered with them and cannot register as an NHS patient at this time." "NHS practice has now told me that I have to go private."***
- The Black, Asian and Minority Ethnic (BAME) communities are disproportionately affected in accessing services.

  Those with Mental Health conditions, Carers, Black, Asian and Minority Ethnic (BAME) respondents and those of working age are disproportionally impacted, in terms of access, confidence across platforms and overall satisfaction.

- Accessibility is particularly an issue for those patients with language, mental health and learning disabilities.

Recommendations

1. CCG to work with the Primary Care Networks and Harrow GP surgeries to put in place improved, quicker and more accessible phone and online appointment booking systems to reduce patient waiting times and cancelling appointments, and to review the effectiveness of their GP texting service in reducing missed appointments.

2. NHS England to review the commissioning of NHS Dental Care in Harrow, to ensure commissioning is kept up to date with demand and that the dental contract is fit for purpose. For example, one element is the Units of Dental Activity (UDA'S), as each dental practice is commissioned for a set number of UDA's and in Harrow this is not meeting the current demand.

3. Primary Care Networks, GP practices and Dental Surgeries to work collaboratively with the Black, Asian and Minority Ethnic (BAME) communities to further understand the issues which are affecting these communities in accessing services e.g. language barriers, lack of digital access etc. and to put a plan of action in place to address these issues.

4. CCG to work with the Primary Care Networks and Harrow GP surgeries to improve accessibility particularly for those patients with language, mental health and learning disabilities.

Responses to report:

Clinical Commissioning Group Response:

- The Executive team have agreed that as they support General Practice in their transition back to normal business arrangements, supporting access, particularly telephone access to services, will be a critical component. They will work with Practices to look at what the right capacity and balance of virtual and face to face conversations will be within this.

- The issue of GP access was discussed at a GP Forum, highlighting the findings of the HWH report, and practices were asked to consider the access challenges that patients are facing as part of their recovery plan. Many Practices have highlighted that telephone access has been a significant problem over recent months due to the volume of patients calling with COVID vaccination queries. As a result, the CCG have worked with Harrow Council to promote the Harrow contact centre as a place local people can call with queries about COVID vaccinations.

- Looking at how extended access GP arrangements can support some of the issues that patients are facing. Encouraging Practices to re-engage in using these extended access services for Harrow patients, as well as looking at how they can provide additional access to essential services, such as NHS Health Checks, they may have been paused over the COVID surge period.

Responses to report (continued):

- Where specific issues were highlighted about Practices, this has been shared with them.

- We will continue to keep this as a priority area under review in our discussions with primary care networks and our own Clinical Directors.

NHS England:

- Responded to state the context is that the NHW General Dental Services are currently operating a significantly reduced capacity due to the pandemic and the controls now in place set out by the Chief Dental Officer for England and Public Health England.

- If a patient is seeking an earlier routine NHS appointment than is currently available, a private appointment may be offered by the practice.

- The response did not address the recommendation to ensure commissioning is kept up to date with demand to ensure NHS patients are receiving the service they are entitled to.

Responses to report (continued):

CQC Response:

- They are aware of access concerns continuing across NWL which includes Harrow. It does appear to be largely based around the new remote methodologies implemented at pace.

- They are monitoring this risk in line with other regulation monitoring activity. This includes provider reviews and if required inspection activity.

In summary:

- CCG have responded and are taking steps to address the issue of access to GP Surgeries

- Issues relating to specific GP Practices are being addressed with a plan of action being put in place

- CQC are monitoring

- NHS England have not responded on the issue regarding commissioning not being kept up to date with demand

- Working in partnership we all need to build in improving communications for those communities who suffer from the greatest inequalities.

This page is intentionally left blank