HEALTH SCRUTINY SUB-COMMITTEE

Tuesday, 14 March 2017 at 6.30 p.m.

MP701, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members:
Chair: Councillor Clare Harrisson
Vice-Chair**:** Councillor Sabina Akhtar

Councillor Dave Chesterton, Councillor Peter Golds, Councillor Muhammad Ansar Mustaquim and Councillor Abdul Asad

Substitues:
Councillor Danny Hassell, Councillor Amina Ali, Councillor Rajib Ahmed, Councillor Chris Chapman, Councillor Mahbub Alam and Councillor Md. Maium Miah

Co-opted Members:

David Burbidge	Healthwatch Tower Hamlets Representative
Tim Oliver	Healthwatch Tower Hamlets

[The quorum for this body is 3 voting Members]

Contact for further enquiries:
Farhana Zia, Democratic Services
1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, E14 2BG
Tel: 020 7364 0842
E-mail: Farhana.Zia@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

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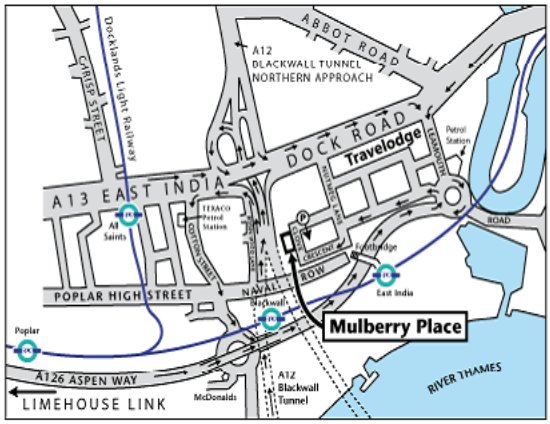

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	APOLOGIES FOR ABSENCE	
1.	**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS**	**1 - 4**
	To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Monitoring Officer.	
2.	**MINUTES OF THE PREVIOUS MEETING(S)**	**5 - 12**
	To confirm as a correct record the minutes of the meeting of the Health Scrutiny Sub-Committee held on 17th January 2017.	
3.	**REPORTS FOR CONSIDERATION**	
3 .1	**Healthwatch GP Access Report**	**13 - 34**
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DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-

- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-

- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:

Graham White, Acting Corporate Director, Governance & Interim Monitoring Officer,
Telephone Number: 020 7364 4800

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY SUB-COMMITTEE

HELD AT 6.35 P.M. ON TUESDAY, 17 JANUARY 2017

MP701, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Clare Harrisson (Chair)
Councillor Sabina Akhtar (Vice-Chair)
Councillor Dave Chesterton
Councillor Muhammad Ansar Mustaquim

Co-opted Members Present:

David Burbidge	Healthwatch Tower Hamlets Representative

Other Councillors Present:

Apologies:

Councillor Abdul Mukit MBE
Councillor Md. Maium Miah

Councillor Rachael Saunders	Cabinet Member for Education and Children's Services
Tim Oliver	Healthwatch Tower Hamlets

Others Present:

Jackie Sullivan	Managing Director of Hospitals, Bart's Health Trust
Neil Hardy	Director, Carers Centre Tower Hamlets
Patrice	Carer
Yvonne	Carer
Archna Mathur	Tower Hamlets CCG

Officers Present:

Daniel Kerr	Strategy, Policy & Performance Officer
Dr Somen Banerjee	Director of Public Health
Barbara Disney	Service Manager, Strategic Commissioning, Adults Health & Wellbeing
Christine McInnes	Divisional Director, Education and Partnership, Children's
Denise Radley	Corporate Director, Health, Adults & Community

Esther Trenchard-Mabere	Associate Director of Public Health, Commissioning & Strategy
Sarah Williams	Team Leader Social Care, Legal Services, Law Probity & Governance
Farhana Zia	Committee Services Officer

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

The Chair, Councillor Clare Harrisson welcomed everybody to the Health Scrutiny Sub-Committee meeting and asked everyone to introduce themselves.

She stated the Sub-Committee would be considering reports on Unpaid Carers – a scrutiny review update, Early Years and access to care and a report from Bart's Health Trust giving an update on the Care Quality Commission (CQC) inspection and rating of Royal London Hospital.

Apologies for absence were received from Cllr Abdul Mukit MBE, Cllr M Maium Miah, Cllr Racheal Saunders – Cabinet Member for Education and Children's Services and Tim Oliver, Co-opted Member representing Healthwatch Tower Hamlets.

No member of the Sub-Committee declared an pecuniary interest.

2. MINUTES OF THE PREVIOUS MEETING(S)

The Chair referred members of the Sub-Committee to the minutes of the previous meeting held on the 2nd November 2016. She asked members to approve these minutes as an accurate record of the meeting.

No points were raised and the minutes were approved.

3. REPORTS FOR CONSIDERATION

4. UNPAID CARERS - SCRUTINY REVIEW ACTION PLAN UPDATE

Barbara Disney, Service Manager for Strategic Commissioning introduced the report stating the paper outlined the progress made against recommendations identified by the Health Scrutiny Sub-Committee's previous review meeting entitled *"Unpaid Carers' Scrutiny Challenge session" – May 2015.*

She introduced Yvonne and Patrice, who gave Members of the sub-committee a personal and moving account of being a carer for a loved one. It provided members with an insight of what it's like to be an unpaid carer and the challenges faced by them.

Points to note:

- Being a carer is often easier than the battles a carer needs to fight on behalf of their loved ones with professionals. A battle plan is required.
- Carers feel isolated and alone and their own mental health and wellbeing suffers under the strain of caring and fighting battles.

- There is a lack of empathy from professionals and poor signposting to services available to help. For example, GP's do not inform unpaid carers about organisations like the Carers Centre.
- Neil Hardy, Director of the Carers Centre added his organisation provided support and assistance to carers. He said the centre empowered carers to navigate a raft of agencies and form – filling; and provided carers with long term support.

Barbara Disney informed Members the 2011 census identified over 19,000 unpaid carers in Tower Hamlets, however many people were not forthcoming to identify themselves as carers or accessed the services provided.

She said the Council was developing its Carers Strategy with the support of carers and the Carers Centre and she hoped it would provide solutions to how the Council and its stakeholders could support carers better in the future. A carers' dignity code and carers charter is being proposed, as well as a Carers Academy where people can get the help they need.

This was followed by questions and comments from Members, who stated:

- Is information shared between government and council departments? For example, do we know the number of carers claiming Carers allowance?

- Primary Care needs to improve in identifying carers as well as signposting them. The Over 40's healthcheck does ask this question but those under 40 may not be easily identified. GP's need to ask the question.

- The Chair recommended Kirklees Council as an example of good practice regarding primary care and the identification of carers.

- The Carers Dignity Code and Charter needs to be linked with the Bart's Compassionate Care agenda.

- Do schools provide data regarding the identification of young carers? **Response:** A whole raft of work is required and the Carers Strategy will include Young People and their transition to Adult Services.

- What feedback does the Carers Centre undertake regarding its service and the support provided by professionals? **Response:** An Annual survey of our members is conducted and we ask for feedback and comments about our service. The Carers Strategy will include how we meet unmet need.

- Do carers have access to mental health services when in their caring role?

- The Carers Strategy needs to ensure issues around lack of empathy, co-ordination and signposting are included in the strategy and the supporting action plan delivers on the expectations set out in the strategy.

- The Carers Strategy ought to return to the Health Scrutiny Sub-Committee in order for Members to have an input.

- Society undervalues caring but individuals build up an incredible amount of knowledge. How do we link their experience and skills with workforce challenges faced by the health service?

The Chair thanked everyone for their input.

The Sub-Committee **NOTED** the progress made with regards to the recommendations and the action-plan and looked forward to receiving the Carers Strategy once it was complete.

5. EARLY YEARS AND ACCESS TO CARE: EARLY INTERVENTIONS IMPROVING OUTCOMES FOR 0-5 YEAR OLDS

Christine McInnes, Service Head of Education and Partnerships presented her report on Early Years and access – early interventions to improve outcomes for 0-5 year olds.

She apologised to Members for missing the publication deadline due to sections 6-10 of the report not being completed in time but said the report included important contextual information describing the vision for an integrated Early Years' service.

She referred Members to pages 2-3 of the report and said it was critical to ensure 0-5 years were supported correctly and at the right time. Key health and social care issues for children in Tower Hamlets and the barriers to accessing services were listed on these pages, with Child Poverty and School readiness being key areas to improve.

Children's Centres were physically accessible and well distributed across the Borough but there were difficulties in estimating coverage as they do not have access to data on the number of eligible children in their catchment area.

Esther Trenchard-Mabere, Associate Director of Public Health, Commissioning & Strategy said live birth data needs to be shared by hospitals and the integrated system would strengthen that link. She said a more streamlined registration system was required with children automatically registered with Children's Centres with an 'opt out' for families who did not want use the services provided.

Confident, well-informed families made good use of Children's Centres however identifying vulnerable families and those that need services the most is a challenge. A multi-agency approach was required.

This was followed by questions and comments from the Members, who stated:

- Members agreed there had to be a stronger link between hospitals and children's centres.

- There has been criticism of Children's centres not reaching out to vulnerable families that need it most. Can you guesstimate the number of families missing out? – **Response:** Analytical work looking at back data to identify families which fall into this category needs to be undertaken. However other factors such as child poverty, those eligible for school meals and language barriers need to be factored in.

- If data collection and contact improves, with increased use of Children's Centres, how and what services will be provided by Children's Centres? **Response:** Centres are not fully utilised so we are proposing changes to how they are used. We need to ensure they are open for longer and services are tailored to the people that need it plus ensure we offer a more universal service.

- Will there be an option for parents who use the centres and who can afford it, to pay for services in order to help support those who need the support? Will this create a two-tier system? **Response:** These are difficult decisions that will need to be made but we hope we can achieve a balance.

- For many new mothers the whole experience can be overwhelming. BME communities feel isolated, English is not their first language and they lack confidence to use Children's Centres. Will the Children's centres provide an adult offer at their localities? **Response:** Yes, we are hoping that we can. A pilot project called 'Better Beginnings' has been trialled which is peer lead and looks to bring isolated communities into contact with Council services. It needs to be evaluated before it can be rolled out.

  There is an integrated employment service provided through the Children Centres.

The Chair thanked Christine McInnes and Esther Trenchard-Mabere for their presentation and said the sub-committee looked forward to seeing how the integrated Early Years services will be structured once the Council re-organisation had been completed.

The Sub-Committee **NOTED** the report.

6. ROYAL LONDON HOSPITAL CQC INSPECTION RESULTS

Jackie Sullivan, Managing Director of Royal London Hospital informed Members the hospital had been inspected by the Care Quality Commission (CQC) in July 2016 and had published its findings in December 2016.

She said the inspectors reviewed eight core services: Urgent and Emergency Care, Medicine (including older people's services), Surgery, Critical Care, Maternity and Gynaecology, End of Life Care, Services for Children and Young People and Outpatients and Diagnostics.

The overall rating for Royal London Hospital had improved from 'Inadequate' in 2015 to 'Requires improvement'.

The hospital had introduced a site based management structure in October 2015, which had resulted in hospital staff having a better understanding of who the leadership team is.

End of life care had made a big improvement from 'inadequate' to 'good' – however more work was required in particular with regards to maternity services.

Jackie described how the hospital was looking to improve security and baby wrist band tagging, which the CQC had previously flagged as a concern.

The Trust had a CQC summit meeting scheduled for the 23rd January 2017 and every department has been assigned to draft an action plan – which goes beyond a tick box exercise and challenges them to understand 'what does good look like'. Best practise from other hospitals was also being looked at as well as the recruitment and retention of staff. Jackie stated that she is happy to come back and present the findings from the summit to the Health Scrutiny Sub-Committee.

Jackie informed Members the hospital had successfully increased its permanent staff cohort by 4% and had reduced agency staff by 31%. Maternity hold their own recruitment campaigns and had an 88% in fill rate of staff.

She said the Trust had discussed how it can improve the culture of the hospital and not just issues and behaviour of staff.

The Chair thanked Jackie for her presentation. This was followed by questions and comments from Members, who stated:

- Is the Royal London meeting A/E targets – are patients being assessed within 15 minutes of arriving and are they seen within 4 hours? How often do the CQC visit the hospital?

- The CQC report states 16-18 year olds are looked after in Adult Wards. With pressure on beds, can vacant beds in children's wards be used?

- Healthwatch recently conducted a 'enter and view' exercise of Day surgery and noted that family members are not allowed to stay and/or accompany their loved one on wards, whilst waiting for minor surgery. Can this be improved?

- How can volunteers be better used in the hospital?

- Improved signage is required at the hospital? **Response:** a 'Way-Finding' meeting is scheduled to take place next week, in order to tackle this very issue. Jackie invited Healthwatch to attend.

The Sub-Committee **NOTED** the outcome of the inspection and developed a better understanding of the performance of RLH across all areas inspected and where improvements were required.

7. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

The Chair, Councillor Clare Harrisson reminded members that the meeting regarding re-ablement was taking place on the 26th January 2017 at 5:30 p.m. and that the Policy & Performance officer was also arranging a visit to the new Lotus Birthing Centre at the Royal London Hospital.

The meeting ended at 8.33 p.m.

Chair, Councillor Clare Harrisson
Health Scrutiny Sub-Committee

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Non-Executive Report of the: **Health Scrutiny Sub-Committee** 14th March 2017	TOWER HAMLETS
Report of: Dianne Barham **(Healthwatch Tower Hamlets)**	**Classification:** Unrestricted
Report on accessing GP services in Tower Hamlets	

Originating Officer(s)	**Dianne Barham** **(Healthwatch Tower Hamlets)**
Wards affected	All

Summary

1.1 This report provides the Health Scrutiny Committee with evidence to support their theme of access to health and social care. It details the main issues that local people have in accessing GP appointments across the Borough, their impact and how access might be improved

1.2 Healthwatch Tower Hamlets visited ten GP Practices across Tower Hamlets in October 2016 and spoke to 134 patients about their experience of accessing GP appointments in order to:

- highlight what is working well and what is not working so well from the patients perspective;
- understand how patients believe access could be improved;
- identify best practice;
- suggest potential opportunities for improvements.

Recommendations:

The Health Scrutiny Sub-Committee is recommended to:

1. Understand some of the issues and potential solutions to problems residents face in accessing GP services in Tower Hamlets and note the report recommendations;
2. Note that the GP Care Group and the Clinical Commissioning Group are working collaboratively with Healthwatch and local patients to develop a joint response to these recommendations;
3. Consider how the Committee could be involved in supporting a patient partnership approach to tackling the current over demand for GP services.

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healthwatch Tower Hamlets

The GP access challenge

Report on accessing GP services in Tower Hamlets

December 2016

Contents

Healthwatch Tower Hamlets is an independent organisation led by local volunteers. It is part of a national network of Healthwatch organisations that involve people of all ages and all sections of the community.

Healthwatch Tower Hamlets gathers local people's views on the health and social care services that they use. We make sure those views are taken into account when decisions are made on how services will be delivered, and how they can be improved.

www.healthwatchtowerhamlets.co.uk

Introduction

Healthwatch Tower Hamlets visited ten GP Practices across Tower Hamlets in October 2016 to talk to patients about their experience of accessing GP appointments.

The aim was to:

- highlight what is working well and what is not working so well from the patients perspective;
- understand how patients think access could be improved;
- identify best practice;
- suggest potential opportunities for improvements.

The purpose was:

- for providers, commissioners and local residents to be better informed about GP services in Tower Hamlets;
- to be able to identify patient-led solutions to the difficulties of over-demand facing primary care services;
- for the patient intelligence gathered to influence the development of the Clinical Commissioning Group's primary care programme;
- to provide the Care Quality Commission with up-to-date information on the views of patients regarding the quality of GP Practices in Tower Hamlets;
- to increase the number of patients involved in working with practices to improve services.

This was done in order to lead to:

- an improvement in GP access;
- patients understanding and utilising primary and urgent care more effectively and efficiently;
- a reduction in patients accessing GP Practices unnecessarily;
- a reduction in patient DNAs;
- an increase in the number of co-designed services with patients and practices.

Why we undertook the project

Between 1 April and 31 Aug 2016 Healthwatch collected 224 comments from local residents on the quality of services in Tower Hamlets. Of those 224 comments, 87 related to GP services. The two main negative issues raised were:

1. Surgery telephone systems that prevented people from accessing appointments;
2. Long waits or unavailability of appointments.

The Healthwatch Tower Hamlets Board agreed that more work need to be undertaken to understand in more detail:

- how widespread these difficulties were;
- whether they related to a small number of practices or if they were more systemic;
- if some practices had better systems and mechanisms in place to cope with increased demand;
- whether patient behaviour changes could help tackle problems;
- what solutions patients felt were necessary to bring about improvements.

We worked with a group of local residents (Patient Leaders) and key stakeholders including the GP Care Group, GP Practice Managers Forum, Tower Hamlets CCG Primary Care Commissioning, and local councillors (Health Scrutiny Panel) to review expectations of the project and consider potential impacts.

Executive summary

Fewer than half of the 134 people we spoke to had had positive experiences of accessing appointments at their GP practices. Men were slightly more negative about their experience than women, and Bangladeshi patients felt more negative than White English patients.

The most common issues with accessing appointments across the ten practices visited were:

- Getting an appointment
- Poor phone access
- Phone triage
- Health management
- Booking in person
- Online booking
- Waiting to be seen
- Urgent care

Some of the suggestion on how access problems might be resolved included:

- Increase doctors
- Increase government funding
- Utilise pharmacies more
- Online appointments, information and record sharing
- Expand doctor phone triage
- Better information and education
- Tackle patient misuse
- Doctors listen more
- Expand opening hours

Recommendations.

1. Best practice from doctor based phone triage systems should be shared across practices and similar systems adopted where possible.
2. Consider the opportunity that phone consultations could provide to further develop patient knowledge of the urgent care system and where to access reliable health advice and support.
3. Increase the level of information and links to reliable external sources on GP Practice websites to enable patients to self-manage with greater confidence.
4. Use the opportunity of people waiting on hold for extended periods to provide information on common symptoms and appropriate patient action.
5. Put systems in place to better enable working patients, the seriously unwell or vulnerable to access practices appropriately. It cannot be a one size fits all system.
6. Increase the use of online technology for appointments, prescriptions, referrals and the sharing of medical records.
7. Continue and expand the hub system of referring patients to other network practices on the basis that partner GP Practices have access to patient records.
8. Expand and promote pharmacy services providing reassurance to patients of the qualifications, confidentiality and the professional approach of pharmacy consultations.
9. Healthwatch Tower Hamlets to work with local residents to campaign at a local, regional and national level to increase resources allocated to supporting Tower Hamlets GP services.
10. GP Networks to seek patient agreement to use their mobile numbers for non-medical texts.

Method

The GP Access Project was developed and delivered by a group of 12 trained Healthwatch Tower Hamlets volunteers under the Healthwatch Enter and View Programme structure. You can find more information on the Enter and View process here (Enter & View). Or visit www.healthwatchtowerhamlets.co.uk

With the support of Healthwatch staff they developed the project, set the topic guide and over saw the data analyses and report writing.

The visit programme was arranged to enable us to cover practices:

- in each of the four GP Locality in Tower Hamlets
- with similar patient populations and size
- participating in the Prime Minister's Challenge Fund and CCG support programme
- that our patient feedback indicated were working well, or not so well.

Practices selected to visit were:

Aberfeldy	Albion
All Saints	Bethnal Green
East One	Jubilee Street
Limehouse	St Paul's Way
Tredegar	XX Place

Practices were notified that we would visit within a two-week period and visits were undertaken over three days between 18th and 20th October 2016.

We followed a semi-structured interview process to discuss with patients their experience of accessing appointments, and to gather their views on how access could be improved. A copy of the topic guideline for the interviews can be found in Appendix 1 on page 18.

Limitations

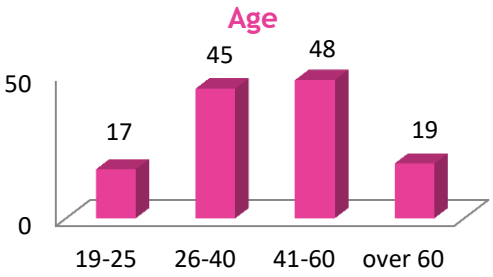
Some of the interviews were short or incomplete as people were called in to appointments during the course of the interview.

Interviews were undertaken in GP waiting areas, this can result in a certain level of reluctance to be completely honest with responses and a reluctance to criticise the practice when there is a risk of being overheard by staff.

Participants

We spoke to 134 patients (80 women and 54 men) during our visits. The ethnicity of respondents was largely Bangladeshi (56) and White English (48).

Participants broadly reflected the age of the Tower Hamlets patient population.



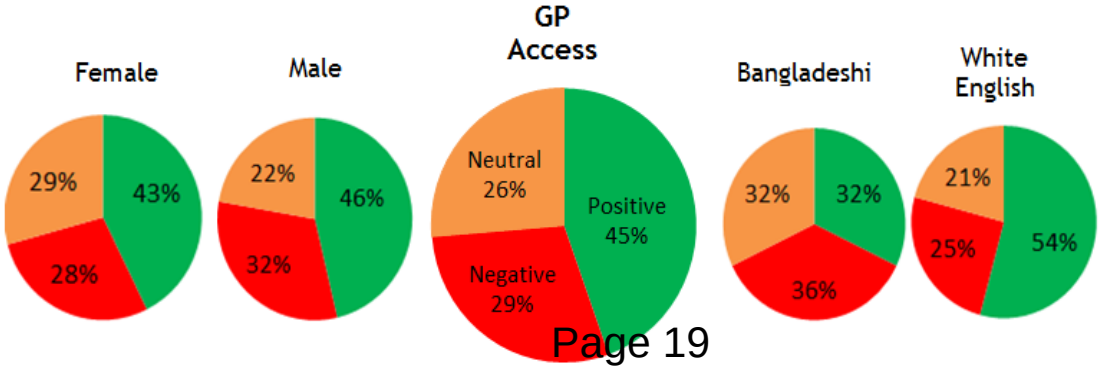
Access

The primary question we asked patients was "*What was your experience of making the appointment for your visit today?* The aim was to understand their experience of:

- getting through on the phone or online;
- obtaining an appointment;
- any triage process (a GP or health professional phoning back to assess the need for an appointment);
- the front-line staff, and
- being able to access the information they needed.

Fewer than half of the people we spoke to had had a positive experience of accessing an appointment at their practice. Men were slightly more negative about their experience than women, and Bangladeshi patients felt more negative than White English patients.

As you might expect younger people were more positive about using the triage system and were more likely to use walk in centres. Over 60s were

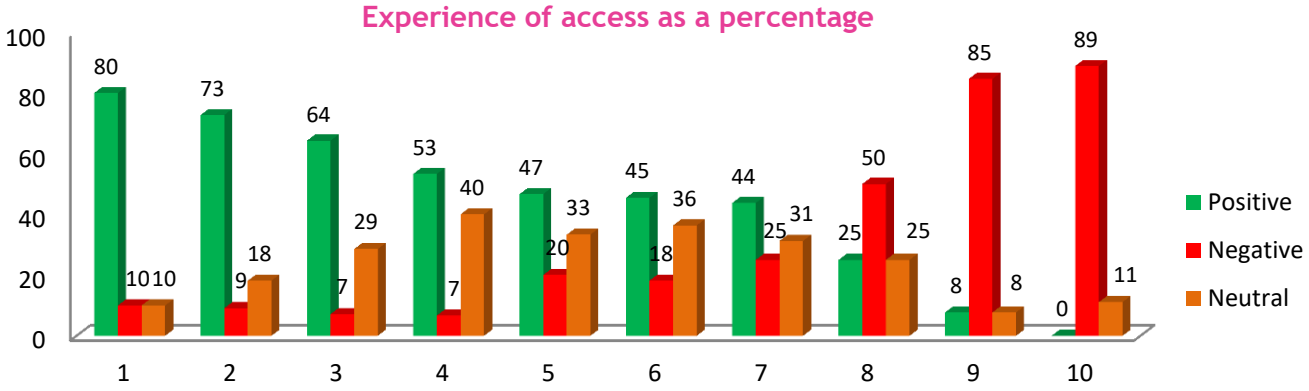


more positive about their experience, possibly because they received more support from the practice to access appointments, book follow up appointments, or had more time to come in to make appointments in person.

"This is an on-going appointment with a nurse. The nurse books an appointment at the end of every visit (Over 60)"

"Making my appointment was good. I got an appointment straight away. I made the appointment in person while I was already here (from a different appointment). There hasn't ever been a past time where I haven't got an appointment. (Over 60)"

Experience varied significantly across practices from 80 percent positive at the top end to 89 percent negative at the bottom end.



The two practices at the top end of the scale of experience operate a phone triage or doctor-first system.

"Called the surgery at about 9:30 am and got through straight away on the phone. They asked me for the details of why I was calling and whether I would like to say. Manner was very good. Doctor called back within 10 minutes and I was given an appointment to come in at 9:45 am. I like the call back service; it's a good idea to talk to the Doctor first."

"At the reception, the telephone is answered in good time. I get a call back from my doctor within two hours. I get seen the same day or consultation is done over the telephone and I get my prescription sent to my local pharmacist for collection within a day or two"

Whilst the third from the top operates a walk-in surgery.

"Good experience. Walked-in at 9:15am and got an appointment. The practice has a daily walk-in surgery. Names are taken from 9:15am to 11:00am."

The two practices at the bottom end of the scale appear to have an acute shortage of appointments to meet current practice population demand and a perceived shortage of doctors.

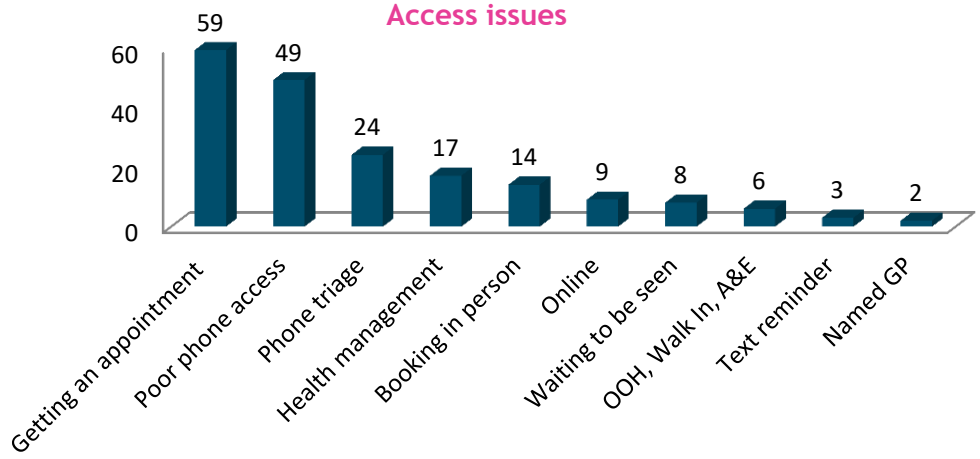
"Emergency appointments and routine appointments are very hard to get. The telephone lines are always very busy, you're waiting on the telephone for 30 minutes sometimes and then when you get through they say there are no appointments left."

"I telephone for an appointment, it just rings and rings and there are never any appointments left by the time I get through. I can't queue first thing in the morning because I am on medication that makes me drowsy and sleepy. My son has tried to get me appointments online. Sometimes you get them and other times there are none available."

It was common at one of these practices for it to take at least two to three weeks to get an appointment and longer if you wanted to see the same GP. In some cases a nurse would call back and try to access appointments for people. People felt it was necessary to use the walk in centres and A&E instead.

"Getting an appointment can take up to 2-3 weeks…I usually phone to make an appointment, getting through on the phone can take up to 20 minutes, I get annoyed and end up putting the phone down and trying again the next day… no

one answers the phone, and sometimes the line goes dead…. someone should answer! I have been to A&E and walk-in centres as a result of not being able to get an appointment"



The most common issues with accessing appointments across the ten practices visited were:

1) **Getting an appointment when you need it**

Fifty nine people commented on being able to access appointments when they needed them.

The system used to access appointments varied widely. In some practices patients are only able to get appointments for that day or within 24 or 48 hours; in others they can only get appointments for two or three weeks' time. In some cases patients are told there are no appointments available at all and advised to ring every morning or come down to the practice and queue.

"The telephone lines are always very busy. You're waiting on the telephone for 30 minutes sometimes and then when you get through they say there are no appointments left."

"It's very difficult trying to get this appointment, there are no appointments! You have to call in every day to see if they have anything."

Again this is leading to more people going to walk-in centres or A&E

"I have been to A&E and walk-in centres as a result of not being able to get an appointment. I thought it was an emergency as I had a rash all over my body; the rash has not gone away therefore I have had to make an appointment with my GP."

In some cases people just give up and do not make appointments at all.

"I only wanted a routine appointment but I was told I would have to call in each morning to see if there were any that had come on to the system. Alternatively I could come down in the morning and queue outside the practice. I work so both of these options are difficult, so I didn't book anything."

This may be leading to people not making routine appointments and consequently serious medical conditions going undiagnosed. We feel that some analysis should be undertaken of the late diagnosis of medical conditions against practices with poor access.

For people who work, to have to come in and queue in the morning to be told they can either take an appointment that day (when they may not have approved time off work) or they will have to come back and queue again the next morning can be extremely frustrating.

There is no system to give preference or priority to people who may have long-term conditions or significant health needs.

"I asked for an appointment on 1 Oct and wasn't offered one until 25 Oct. I could die in that time. I have cancer but they don't treat me with any priority. I was given equipment at the hospital but I don't know how to use it and need to talk to the nurse. I haven't been using

the equipment and have had it for nearly a month."

"The appointment is for my mother but she does not speak English very well. My mother came here three times trying to make an appointment and each time she was turned back, it is a real struggle for her as my father (her husband) needs 24 hour care and it is hard for her to leave her house to be turned back each time. I do not live with her but when I came over to her house today she told me how she was trying to get the appointment and the problem she was having so I called and I was told to make the appointment online."

The Hub system received positive feedback from the three patients who had used it: two who appreciated the rapid access to appointments for children; and one who worked and preferred a Saturday appointment.

"It was a straightforward experience. I was referred by Cable Street practice. There were no issues; the practices have good lines of communication and work well together, which eases appointment making."

2) Poor phone access

Thirty nine people committed on poor phone access. The common problems identified were:

- Long waits on hold for the phone to be answered by a receptionist, with people commonly having to wait between 15 and 30 minutes.

"For emergency appointment, have to book at 8 am, very difficult to get through by phone to reception. Today had to call practice 20 times as line was always engaged. The practice should have a queue system for the phones so you can at least be put on hold and wait on the line to speak to them."

- Phones not being answered at all particularly early in the morning. This led to people having to call on multiple occasions throughout the day, sometimes taking several days to get through.

"The telephone lines are horrible. They pick up the telephone and they drop the telephone."

"One time I was at the A&E and they tried to call my GP and they couldn't even get through."

Some people in the same practice seemed to have different experiences of getting through on the phone. This could be down to the time of day they were calling. Experienced patients start to learn what time of day to call to get the best chance of getting an appointment, leading to unfairness in access.

3) Doctor led phone triage

Twenty four people commented on being called back by a doctor, nurse or receptionist in order to access appointments. The bulk of these related to practices that had more positive feedback overall in relation to access.

Patients were generally positive about the call back system even when they were advised that they did not need an appointment.

People said it was quicker to get a response in that you are able to talk to a health professional quickly and arrange the most appropriate appointment or course of action. This tends to speed up the whole treatment process as it enables patients to self-manage initial symptoms until they persist to a level where doctors are likely to take them more seriously.

It appeared that some practices ran more ad hoc triage systems and in some cases it was nurses or receptionists who called back rather than doctors. Patients were less positive about what they considered unqualified staff asking them why they wanted an appointment.

"In relation to today's appointment a nurse called back and spoke with us and

then offered an appointment. This system is ok, at least you can be seen quicker or get to speak to someone."

There was some sense that people were less likely to be happy with the triage system when dealing with children.

"Typically for a regular appointment I call the reception and the GP calls back to advise on appointment. Sometimes the GP will not advise appointment but pharmacist etc. This can be very frustrating, especially with child ear infections etc. Sometimes, due to unhappiness with triage service I end up seeing private GP. Do not like to do this, not only for money costs but private GP's have less experience. I only use them when NHS GP will not/cannot see me."

However one patient who worked found the call back system made it particularly difficult to access an appointment.

"It's really difficult to get an appointment if you work. They say they will call back and then they say come in at 3. I can't keep my mobile with me at work to get the call back. I'm the manager and I tell the staff not to carry a mobile around so I can't be seen to do it myself."

4) Health management

Seventeen people were attending appointments that were arranged by the Practice to better manage their health (Flu jabs, smoking cessation, blood pressure monitoring, blood tests, baby clinics etc).

There were two cases of people living with cancer that indicated both a positive and a negative experience of managing their care.

First was a patient with pancreatic cancer who had been cancer free for three or four years. He had a good experience at the practice and was there having a 24-hour blood pressure monitoring test.

"They take my health seriously and manage it. I think I'm on a watch list of some description due to the cancer. No complaints about front-line staff. Get text and follow up reminders and a call. Not sure what else they could do."

His cancer was picked up through a regular check-up at a private health care clinic.

The second cancer patient was in remission and felt very unwell (chest pain, earache and sore throat) on the day of the interview. Owing to her weakened immune system she has check-up appointments every six months in hospital. If in the meantime she is unwell, she needs to go to her GP practice. She works at a school, so is exposed to germs.

"Called last night and was told to call next day at 8 am. Called back at 7:58 am but the GP practice was still closed; called two minutes later and I was 13th on the telephone. When connected emergency appointments weren't available. I was told I could have come to the practice at 8 am and queue (this was not mentioned when I called in the evening a day before). Finally was told that a doctor will call me. A female doctor did and gave me an emergency appointment at 10:30 am."

5) Booking in person

It is now common in some practices for patients to need to come down to the practice early in the morning to queue outside prior to the practice opening in order to access appointments.

"I queued today, the queue is so long. Sometimes it takes some 30 minutes to get to the front. You have to queue before 8am. I don't live close by, I have a special needs son, and there is no special allowance made for us. So I make my appointment then I have to walk back home and come back for the time of my appointment, this is hard."

"Once I had to stand outside at 7:30 in the rain and cold to get an emergency appointment (which is even worse for my health)."

This has a disproportionate impact on people who work or who need to get children ready for school. They are likely to receive poorer access or use inappropriate urgent services as a result.

6) Making appointments online

There was an appetite for using the online booking process, particularly if it meant not having to sit on the phone for long periods trying to get through to the surgery.

"The online booking is much easier to use. If I call, I have to stay on the telephone for more than half an hour. So now I only book online. . . I wait until 10 am and then I book online for an appointment and always get one."

The main concerns were the difficulty of registering on the system and the ease of use.

"The online system is not working properly; I tried using it once and did not work. If they don't want patients to use it properly then they should shut it down completely…"

Some people were unaware of online options and one person said that it would be very difficult for their mum to use as she did not have internet. It can also be difficult to get an appointment with your named GP through the online booking.

Online booking also does not solve the underlying problem of there being no appointments.

"I've used the online appointment system in the past. It's the same as the telephones. You can't get an appointment. I'm really not happy with this GP surgery. I'm looking to move."

There was also a sense that you had to know what time they were released on to the system to be successful.

7) Waiting to be seen

Seven people said they had to wait too long at the surgery to see a GP. People seemed resigned to the fact that they may need to wait (in several cases it was more than 40 minutes). However, they did feel very aggrieved that in some practices if you turn up late yourself to an appointment it is cancelled and you have to rebook.

"Two weeks ago we were told to come 10 minutes early. If you're a few minutes late then they say you can't be seen; today they're 45mins late. It's not fair."

Long waits impact more on people with a learning disability or people with young children, and it was felt some system to fast track or make space available earlier in the day would be useful.

"We have been waiting now for 40 mins. My son doesn't like to wait in the waiting area and gets anxious. In an ideal world they would fast track us in or we would be given the first morning appointment." Mother and adult son - son has a physical and learning disability (wheelchair).

One of the GPs was running late the day of our visit and came out to explain to patients in the waiting area the reason which was a particularly complex patient. This explanation was appreciated by the patients waiting.

8) Out of Hours, Walk-in Centres and A&E

Some patients, particularly those who are working, are choosing to access services through walk-in centres.

"You never know if you are going to get an appointment here, by default I end up going to the Barkantine Walk-in Centre "

Some practices with a shortage of appointments are advising people to go to their local walk-in centre.

"Yesterday I waited 30 minutes for someone to answer the phone, I really dislike this phone system...it so frustrating! If there are no appointments, they do advise you to go to the walk-in centre."

People did not feel that the walk-in centre service is appropriate for people

with a pre-existing condition or more complex medical history as they could not access your medical history.

"The walk-in centres do not have your records so they cannot help you. The walk-in centres are always busy and short staffed as well."

"I've been to the walk-in centre and there's nothing they can do. They don't have all your records and tell you to go back to your GP."

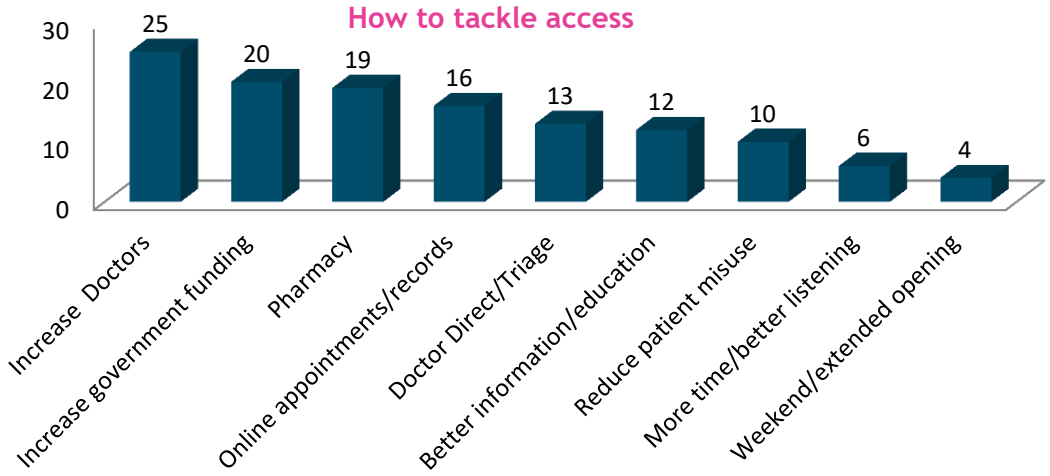
9) Text

People appreciated text reminders however one patient mentioned that she didn't really expect to get texts from her GP saying that there was a bake sale on that weekend. She did not feel this was an appropriate use and was not why her number was provided to the practice.

Solutions

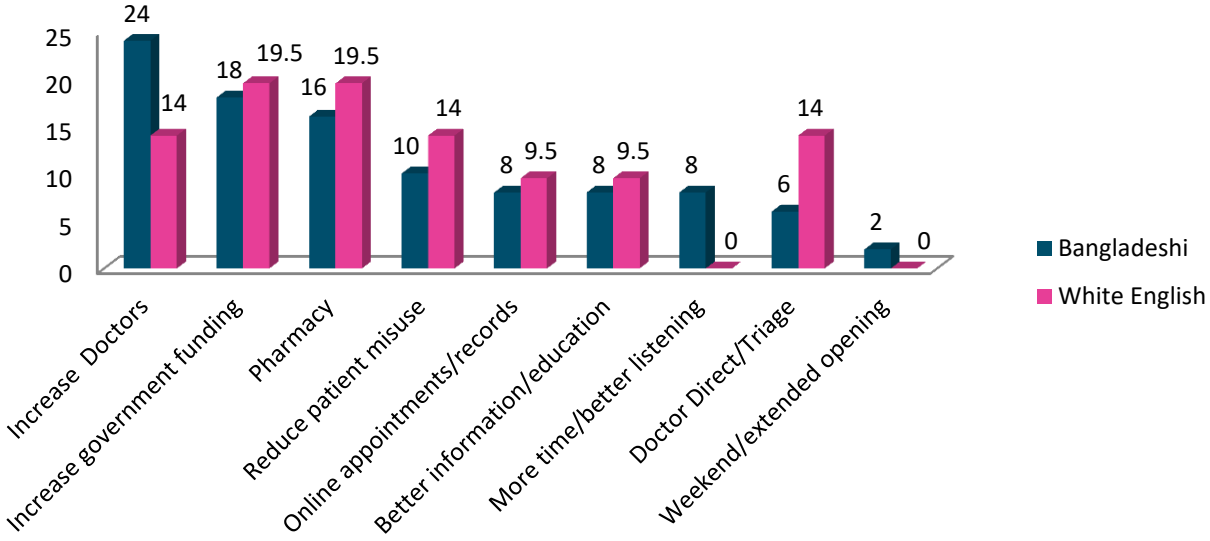
The second key line of inquiry with patients was how they thought problems with access might be resolved. The question to them was "*We all know that the NHS is very stretched at the moment and that GP Practices are struggling to meet the demand. What do you think can be done to help tackle this problem in Tower Hamlets?*"

We wanted to get local people's ideas as to what they, or local residents generally, could be doing to reduce the demand and increase supply in relation to overstretched practices.



The Bangladeshi community were more likely to suggest that more doctors were needed than the White English. While the White English were more likely to suggest improved triage systems and use of information technology.

Suggestions as percentage of Bangladeshi and White English



a) Increase the number of doctors

Understandably a large number of patients suggested that an increase in staff was needed within GP Practices, particularly GPs. There was a strong awareness that the local population is increasing and that GP Practices are not expanding to meet a growth in demand.

"It is difficult to do because it is very overcrowded. There are too many people in a small area. We need more GPs to open and more staff/doctors, however this is hard to do."

"Increase number of doctors. I don't understand why numbers of doctors are cut. There is more demand, there should be more doctors. They should find the way to solve this problem within the government."

b) Increase government funding to the GPs

Many local people feel strongly that the government has a responsibility to fund the NHS and GP services appropriately to meet local need and that this is not happening. However, they also understood that the NHS faces increasing pressures from population growth and increased life expectancy, and that there is unlikely to be a significant increase in funding from the government any time soon.

"The government keeps cutting funding and this is the result! There is not enough money being invested to improve the services."

"I believe with this Brexit they can put more funds into the NHS as our health system needs a lot of help. The health of the country should be the government's most important issue to address."

"I also think the government spends so much money on other things that the funding needs to be increased for GP practices; it needs to become a priority. There is also too much work for the doctors to handle, which is why the staff should also be increased because doctors are very overstretched which causes them to make mistakes, be tired, and not have enough time to speak to the patients."

"Government to invest more... doctors to be continuously trained and given on-going support."

"Money is distributed badly in the NHS. Many people would agree to increase percentage of funding but not confident that the government wouldn't use it for something else."

c) Utilise pharmacies more

There was strong support for better utilisation of pharmacies as the first point of advice and information on health problems.

"I prefer going to a pharmacy if possible. It is quicker and you can see someone at

your convenience (e.g. during a lunch hour)."

"Encourage people to use pharmacies, the pharmacy needs to be able to offer better advice and maybe refer to doctors if they can't help the patients- this will make things quicker for patients."

"Sometimes people go to the GP when they don't need to e.g. cold. They should treat themselves or go to the pharmacy - they care about you. e.g. fever, temperature, teeth. They can refer you to the GP or hospital. They can tell you good information."

"The surgery and chemists should work more closely, and the pharmacy should be able to make referrals to the GP for appointments."

Patients felt that this might require: more information on what pharmacist can do; better awareness of one-to-one consultation facilities; pharmacist being able to make appointments at the GP; and pharmacist being able to prescribe more medications. Some thought may need to be given to improving pharmacies so they look more like places where you would go for one to one advice. Highlight qualifications and skills, better lay out, promote consultation rooms and decrease the 'shop' environment.

The chemists should be able to offer more medicines and also offer patients private time to speak to them.

d) Online appointments, information and record sharing

Some sections of the patient community were certainly keen on increased online appointment processes though this is not going to reduce the over demand for appointments. However there was also an appetite for using online diagnosis and referral tools. As with the doctor phone triage service it was seen as an opportunity to put your mind at rest that your self-diagnosis was sensible.

Better on-line system for NHS, where you could put your symptoms in and should tell you if you could go to the pharmacy first rather than to a GP practice.

Better utilisation of online appointment, prescriptions, records and referrals was seen as a mechanism for freeing up capacity in the system. The ability of walk-in centres and out of hour's doctors being able to access your medical records was suggested as an improvement. One patient suggested that they should be able to hold their own patient records on a smart card or USB or have a security code to give people access to their records online.

"More online communication. Q & A sessions online would be very beneficial, would save lots of time for both patient and practice. Email and online communication could also be used to relay information for things such as blood test results, again saving time for both the practice and the patient, avoiding un-needed appointments."

"Computer systems need to be improved. Spent a year at this practice installing new system that still doesn't work. Should be able to go to any NHS service and records should be available in all areas on shared system."

e) Expand doctor led phone triage

There was strong support for the Doctor First triage system by the majority of patients in the practices where it was implemented.

'Doctor Direct' system where you call the surgery and your doctor calls you back same day for consultation over the phone or invites you to come into the surgery if necessary is a good system to reduce overcrowding in the waiting areas and save GP time."

"One of my friends practices has a good system: When you call on the phone to see a GP, they determine if your case is an emergency, if it is, they see you right away, and if not, they offer you information (like a mini consultation) on what you can do to help yourself and if you need to get a prescription or not. This makes it so you can get help if you need it both in an emergency or not."

Some patients are fairly confident that they know what is wrong with them and they are looking for reassurance from the GP that they are doing the right thing.

"The GPs just have too many patients to take care of. I don't think we should tell people not to go to the GP as you often just want somebody to put your mind at ease. Maybe if there was a phone back system. You could talk to a doctor or someone about your symptoms and what you think you should do and they could just put your mind at ease. Don't necessarily have to come into the GP surgery - reassurance that you're on the right track."

Some patients did not feel that phone triage was appropriate for children in cases where it was not easily identifiable as a common illness.

"Not too keen on the idea of phone consultations. You can't really assess someone over the phone. Especially with children - need to see them".

A call back system can be difficult for people who work as they may find it difficult to take personal calls. A system where people are emailed or sent a text giving a time slot when the GP will call back, e.g. in 15 minutes, might go some way to mitigating against this problem.

f) Better information and education

A number of people suggested that while you were placed on hold on the phone trying to access an appointment you could receive information on how the urgent care system works or how to treat common health problems e.g. persistent cough with a cold.

"Whilst you're waiting on the phone, it would be useful if they gave information on local services; at least you will know more about pharmacy services and other services to help patients."

"Practices could offer information and advice whilst waiting for telephone to be answered- e.g. promote online booking, walk in centres, pharmacy."

Keeping patients informed on how access systems work and what they can do to support more efficient systems would be useful.

"Better information sharing with patients, if they are changing systems such as how to book an appointment, then patients should be informed."

"Better information on appointments e.g. purpose of telephone consultation."

More information could be made available on GP websites outlining alternative options to making a GP appointment; when those are appropriate and pathways for common complaints. This could include links to trusted information sites providing symptom checks or self-management advice.

g) Patient misuse

There was a reluctance to place the blame on patients but some people felt that local residents needed to take more responsibility for their health and use the health system appropriately. Nobody suggested that they themselves were guilty of misusing the system but they felt that others were.

"Too many appointments made that are not necessary which is slowing down the service for everyone."

"Turn up for appointments. Because there's no value in it for people; they book up appointments, just in case. Could penalise people but not sure how practical that is. People need to respect the NHS."

"Some people misuse and abuse the system and take medication when they don't need it. I think this is where money is being wasted."

There was a sense that we could all be doing our bit by taking more responsibility for our health and educating our children appropriately.

"People who call themselves patients should take more responsibility for their lifestyles and teach their children that. People think other people have responsibility. Many campaigns say don't go to A&E but people still keep going."

h) Doctors taking more time to listen

There was a suggestion that increasing the length of appointments could free up capacity as fewer appointments would be needed. In the longer term there would be fewer pointless visits to walk-in centres and A&E.

"Because the appointment times are limited you often don't have time to talk about all of your symptoms. You might think that they are unrelated and should be a separate appointment. This takes the GP a lot longer to find out the real issue and it's not holistic care. Your health can end up being dealt with in compartments and the real problem takes a lot longer to diagnose. It can depend on the doctor writing everything down at each appointment and several appointments to build up the picture."

"You can only talk about one issue with the GP. I want to talk about more issues so they ask you to make double appointments…they can't even offer one appointment; how can they offer double appointments? Because you can only talk about one issue, you end up making another appointment and again you have to wait another 15 days. This is a waste of everyone's time…very frustrating"

i) Expand opening hours

People suggested that GPs should be open on Saturdays.

"All GPs should be open on Saturdays"

"GPs should open on Saturdays; I would personally prefer to come to my own GP."

There was appreciation of there being one GP within a hub network providing Saturday appointment slots (this was a patient at Jubilee Street who was able to get a Saturday appointment at East One Health.

People were positive about the out of hour's service.

"The out of hour's service is quite good. You call up and a GP will call back, if they think an emergency appointment is required they will advise of the nearest open practice."

Findings

For many patients across Tower Hamlets the process of obtaining a GP appointment has become a battle. Patients are left frustrated by phone systems that leave their calls unanswered, place them on hold for long periods or simply cut them off. The alternative to phone access can be to queue outside a practice early in the morning before they open. But, if you are not at the front of the queue, you can still miss out on limited appointments. Patients are now making multiple trips or queuing earlier and earlier in all-weather when they are in poor health. Both of these systems make access difficult for those who work, have children, or are seriously unwell or vulnerable. There was a sense that people who have learnt how to access the system are more likely to get the limited number of appointments available. This leads to inequality of access.

When patients are able to get through to their practice they are often told that there are no appointments available. Some patients are finding that there are no urgent appointments available and others no routine appointments. Our concern is that this is preventing some patients from accessing care and that severe illnesses maybe going undiagnosed leading to serious delays in treatment.

If no urgent appointments are available patients are often advised to go to a walk-in centre or A&E. Without access to patient records the services they receive within the urgent care setting are often limited, unlikely to pick up longer term symptoms, can result in repeated visits or end in patients being referred back to their GP. This is also putting additional pressure on urgent care services that are already under strain.

Experience of the doctor call back triage system is generally positive and welcome. However there are a minority of people, who work or who have language issues, for which the service is not appropriate. Groups such as children with uncommon symptoms, older people and people with long-term conditions should still be able to see a doctor if they wish.

There was no strong sense that people were inappropriately accessing GP services. Participants generally mentioned trying to self-manage or seeking advice from a pharmacist prior to making an appointment.

There was significant support for increased use of pharmacies as a mechanism for providing more timely advice, information and support.

There was interest in improved access to online information through the practice and online referral to NHS or trusted websites. People spoke about needing reassurance as opposed to medical treatment in some cases. There is an opportunity to provide that reassurance outside of face to face GP appointments through triage or online symptom checkers.

There was some confusion around how the GP and urgent care systems in Tower Hamlets work and what pharmacists and other health professionals are able to do. Better education and a more stable system would be beneficial.

The people who used the hub system were positive as it gave faster access to appointments and the possibility of appointments outside of work hours.

Local people accept that some behaviour change is necessary and changes to how they access services. But they also believe strongly that more government investment is needed to increase the number of GPs and improve GP services to meet the growing Tower Hamlets population.

Recommendations

1. Best practice from doctor based phone triage systems should be shared across practices and similar systems adopted where possible.

2. Consider the opportunity that phone consultations could provide to further develop patient knowledge of the urgent care system and where to access reliable health advice and support.

3. Increase the level of information and links to reliable external sources on GP Practice websites to enable patients to self-manage with greater confidence.

4. Use the opportunity of people waiting on hold for extended periods to provide information on common symptoms and appropriate patient action.

5. Put systems in place to better enable working patients, the seriously unwell or vulnerable to access practices appropriately. It cannot be a one size fits all system.

6. Increase the use of online technology for appointments, prescriptions, referrals

and the sharing of medical records.

7. Continue and expand the hub system of referring patients to other network practices on the basis that partner GP Practices have access to patient records.

8. Expand and promote pharmacy services providing reassurance to patients of the qualifications, confidentiality and the professional approach of pharmacy consultations.

9. Healthwatch Tower Hamlets to work with local residents to campaign at a local, regional and national level to increase resources allocated to supporting Tower Hamlets GP services.

10. GP Networks to seek patient agreement to use their mobile numbers for non-medical texts.

Requests for information

1. There appeared to be a significant number of people in some practices who were there for health management reasons e.g. flu jabs, blood tests and blood pressure monitoring. How do practices balance the number of appointments that they manage and those requested by patients?

2. Is there any evidence of a higher instance of late diagnosis of terminal illnesses and chronic diseases in practices where access is particularly difficult?

3. What plans are there to build health management into education both at primary and secondary school?

4. Working people are going to the walk in centres, A&E and now the hub. Can the other practices in the hub view their medical records?

Appendix 1

GP Access Topic Guide

What was your experience of making the appointment for your visit today?

- We want to identify any issues with getting through on the phone or online; are appointments available when they do get through; any triage process (the GP phoning back before they got an appointment), are the people on the phone helpful, if they needed information did they get.
- If it's a good experience, why is it a good experience?
- If there have been times when you haven't been able get an appointment what do you do? Do frontline staff provide any information on what to do? Do you online advice on symptoms/ remedies or speak to the Pharmacy before making an appointment with the GP?
  Happy for them to talk about general past experience if it's recent

Do you know who you will be seeing today?

- Do they know if they are seeing the GP, a practice nurse, a healthcare assistant, a physician associate?
- Do they care who they see today?
- Do they have enough information about the practice staff and their roles?

This will help us to understand how different practices are using their staff structure to meet the demands of patients and how patients feel about non-GP consultations.

What do you hope the outcome from your visit today will be?

- Are they looking for a diagnosis, a referral, a prescription, more information on where to go, a chat with the doctor or they don't know?

  We're trying to understand if they really need to see the GP or if they could have found what they needed online, could have talked to a nurse or could have referred to a voluntary sector organisation.

We all know that the NHS is very stretched at the moment and that GP Practices are struggling to meet the demand. What do you think can be done to help tackle this problem in Tower Hamlets?

- Do they have any ideas about what they, or local residents generally, could be doing to reduce the demand.
- Do we need more doctors, how would we afford them?
- Would they be prepared to get more involved in the practice?

Is there anything else you would like to discuss about the practice and the staff?
If there is a chance to talk to them after their appointment then you can ask if they were happy with the quality of the consultation with the GP, did they feel listened to, were they involved in making decisions about their care, and were they satisfied with the outcome.

Pick up equalities data.

Would you be interested in getting involved in working with the practice to improve services? Collect their email details.

Would you be interested in getting involved with Healthwatch? Collect their email details.

This project was developed and the interviews conducted by Healthwatch Tower Hamlets volunteers. We would like to thank all them for giving up hours of their valuable time to undertake this important work.

Aldona Milek
Christine Mbabi
Emdad Islam
Firdaus Sultana
Lilyma Akhter
Liz Bollan
Lydia Carr
Nasiha Khatun
Rima Khanom
Shahanara Begum
Sultana Rouf
Sydney Fontaine

healthwatch
Tower Hamlets

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Non-Executive Report of the: **Health Scrutiny Sub-Committee** 14th March 2017	TOWER HAMLETS
Report of: Jackie Sullivan, Managing Director Royal London Hospital Helen Callaghan, Associate Director of Nursing	**Classification:** Unrestricted
Royal London Hospital and Community Health Inpatient Services at Mile End Hospital, CQC Inspection Update	

Originating Officer(s)	Jackie Sullivan Managing Director Royal London Hospital Helen Callaghan, Associate Director of Nursing
Wards affected	All

Summary

1.1 The Care Quality Commission (CQC) undertook an inspection of the Royal London Hospital in July 2016, and published its findings in December 2016.

1.2 The inspectors reviewed eight core services: Urgent and Emergency Care, Medicine (including older people's services), Surgery, Critical Care, Maternity and Gynaecology, End of Life Care, Services for Children and Young People and Outpatients and Diagnostics.

1.3 Overall the Royal London Hospital improved from a rating of 'Inadequate' in 2015 to 'Requires Improvement'. A CQC summit was held by Barts Health Trust in January 2017 to review their approach to responding to the CQC inspections.

1.4 The CQC undertook an unannounced visit of Community Health Inpatient Services at Mile End Hospital in May 2016, and published its findings in January 2017. The CQC inspected two inpatient wards, Gerry Bennett and Jubilee and identified a number of areas for improvement.

Recommendations:

The Health Scrutiny Sub-Committee is recommended to:

1. Note the outcome of the inspection;

2. Develop an understanding of the performance of the Royal London Hospital (RLH) across all areas inspected and where improvements are required.

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Community Health Inpatient Services

Mile End Hospital

Care Quality Commission Report published January 2017

Date of Inspection: 24th May 2016

Presenter: Helen Callaghan, Associate Director of Nursing

Ratings

The site was not formally rated

This was an unannounced, risk based inspection following two reports following concerns regarding patient care

The focus of the visit was on essential elements of patient care and safety

As this was not a comprehensive inspection there was not a pre inspection data request and as such the CQC state they did not have sufficient evidence to rate the five domains

Barts Health NHS Trust

The inspection

Unannounced on the 24th of May 2016

The team comprised of two CQC specialist advisers ‘one expert by experience’, one CQC inspection manager and one CQC hospital inspector

Inspected the 2 inpatient wards, Gerry Bennett and Jubilee

NHS
Barts Health
NHS Trust

What people who use the provider say

'they look after me well. All nice, all talk to you'

'food is okay'

'its always clean. If you want something they get it for you. They do a lot for you'

'so far I've been treated well, with dignity and confidence'

'Physiotherapy is very nice. Staff have time to talk'

'I'm looked after very well, they treat me with respect'

'the food is okay and I can sleep well'

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider should ensure that patients' dignity is maintained with the clothing they wear.

The provider should ensure that wheelchairs have footplates.

Staff should always treat and speak to people with due dignity and respect.

Safe

The CQC found

Summary

Essential elements to keeping the service safe were being routinely collected and regularly monitored in areas such as infection, falls and pressure ulcers. Case notes regularly updated patient progress. Patient assessments to monitor specific areas of risk such as nutrition and hydration, continence and falls were being completed although subsequent action plans were not always being documented.

Gerry Bennett ward had experienced some performance issues that included recent blips in harm free care and a safeguarding concern. The trust had taken appropriate action on these that included seconding a matron to the service and acting on poor practice. This had impacted on staffing numbers for which the trust had also acted on by reducing the bed numbers on Gerry Bennett in order to continue safe staffing levels.

Staff acuity and dependency was measured and monitored on a daily basis through e-rostering, using the NICE endorsed Safer Nursing Care Tool. Acuity and dependency was coded for each bed number on each ward along with the number of escorts and discharges. This was submitted each month and pulled in to the e-roster.

The senior sister we spoke with told us that when she had raised safety concerns around staff and patient care she had been listened to and had not encountered resistance around agency/bank booking of staff.

Effective

The CQC found

Summary

People received timely pain relief and nutrition and hydration needs were being managed. Referrals were almost exclusively from the trust's local acute hospital and consultants worked across both sites for continuity of care. Consultant led multidisciplinary team meetings took place weekly on each ward.

Admission was for more complex rehabilitation and therapy teams worked with patients and their families towards more independent living. Community teams became involved in patient care prior to discharge although the service was hoping to improve upon discharge processes and had taken on a discharge coordinator.

We were told that the consultants were gatekeepers to the beds. Referrals to the hospital were almost exclusively from the Royal London Hospital (RLH), one of the trust's acute hospitals, located nearby. Consultants knew the patients as they worked across both sites, and we were told that the service did not take patients whose condition was not stable. Admission was for
more complex rehabilitation and the commissioned length of stay was 42 days. The service was currently averaging 45 days although this was due to be brought in line.

Caring

The CQC found

Summary

We observed staff and patients interacting in a positive way and staff offered practical assistance to those who needed it. Patients told us they were treated with dignity and respect. All of the seven the patients we spoke with were positive about the friendliness of staff and their readiness to offer help and support.

A lack of accessing to appropriate clothing had led to people wearing open backed hospital gowns when leaving the ward for groups. These were closed to differing degrees and which did not observe their dignity.

We also came across examples where staff had not treated people with due dignity and respect. We reported back our observations to senior staff. They elaborated on action that had been taken recently on Gerry Bennett ward and generally because they wanted to raise standards of kindness and compassion.

Friends and family results for April 2016 showed there were twelve responses which represented 85% of all discharges. The average score for the five questions was 4.81 with 100% likely to recommend and 0% likely to not recommend. The hospital was 42nd out of 175 trust services, which was an improvement from 89th six months ago.

Responsive

The CQC found

Summary

A falls prevention programme was being implemented at the time of our visit. The length of stay reflected the more complex rehabilitation that patients were in need of and patients were assessed and involved in a number of rehab groups.

An extra matron had been recently seconded from within the trust to work at the hospital following requests for a site based person to support staff competency and practice. She had been working on the implementation of a falls prevention programme which was due to be formally launched the week after our inspection visit. Band 6 nurses had completed training
on falls prevention and other staff were due to follow. There was a half day workshop that took place monthly for all staff to attend over the course of time. It covered assessment, post fall planning, manual handling following a fall and treating injury. Bedside competency assessment of staff and practice support was also planned as was audit. A pilot audit took place the week
prior to our visit and were planned to continue on a weekly basis. Audits were to check on the timeliness of assessments and if patients found to be at risk had a care plan, whether a bed rail assessment had been completed, whether patient information had been sufficiently handed over and whether reassessment had taken place.

Well-led

The CQC found

Summary

There was a governance structure in place that enabled the hospital to monitor the quality of the service it provided. There was a clear leadership structure and the visibility of local leadership had recently been increased to meet the needs of the service.

There was some uncertainty among staff over planned future change to the service that had affected morale and placed recruitment on hold.

Since the inspection

- Reduction in length of stay and community rehabilitation activity has meant we have been able to close Gerry Bennett ward. This has enabled the movement of staff onto the other older adults ward on site and on the acute site.
- Recruitment to Jubilee ward has continued and recruitment turnaround times reduced as part of the wider activity on the Royal London Site
- At the time of the inspection the team were working with patients and carers to ensure they had their own clothes. This is being further enhanced to encourage patients to get dressed during the day
- Staff development activity undertaken including rotation of staff across sites and specific individual improvement programmes where appropriate
- Changes in leadership
- Confirmation of the next steps for the contract

Questions?

Non-Executive Report of the: **Health Scrutiny Sub-Committee** 14th March 2017	
Report of: Carrie Kilpatrick, Deputy Director of Mental Health and Joint Commissioning	**Classification:** Unrestricted
Access to care for people with a mental health problem	

Originating Officer(s)	Carrie Kilpatrick, Deputy Director of Mental Health and Joint Commissioning
Wards affected	All

Summary

1. This report forms part of the Health Scrutiny Sub-Committee's review of access to health and social care services in Tower Hamlets. As part of their review the Sub-Committee wants to look at the key access issues facing people with a mental health problem in Tower Hamlets. This report describes the main barriers to service access and details the plans in place to improve mental health service provision from both a commissioning and delivery perspective.

Recommendations:

The Health Scrutiny Sub-Committee is recommended to:

1. Develop an understanding of the key barriers restricting access to mental health services.

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Health Scrutiny Challenge Session: Access to Mental Health Services

Carrie Kilpatrick: Mental Health and Joint Commissioning Team

Craig Chalmers: Interim Operational Service Manager Mental Health

Edwin Ndlovu : Borough Director for Tower Hamlets ELFT

key access issues facing people with a mental health problem in Tower Hamlets and the plans in place to address them.

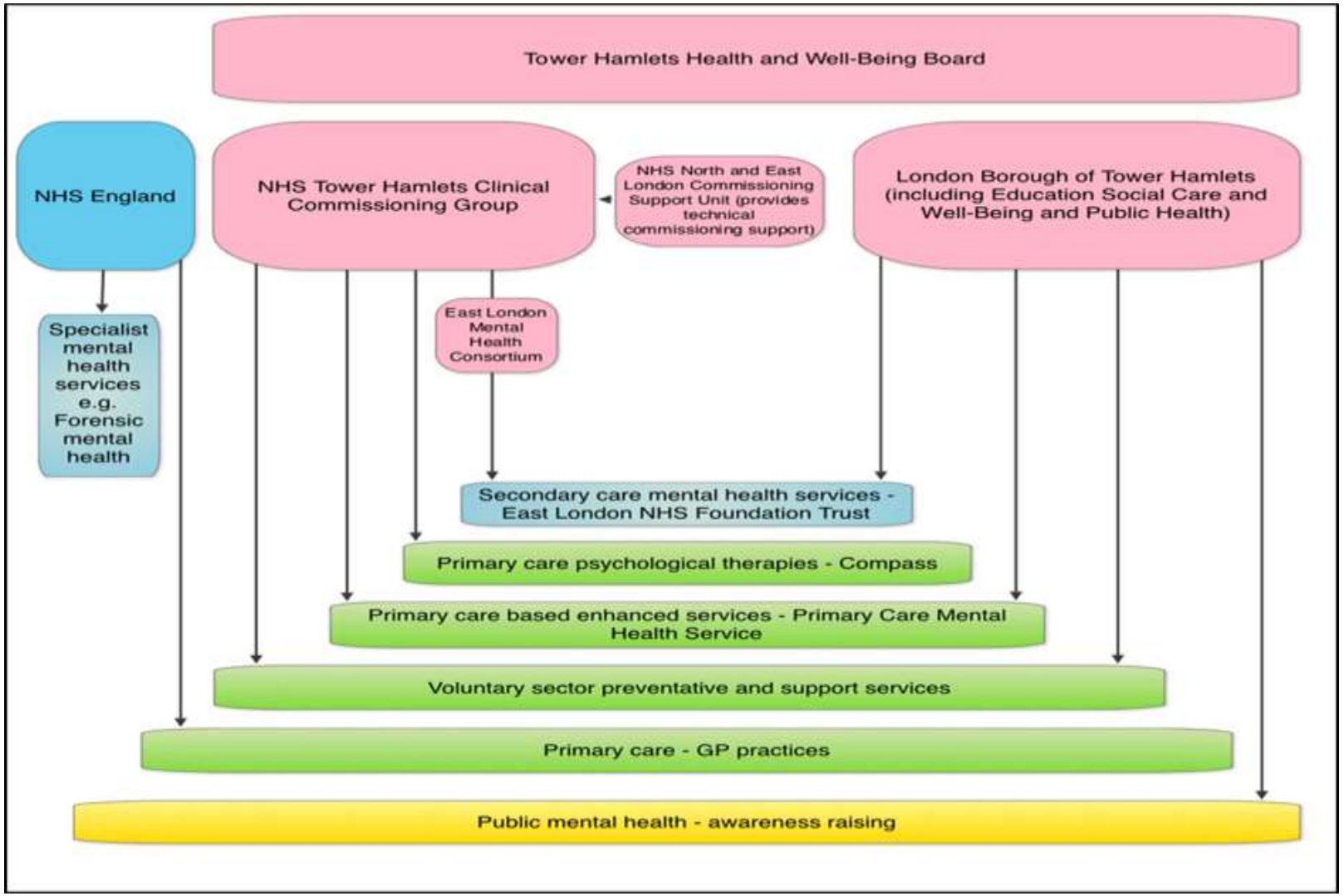
- Health and social care issues for people with mental health problems and barriers to service access
- Personal budgets for those with mental health problems: empowerment and choice
- The Impact of the ELFT community pathways redesign on access
- Mental health community based services: localised, integrated and promoting choice, independence and wellbeing?

"Our vision is to deliver substantially improved outcomes for people with mental health problems in Tower Hamlets through integrated mental health services that are safe and effective, with friendly staff that inspire confidence in the people and families using them, and which help people to take control of their own lives and recovery"

A life course approach to mental health and well-being

Building resilience: mental health and wellbeing for all	High Quality Treatment & Support	Living well with a mental health problem
Fewer people will experience stigma and discrimination	People in general settings like schools and hospitals will have access to mental health support	People will feel that mental health services treat them with dignity and respect, and inspire hope and confidence
People will have access to improved information on what services are available	People will have access to high quality mental health support in primary care, including GP practices and primary care psychology	People will have access to support from peers and service user led services
Mental health awareness across our communities, schools and employers and in the health, social care and education workforce will improve	People will receive a diagnosis and appropriate support as early as possible	People will be able to make choices about their care, including through personal budgets
People will have access to a range of preventative and health promotion services	People will have timely access to specialist mental health services	People will feel supported to develop relationships and connections to mainstream community support
Families and carers will feel more supported	People will be able to access timely crisis resolution, close to home	People will have access to support to find employment, training or education
People will experience smooth transitions between services	When they need to access multiple services, people will feel that they are joined up	People will have access to accommodation that meets their needs, in the borough
At risk communities will have access to targeted preventative support	People with a mental health problem will have high quality support with their physical health	
Shared values: a whole person approach		
Mental health is everybody's business		
Focus on quality improvement		
Commissioning with commitment		

Mental health Services in Tower Hamlets



The Tower Hamlets Mental Health Partnership has a very strong collaborative approach across health and social care, service users, commissioners and statutory and voluntary sector providers in mental health, supported by a joint health and social care commissioning team . The Partnership has delivered a number of highly successful change programmes over the last two years, for example:

- Redesigned dementia care pathways, winning the 2013 LGC Health and Social Care Award
- Crisis pathway for adults with a mental health problem working very effectively, with in-patient bed occupancy c. 75% year to date
- Accommodation Strategy for people with mental health problems, delivering high quality in-borough supported accommodation as an alternative to out of borough residential care
- Primary care mental health service, supporting people with mental health problems to move to recovery

TOWER HAMLETS

NHS Tower Hamlets Clinical Commissioning Group

Strengths

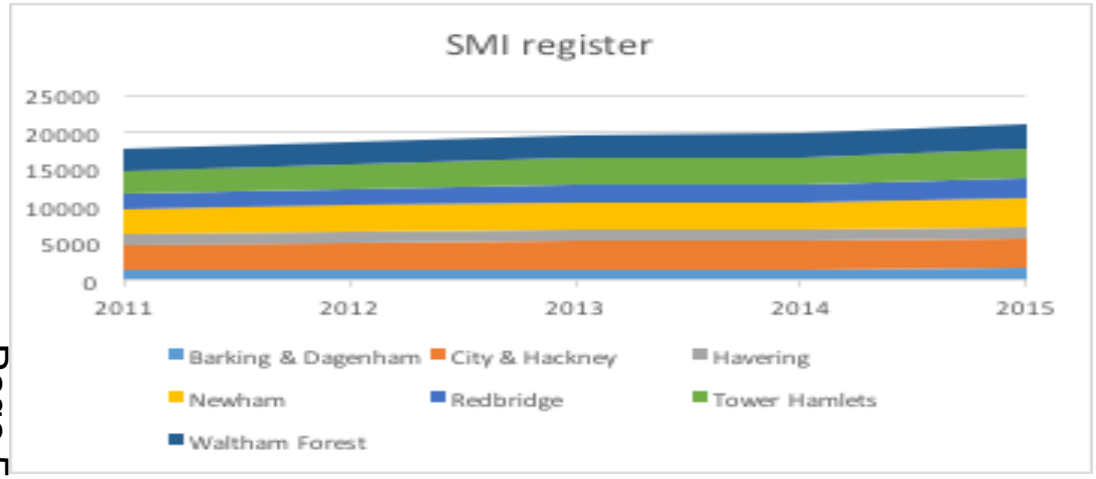
- Crisis pathways including RAID service and local availability of beds
- Primary Care Mental Health Service
- Accommodation Pathways
- Good clinical services – ELFT rated as “Outstanding “ by the CQC
- Diverse and well established third sector
- Outline suicide prevention plan
- Investment in CAMHS to keep on trajectory for 35% of diagnosable population
- CYP transformation plan
- Health Watch MH task group
- Recovery college
- Service user-led grants
- Social investment for more jobs
- Investment (co-commissioned with NHS England) in Youth Justice Mental Health Diversion and Liaison Worker)

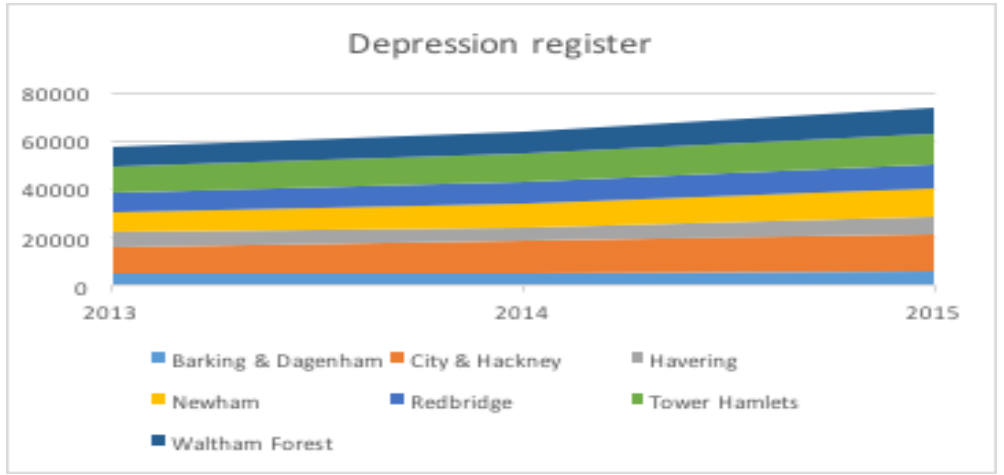
The Local Challenges

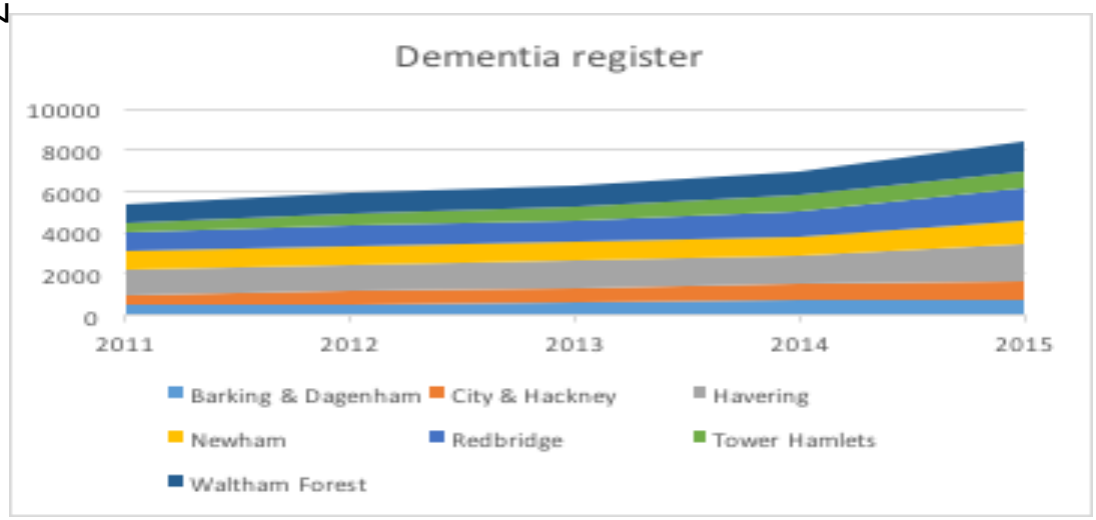
- Our **population** is growing fast – **20%** in the next five to ten years
- Both **younger and older** populations are growing
- Parts of our population are **transient** and there are areas of intense **deprivation**
- Wider societal challenges; **welfare reforms, homelessness**
- People want their **whole health and social care needs** considered as one and we too often treat and manage people in parts, in particular not making sure that people's mental as well as physical health are treated equally
- **Capacity** is not necessarily in the right places to meet demand or support new models of care in the community
- Finding and keeping the **workforce** is challenging
- **Access, quality and outcomes are variable** – we have some areas of excellence, but sharing good practice could be better and some services need improvement
- We have significant **financial pressures** that may be de-stabilising to the system
- In recent years the system has become **fragmented:** causing duplication, not always working to the best advantage for the patient or local people and putting artificial barriers between professionals and organisations across health and local government services
- Increasing use of A&E in **crisis**

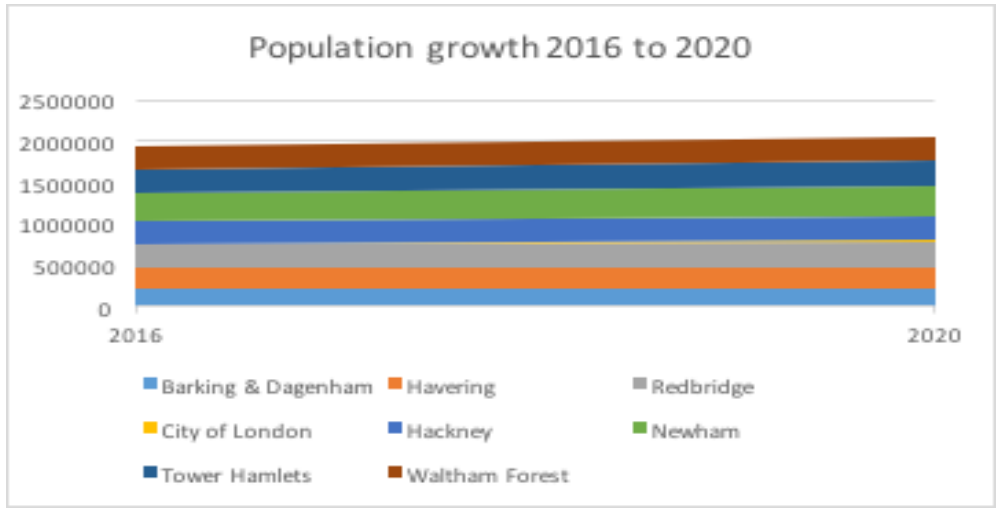
Historic and projected growth in need

Tower Hamlets has amongst the highest level of mental health need in the country, particularly the inner London boroughs, where there has been significant growth in need over the last 5 years. The growth in need is set to continue with population growth and demographic change over the next 5 years





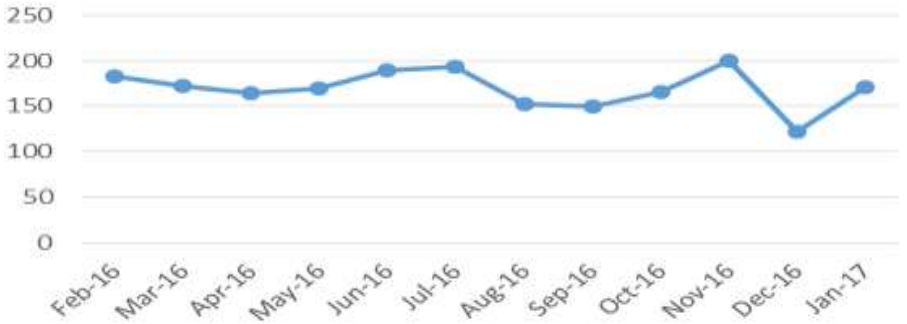




Barriers to access

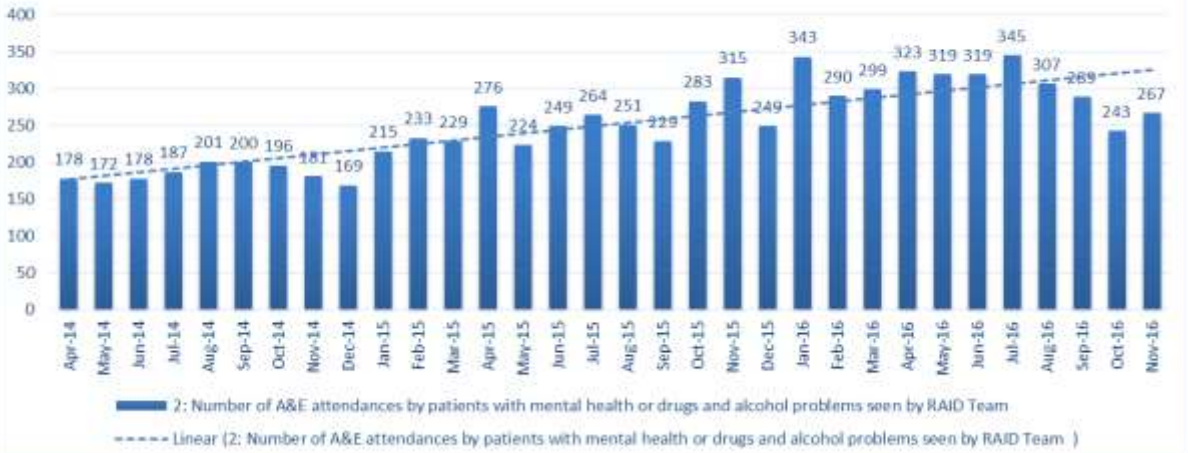
- **Lack of awareness** – many people do not have knowledge of mental illnesses
- **Stigma** – reluctance to approach particularly in some communities
- Confusion about which service for which need – also fragmentation of services, especially for student population
- Negative symptoms and mistrust of services
- Disproportionate use of section 136
- **Carers** may experience problems accessing services or being a partner
- Poor take-up of personal budgets and IPC
- Transition at age 18
- Schools – some excellent on MH, some not known
- Waiting times to access services variable

Referrals to CRHTT

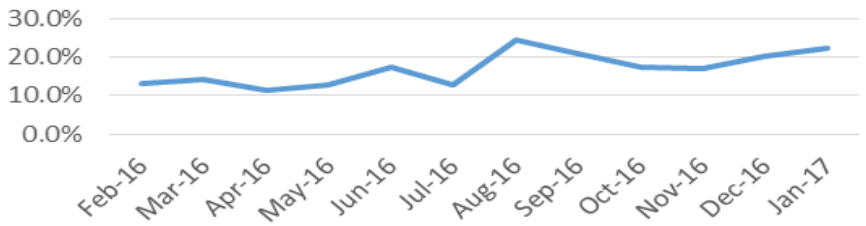


	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Referrals to CRHTT	183	173	165	170	189	194	152	150	166	200	122	171

2: Number of A&E attendances by patients with mental health or drugs and alcohol problems seen by RAID Team

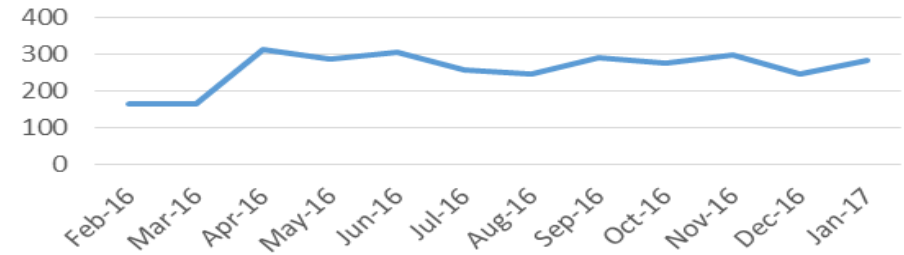


Admissions - patients no prior contact with ELFT services within the past two years



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Admissions - patients no prior contact with ELFT services within the past two years	13.1%	14.3%	11.2%	12.9%	17.3%	12.9%	24.3%	20.7%	17.4%	16.9%	20.3%	22.3%

Number of referrals made to Community CMH Teams



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Number of referrals made to Community CMH Teams	163	166	311	285	304	258	247	290	274	299	245	282

Mental Health Services Tower Hamlets

Primary care Mental Health

Voluntary sector recovery & wellbeing services

URGENT REFERRAL PATHWAY FROM PRIMARY CARE TO SECONDARY CARE MH SERVICES

EMERGENCY
INMEDIATE RISK TO SELF
OR OTHERS:
CONTACT 999

OUT OF HOURS
24hr 7 days/week

URGENT
VIA SINGLE POINT OF ENTRY
ADVICE & ASSESSMENT WITHIN 48HR / MENTAL HEALTH ACT ASSESSMENT **(MHAA)** OR ACCESS TO HOME TREATMENT TEAM **(TH-HHT)**

OFFICE HOURS
Mon-Fri 9am-5pm

PSYCHOSOCIAL CRISIS
Not Psychotic QUICK ACCESS BRIEF PSYCHOTHERAPY
(Phone triage 24hrs)
CIS
Tel: 020 8121 5499
Fax: 020 8121 5487

EMERGENCY MENTAL HEALTH ADVICE AND LIAISON SERVICE
(DEPARTMENT OF PSYCHOLOGICAL MEDICINE)
Royal London Hospital A&E Department
TEL: 020 3594 3179
FAX: 020 3594 3178

SINGLE POINT OF ENTRY

BETHNAL GREEN CMHT (Network 1&2)
Tel: 020 3487 1400
Fax: 020 3487 1401

BOW & POPLAR CMHT (Network 5&6)
Tel: 020 3487 1350
Fax: 020 3487 1351

STEPNEY & WAPPING CMHT (Networks 3&4)
Tel: 020 7791 5200
Fax: 020 7791 5201

ISLE OF DOGS CMHT (Network 7&8)
Tel: 020 7791 8299
Fax: 020 7790 1829

THEIS
First Episode of Psychosis
Tel: 020 3487 1310
Fax: 020 3487 1311

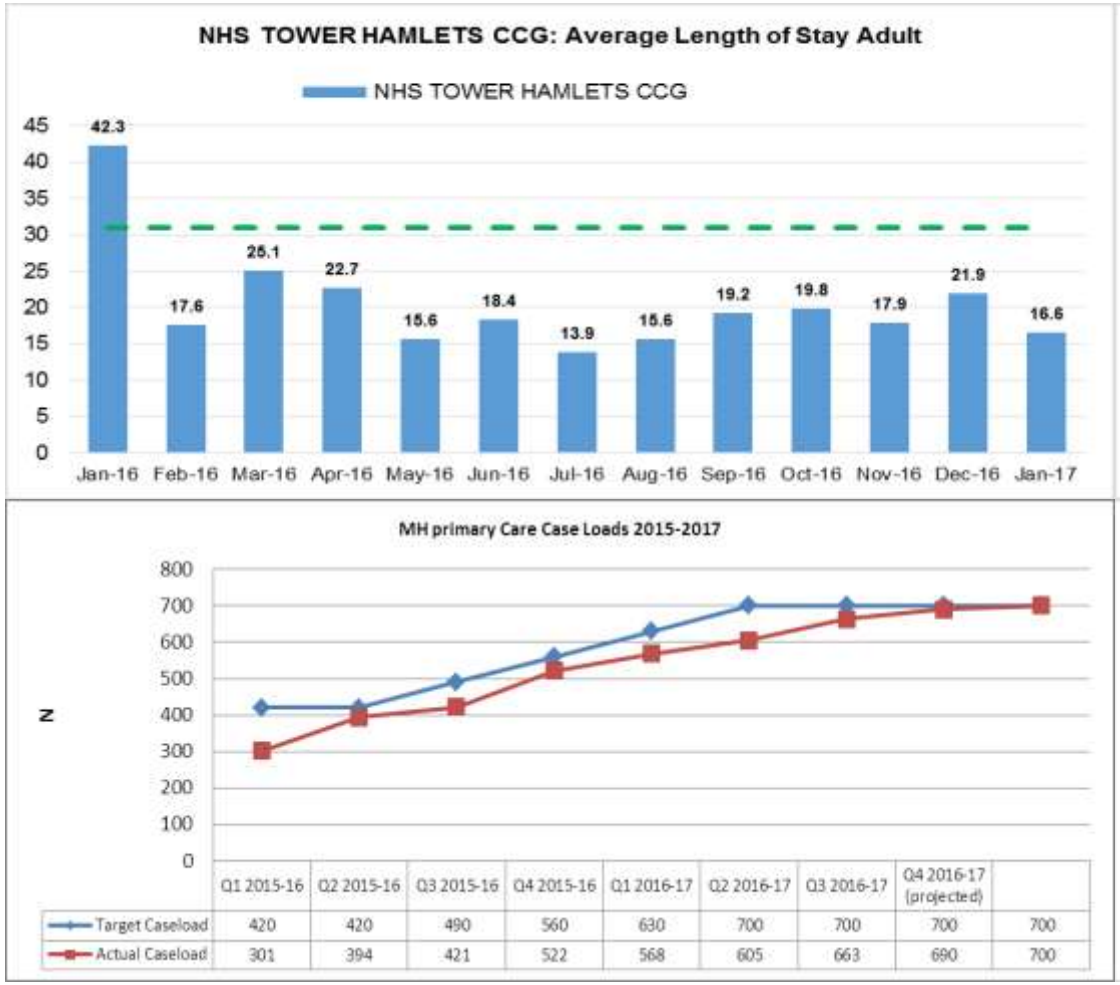
OLDER PEOPLE MH AND DEMENTIA TEAM (All Networks)
Tel: 020 8121 5650
Fax: 020 8121 5670

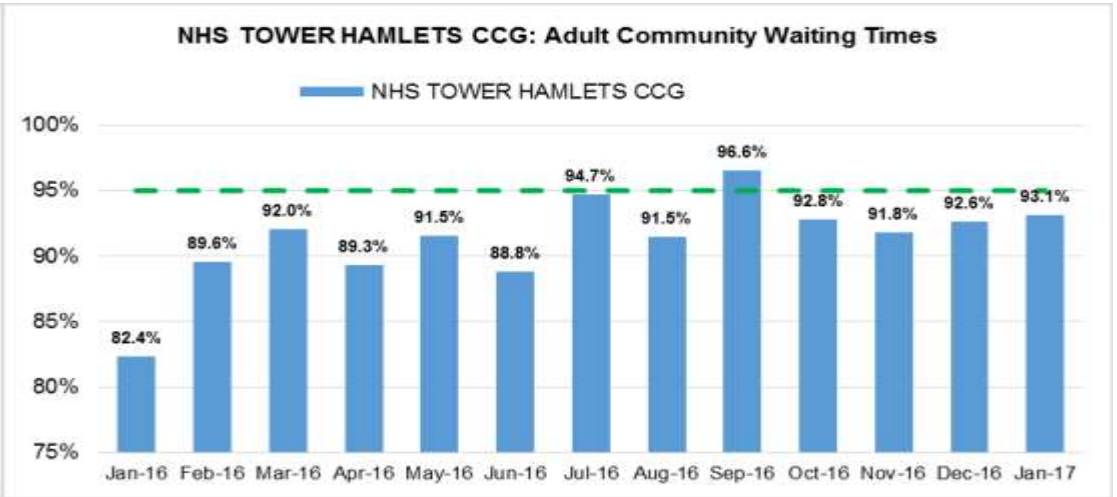
LEARNING DISABILITIES TEAM
Tel: 020 8121 4444
Fax: 020 8121 4445

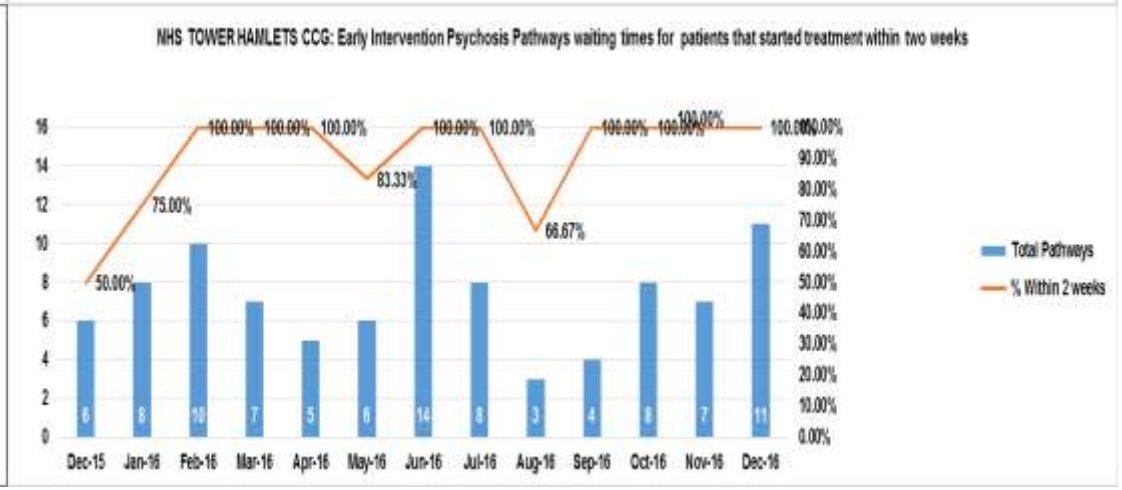
CAMHS (All Networks)
New Referrals
Tel: 0207 426 2375
Fax: 0207 426 2494
Known Patients
Tel: 020 7515 6633
Fax: 020 7537 3770

RESET
Substance Misuse
Tel: 020 8121 5301
Fax: 020 8121 5302

Local Access







Tower Hamlets has the second highest number of people open to secondary care mental health services in London.

The Mental health Primary Care Service

- **Treating the whole person** integrating physical and mental health to address the higher prevalence of physical health problems in people with long term mental health issues.
- **A normalized environment** reducing stigma and supporting recovery
- **Continuity of care**. People and their families often form important long term relationships with their GP practice.
- **Early intervention.** GP Practices, see problems early and have the opportunity to intervene early if supported with mental health expertise.
- **Peer support and care navigation.** Critical to the development of a recovery orientated service. Engagement in support networks and community resources

Immediate Opportunities

- **Prevention** - a population-based approach to mental health : tackling the wider determinants –

  - ✓ Recovery and well being model – Inspire and Recovery
  - ✓ Development of Local Suicide Prevention Strategy
  - ✓ Time to Change programme to combat stigma and discrimination
  - ✓ CYP Transformation plan and strengthening of early intervention services
  - ✓ Awareness raising events

- **Personal health budgets** - a new way of offering individuals with disabilities and long term conditions greater choice and control in how the NHS supports them in improving their health and well being.

- **Integration and whole system approach**

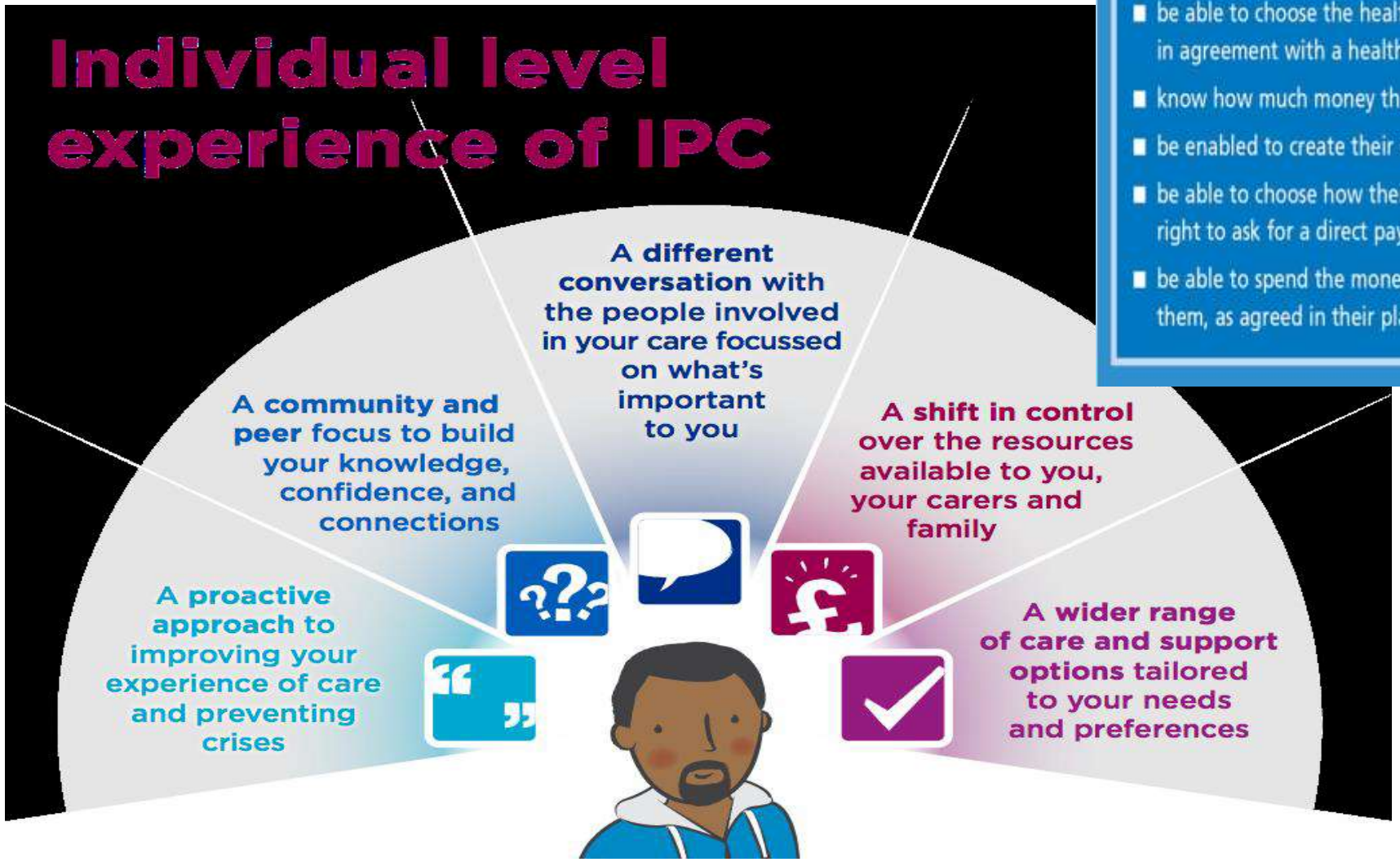
  - ✓ Services for people with a mental health and substance misuse problems joined up
  - ✓ Integrated Commissioning
  - ✓ Tower Hamlets Together
  - ✓ Mental health primary care services
  - ✓ Community health services

- **5 Year Forward View Mental health**
  - ✓ Investment Standard
  - ✓ Strengthening community services, recovery and crisis response.

TOWER HAMLETS

NHS
Tower Hamlets
Clinical Commissioning Group

Integrated Personal Commissioning



THE ESSENTIAL PARTS OF A PERSONAL HEALTH BUDGET

The person with the personal health budget (or their representative) will:

- be able to choose the health and wellbeing outcomes they want to achieve, in agreement with a healthcare professional
- know how much money they have for their health care and support
- be enabled to create their own care plan, with support if they want it
- be able to choose how their budget is held and managed, including the right to ask for a direct payment
- be able to spend the money in ways and at times that make sense to them, as agreed in their plan.

Implementation plan for the Mental Health Five Year Forward View for all ages : “Must Do’s”

- **Psychological therapies** – at least 19% of people with anxiety and depression access treatment, with the majority of the increase integrated with primary care
- More high-quality mental health **services for children and young people-** at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, CYP IAPT)
- 53% of people experiencing a **1st episode of psychosis** begin treatment with a NICE-recommended package of care within 2 weeks of referral;
- Increase individual **employment placement support** for people in secondary care services by 25% by April 2019 against 2017/18 baseline;
- **Community eating disorder Services -** 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases;
- **Reduce suicide rates** by 10% against the 2016/17 baseline.
- Ensure delivery of the **mental health access and quality standards** including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the **Mental Health Investment Standard.**
- Maintain a **dementia diagnosis** rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- **Eliminate out of area placements** for non-specialist acute care by 2020/21.

STP Mental Health: Five key themes to address the health and wellbeing, quality and sustainability challenges

1. Improving population mental health and wellbeing

Population-based approach to mental health, tackling wider determinants, reducing inequalities and managing demand

2. Improving access and quality

Deliver the key quality and access requirements of the MH and General Practice FYFVs

3. Ensuring services have the right capacity to manage increasing demand

Improve capacity and productivity by developing best practice urgent and community care pathways orientated around community and primary care

4. Supporting improved system outcomes and value

Integrate preventative mental and physical healthcare to improve outcomes and reduce utilisation of primary care, acute, CHS, social care

5. Commissioning and delivering new models of care

Join up whole person care commissioning, supported by new approaches to contracting, to ensure good value, integrated services