NHS HWE ICB Primary Care Board meeting held in Public

09:30 - 12:00

Thursday 27 July 2023

Conference Room 2, The Forum, Hemel Hempstead, HP1 1DN / MS Teams

Meeting Book - NHS HWE ICB Primary Care Board meeting held in Public

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09:30	1. Welcome, apologies and housekeeping		Chair
09:35	2. Declarations of interest		Chair
09:40	3. Minutes of the last meeting held on Thursday 25 May 2023		Chair
	4. Action Tracker - No open actions		
09:45	5. Questions from public	Discussion	Chair
09:50	6. Directorate Highlight Report	Assurance/information	Avni Shah
10:10	7. Risk Register - to follow	Information	Andrew Tarry
10:20	8. Primary Care Transformation:	Approval	
	8.1 Primary Care Digital Priorities		Trudi Mount / Gopesh Farmah
	8.2 Primary Care Delivery Plan	Approval	James Gleed
10:35	9. Primary Care Contracts Update	Discuss / Information	
	9.1 Progress on Access Recovery Plan	Information	Andrew Tarry
	9.2 Update on Dental	Discussion	Michelle Campbell
11.00-11.15	Comfort Break		
11:15	10. Update from Health Watch:	Discussion	
	10.1 Health Watch Hertfordshire		Neil Tester
	10.2 Health Watch West Essex		Sam Glover
11:15	11. Patient Comms & Engagement report	Information	Heather Aylward / Heather Eardley
11:40	12. Minutes from the Subgroup – information only	Information	Chair
	12.1 Primary Care Digital		
	12.2 Primary Care workforce		
11:40	13. Reflections and feedback from the meeting	Discussion	Reflections and feedback from the meeting

11:50

Close of meeting

Herts & West Essex Strategic Framework- 2022-2027

Our mission

Better, healthier and longer lives for all

We will achieve this by

- **Improving physical and mental health across our population**
- **Tackling unequal access, experience and outcomes**
- **Enhancing productivity and value for money**
- **Ensuring the NHS supports broader social and economic development.**

In the first 3-5 years we will

- Increase healthy life expectancy, and reduce inequality
- Give every child the best start in life
- Improve access to health and care services
- Increase the numbers of citizens taking steps to improve their wellbeing
- Achieve a balanced financial position annually

The ICB will deliver this by:

- Setting direction for the NHS in Hertfordshire and West Essex
- Allocating NHS resources fairly and effectively
- Supporting, equipping, and empowering our people
- Working with and pooling resources with our partners
- Enabling improvement and driving change, with a focus on quality
- Using data and evidence to generate insight and assess impact

Hertfordshire and West Essex Integrated Care System

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☐	*Meeting in private (confidential)*	☒			
	Primary Care Board				**Meeting Date:**	**27/07/23**	
Report Title:	**Committee Declarations of Interest**				**Agenda Item:**	**02**	
Report Author(s):	Gay Alford, IG and Governance Officer Jas Dosanjh, Governance Manager – Conflicts and Policies						
Report Presented by:	Iram Khan, Corporate Governance Board & Committees						
Report Signed off by:	Michael Watson, Chief of Staff						
Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information** ☐
Which Strategic Objectives are relevant to this report:	▪ Relevance to all five ICB Strategic Objectives						
Key questions for the ICB Board / Committee:	▪ Please see the 'Recommendations' section						
Report History:	▪ The full ICB Declarations of Interest Register is routinely reported to the Audit & Risk Committee in line with the Committee Workplan and Terms of Reference						
Executive Summary:	The ICB is required to carry out an annual exercise to refresh the Declaration of Interests Register, this is line with statutory guidance and the ICB's Standards of Business Conduct (Conflicts of Interest) Policy. The annual exercise commenced on 01 April 2023. At the point of drafting this report, the following Committee member/regular attendees declarations remain pending. Each pending response has been logged against the ICBs register: - Geoff Brown - Dr Daniel Carlton-Conway - Cathy Galione - Joanna Marovitch - Dr Vaiyapuri Raja - Neil Tester - Dr Nicky Williams To comply, forms should be completed by the following: • all full and part time staff, • any staff on sessional or short-term contracts,						

<table>
<tr><td></td><td colspan="4">

- GP clinical leads working within the ICB (please include details of the PCN your surgery is part of in your declaration),
- any students and trainees (including apprentices),
- agency staff,
- seconded staff,
- self-employed consultants or other people working for the ICB under a contract for services should return a declaration.

If Committee members/regular attendees have nothing to declare, then a “NIL return” should be provided.
</td></tr>
<tr><td>Recommendations:</td><td colspan="4">The Committee is asked to:
Note the returned declarations and whether these reflect the current membership/regular attendees for this Committee,
Review any potential conflicts of interest that need to be managed at the meeting in accordance with the agenda,
Encourage pending returns from members/regular attendees to submit any outstanding declarations to hweicbwe.coi@nhs.net by 31 July 2023 to comply with the annual refresh exercise for 2023/24.
Remind members and regular attendees that - whenever an individual’s role, responsibility or circumstances change in a way that affects the individual’s interests (e.g., where an individual takes on a new role outside the ICB or enters into a new business or relationship), a further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days. The revised declaration will countersigned by their Line Manager or lead, and then forwarded to hweicbwe.coi@nhs.net for logging.</td></tr>
<tr><td rowspan="4">Potential Conflicts of Interest:</td><td>Indirect</td><td>☐</td><td>Non-Financial Professional</td><td>☐</td></tr>
<tr><td>Financial</td><td>☐</td><td>Non-Financial Personal</td><td>☐</td></tr>
<tr><td colspan="3">None identified</td><td>☒</td></tr>
<tr><td colspan="4">N/A</td></tr>
<tr><td colspan="5">Implications / Impact:</td></tr>
<tr><td>Patient Safety:</td><td colspan="4">N/A</td></tr>
<tr><td>Risk:</td><td colspan="4">N/A</td></tr>
<tr><td>Financial Implications:</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="2">Impact Assessments:</td><td colspan="2">Equality Impact Assessment:</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Quality Impact Assessment:</td><td colspan="2">N/A</td></tr>
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	Data Protection Impact Assessment:	N/A

Hertfordshire and West Essex Integrated Care System

HWE ICB Primary Care Board Register of Interests

Name:		Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Type of Interest					Date of Interest		Action taken to mitigate risk
Surname	Foreame			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct interest	Indirect interest	From	To	
Brown	Geoff	Healthwatch									
Carlton-Conway	Dr Daniel	Clinical Lead Planned care Clinical Lead Primary Care Prescribing	Partner- The Maltings Surgery - NHS GP surgery	√	-	-	√	-	2008	Ongoing	Verbal declaration to be made at the beginning of any meetings
			The Maltings surgery is member of Abbey Health Primary Care Network	√	-	-	√	-	Jul 2019	Ongoing	Verbal declaration to be made at the beginning of any meetings
			Member - The Hertfordshire Clinic LLP (not currently trading)	√	-	-	√	-	Jan 2014	?	
			Speciality Doctor Paediatric Allergy - Lister Hospital, Stevenage.	√	-	-	√	-	2015 approx	Ongoing	Verbal declaration to be made at the beginning of any meetings
			Maltings surgery is a member of St Albans and Harpenden G Federation, STAHFED Ltd.	√	-	-	√	-	2016 approx	Ongoing	Verbal declaration to be made at the beginning of any meetings
			Together with Dr Fraser Booth and Dr Brian Fisher, I am director of Optimise Health Limited, which has developed a hypertension software application (called OptBP) that is being used in GP practices	√	-	-	√	-	2014 approx	Ongoing	Verbal declaration to be made at the beginning of any meetings
			PML NHS ultrasound service hosted at the Maltings Surgery	√	-	-	√	-	2019	Jun-22	Verbal declaration to be made at the beginning of any meetings
			Hosting HertsOne GP Federation Primary Care ADHD service	√					Feb 2022	Ongoing	
			Spouse, Joelle Carlton-Conway, Board Trustee CIMPSA (Chartered Institute of the Management of Sport and Physical Activity)	-	-	√	-	√	Jan 2022	Ongoing	Verbal declaration to be made at the beginning of any meetings
			Spouse, Joelle Carlton-Conway has previously worked with MyHealthSpecialist a medical technology company that may wish to work with health and care providers.	-	-	√	-	√	Sep 2021	Ongoing	Verbal declaration to be made at the beginning of any meetings
			I previously received funding from ALK Abello which contributed to study MSc in allergy at Southampton Medical School (> 7 years ago).		√				2011 approx	2014 approx	
Colegrave	Leighton	Patient Representative	Peartree Patient Voices - Chair The PPG for Peartree Group Practice, Welwyn Garden City			√			2019	Ongoing	
			World Tamils Historical Society (WTHS - registered charity number 1170343) - planning committee (now complete) Also I ndirect Interest, as my father was general secretary of the WTHS for approx 8 years from 2015.			√		√	2019	2023	
Disney	Elizabeth	Director of Operations, HWE ICB	Sister is employed by the ICB on a fixed term basis within the ICB Medical Directorate	-	-	-	-	√	Jan-23	Feb-24	No involvement in recruitment process or decision to employ
Galione	Cathy										
Glover	Sam	Healthwatch, Essex	Representing Patient Experience					√	Jun-05	Current	Verbal declaration to be made at the beginning of any meeting
Halksworth	Rachel	AD for Primary Care Contracting	Nil	-	-	-	-	-	-	-	-
Hickson	Scott	Placements Team Lead	Nil	-	-	-	-	-	-	-	-
Hiley	Marianne	Volunteer Patient Representative (S&W Herts) Primary Care Board	Member of Gade Practice PPG (Rickmansworth			√			Oct-22	Current	
Howard -Jones	Elliott	Partner Member - Community Provider Representative	Nil	-	-	-	-	-	-	-	-
Joyce	Rachel (Dr)	Medical Director	Married to an NHS consultant who works for East and North Herts Trust.	-	-	-	-	√	Jun-01	On-going	To be logged on ICB DoI registers and declared if relevant in meetings/ work
			Director for Ranine Ltd - a company that provides private medical services by one consultant (spouse as above) to local independent hospitals. From 1st April 2022, I resigned my role as Director and now act as secretary who also holds shares in the company. The company does not however provide, or intend to provide, services to the NHS, social care, or NHS patients.	√	-	-	-	-	2018	Ongoing	
Khan	Iram	Corporate Governance Manager - Board & Committees	Nil	-	-	-	-	-	-	-	-
Khan	Roshina	Head of Primary Care Transformation and Integration	Nil								
Marovitch	Joanna	Partner Member - Voluntary Community Faith and Social Enterpirse (VCSFE) Alliance	CEO of Hertfordshire Mind Network	√					2021	Current	Verbal declaration to be made at the beginning of any meeting
			Registered member of the British Association of Psychotherapy & Counselling		√				2015	Current	Verbal declaration to be made at the beginning of any meeting
Moodley	Pragasen	Partner Member for the ICB - Primary Medical services	Partner at Stanmore Medical Group 5 Stanmore Road, Stevenage, SG1 3QA	√	-	-	√	-	2004	Continuing	Verbal declarations to be made at the beginning of any meeting
			Director of AVM Medical. Suite 3 Middlesex House, Rutherford Close, Stevenage, Hertfordshire, United Kingdom, SG1 2EF. Company number 10507387 I use this company to carry out private medicals and nursing home ward rounds	√	-	-	√	-	2012	Continuing	
			Co-clinical director North Stevenage PCN	√	-	-	√	-			
			Partner at Larksfield Medical Practice	√	-	-	√	-	2019	Continuing	
			Partner, Dr A Saha, is a partner at King George Medical Practice	-	-	√	-	√	2016	Continuing	
Perry	Dr Ian	Partner Member, Primary Medical Services	GP Partner in Maynard Court Surgery	√	-	-		-	2013	To date	Verbal declaration to be made at the beginning of any meeting
			Epping Forest North PCN GP Partner	√					2019	To date	
			Stellar Healthcare Shareholder		-	-		-	2014	To date	

Pullen	Annette	EA to Director of Primary Care Transformation	Sister works in Grovehill Medical Centre, Hemel Hempstead as receptionist	-	-	-	-	√	-	Current	-
			Another Sister works as Medical Secretary in Paediatrics at WHHT					√		Current	
Raja	Dr Vaiyapuri	Deputy Chief Executive, North & South LMCs	Nil								
Randhawa	Professor Gurch	Non Executive member, NHS HWE ICB	Professor of Diversity in Public Health & Director, Institute for Health Research University of Bedfordshire. Honorary Academic Contract, UK Health Security Honorary Academic Contract, Office for Health Improvement & Disparities Expert Expert Advisor, NICE Centre for Guidelines, UK Facilitator, faculty of Public Health accredited Practioner Program, UK Faculty of Public Health Non-Executive Director, Forestry England. Adjunct Professor, Ton Due Thang University, Vietnam, Trustee, Race Equality Foundation, UK National Member, National Black and Minority Ethnic Transplant Alliance, UK Member, British Medical Association Ethics Committee, UK Deputy Lieutenant, Bedfordshire Patron of the Bedfordshire Rural Communities Charity Ambassador, Keech Hospice Care Volunteer, Luton Sikh Soup Kitchen Junior Cricket Coach, Harpenden Cricket club							Current	To be declared as appropriate.
Shah	Avni	Director of Primary Care HWE ICS	Spouse works for a Pharmaceutical Industry – Scope, who distribute a number of eye products across the UK.					√	Nov-20	Current	As Director of Primary Care I am not directly involved in the local decision making process of new drugs hence managing conflict
			Spouse provides supervision and support via CPPE to foundation year community pharmacist who required support. This is commissioned through HEE and covered London and South East Area					√	Apr-23	Current	This is commissioned directly from HEE to CPPE hence NO involvement in commissioning and contracting of this
Small	Dr Nicolas	Partner Member Primary Medical Services	Partner Schopwick Surgery Elstree. Provider of GMS Services	√	-	-	√	-	1996	Present	
			Schopwick Surgery is part of the Herts Five Primary Care Network (PCN)	√							
			Practice has shares in GP provider Federation Herts Health & Herts One providing extended GP and community services across south & west Hertfordshire	√	-	-	√	-	2008	Present	
			Schopwick Surgery provides extended GP services to Sunrise Assisted Living, Elstree & Kestrel GroveNursing Home, Bushey	√					1997	Present	To be declared as appropriate
			GP Trainer Schopwick Surgery for North Hertfordshire GP Vocational Training Scheme & Northwick Park Hospital VTS	-	√		-		2007	Present	
			Siblings hold NHS primary and dental care contracts as providers of GP and dental services	-	-		-	√	2001	Present	
			Sibling - associate medical director primary care services, NW London ICS.		-	-		√	2022	Present	
Tester	Neil	Vice Chair, Healthwatch Hertfordshire									
Williams	Dr Nicky	Beds & Herts LMC Ltd Co-CEO	Co-CEO, Beds & Herts Local Medical Committee Ltd, The Shires, Astonbury Farm, Astonbury Lane, Stevenage SG2 7EG		√				2018	Current	Verbal declaration to be made at the beginning of any meeting

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DRAFT MINUTES

Meeting:	**HWE ICB Primary Care Board meeting held in Public**			
	Meeting in public	☒	*Meeting in private (confidential)*	☐
Date:	**Thursday 25 May 2023**			
Time:	**09:30 – 13:06**			
Venue:	**The Focolare Centre for Unity, Welwyn Garden City and Via MS Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Nicolas Small (NS) **(Meeting Chair)**	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Elizabeth Disney (ED)	Director of Operations	Herts and West Essex ICB
Rob Mayson (RM)	Primary Care Locality Lead – ENH	Herts and West Essex ICB
Prag Moodley (PM)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Gurch Randhawa (GR)	Non-Executive Member	Herts and West Essex ICB
Via MS Teams		
Avni Shah (AS)	Director of Primary Care Transformation	Herts and West Essex ICB
Steven Clayton (SC)	Senior Clinical Dental Adviser	Herts and West Essex ICB
Corina Ciobanu (CC)	Clinical Lead -Primary Care Transformation - SWH	Herts and West Essex ICB
Rachel Joyce (RJ)	Medical Director	Herts and West Essex ICB
Joanna Marovitch (JM)	VCSFE Representative	Herts and West Essex ICB
Ian Perry (IP)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Alan Pond (AP)	Director of Finance	Herts and West Essex ICB
In attendance:		
Michelle Campbell (MC)	Head of Primary Care Contracting	Herts and West Essex ICB
Toni Coles (TC)	Place Director, West Essex	Herts and West Essex ICB
Leighton Colegrave (LC)	Citizen Representative, East and North Herts	Herts and West Essex ICB
Joy Das (JD)	Citizen Representative, West	Herts and West Essex ICB

	Essex	
James Gleed (JD)	Associate Director Commissioning Primary Care	Herts and West Essex ICB
Gopesh Farmah (GF)	Digital Clinical Lead	Herts and West Essex ICB
Leanne Fishwick (LF)	Interim Director of Operations: Hertfordshire Division	Central London Community Healthcare Trust
Marianne Hiley (MH)	Citizen Representative, South and West Herts	Herts and West Essex ICB
Iram Khan (IK)	Corporate Governance Manager	Herts and West Essex ICB
Andrew Tarry (AT)	Head of Primary Care Contracts	Herts and West Essex ICB
Emily Perry (EP)	Primary Care Manager – Strategy and Transformation	Herts and West Essex ICB
Phil O'Meara (POM)	Head of Finance – Primary Care Services	Herts and West Essex ICB
Helen Musson (HM)	Chief Officer	Hertfordshire Local Pharmaceutical Committee
Tracey Norris (TN) (minute taker)	Clerk	HFL Education
Neil Tester (NT)	Vice Chair	Healthwatch Hertfordshire
Via MS Teams		
Fergus Bird (FB)		Healthwatch Essex
Sarah Dixon (SD)	Clinical Lead Primary Care Workforce ENH	Herts and West Essex ICB
Jayna Gadawala (JG)	GP Clinical Lead, Herts Valleys	Herts and West Essex ICB
Rachel Halksworth (RH)	Assistant Director for Primary Care Contracting	Herts and West Essex ICB
Chris Harvey (CH)	Assistant Director of Nursing & Quality	Herts and West Essex ICB
Sara Poole (SP)		Healthwatch Essex
Anurita Rohilla (AR)	Chief Pharmacist	Herts and West Essex ICB
Nicky Williams (NW)	LMC Representative	Bedfordshire and Hertfordshire LMC

PCB/30/23	**Welcome, apologies and housekeeping**
30.1	The Chair welcomed all to the meeting, in particular the three new citizen representatives; Joy Das, Leighton Colegrave and Marianne Hiley, introductions were made. He confirmed that this was not a public meeting but a meeting being held in public (members of the public were welcome to attend but were not permitted to participate). Questions from the public were welcomed in advance and there were instructions on the website explaining how to submit these.
30.2	Apologies for absence had been received from: Elliot Howard-Jones and Cath Fenton.
30.3	The meeting was declared quorate.
PCB/31/23	**Declarations of interest**
31.1	The Chair invited members to declare any declarations relating to matters on the agenda: • None declared. All members declarations are accurate and up to date with the register available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB
PCB/32/23	**Minutes from the previous meeting**
32.1	**The minutes of the last meeting held on 23 March 2023 were agreed as an accurate record.**
PCB/33/23	**Action tracker**
33.1	The action tracker was reviewed, and the status of the following actions noted: • Item PCB 21.7/22: ICS digital strategy deep dive: on agenda, item closed. • Item PCB 20.3/23: Committee effectiveness survey: completed, item closed.
33.2	**The Primary Care Board noted the updates to the action tracker and that all actions were completed**
PCB/34/22	**Questions from the public**
34.1	A further statement from Mr. Woodcock had been received (part of an ongoing dialogue with the PCB) relating to the provision of a community pharmacy in Stansted Mountfitchet. This matter had been progressed and a site visit would take place in June. There were no other questions submitted for this meeting.
PCB/35/23	**Primary Care Board Governance**
35.1	Iram Khan (IK) introduced this item (see pages 17-32 of the document pack) and highlighted the following key findings from the committee effectiveness survey: • All committees had been issued with the same survey. • Eight members of the PCB had responded (this was a low response rate but represented higher engagement than other committees). • Issues raised about the volume of papers for each meeting had been noted and would be addressed. Some documents would be removed from the main meeting pack and attached as an appendix. • Suggestions re the balance of attendees had been taken on board. • No particular themes had emerged from the survey with varied comments made. • This would be an annual survey.
35.2	Questions and comments were invited: • The key next step (for all committees) would be to ensure there were appropriate mechanisms to escalate newly identified/emerging risks. • The effective chairing skills of NS were highlighted; time was always allowed for discussion where needed. • The integration of dental, optometry and community pharmacy would be judged in the coming months.

	• Connections between primary care and other parts of the system were often identified and raised and the effectiveness of the committee should be judged on how well these cross-system issues were resolved/addressed. • Moving forward the PCB needed to have sight of the work being undertaken by place in particular on mental health initiatives. • Deep dives into different sectors/providers presented to the main ICB board and the PCB would support the system wide approach. • PCB members asked for greater visibility of diversity – what was being worked on to promote diversity across HWE. • The video synopsis made by different participants of the Health Care Partnership at the end of each meeting was a useful way of sharing initiatives and the work of different partners in the system. • It was explained that it was not possible to have representatives from all parts of primary care at the PCB, for example, audiology, but as and when deep dives were conducted, the PCB would invite participants (if not represented on the board) to present to the meeting.
35.3	**The Primary Care Board noted the governance report.**
PCB/36/23	**Directorate Highlight Report**

36.1	Avni Shah (AS) shared a verbal update highlighting the following workstreams and focus of the primary care team since the last meeting:
	• New appointments to the PCB were very welcome:
	  ○ Dr Steven Clayton: dentistry; and
	  ○ Citizen representatives from each place: Joy Das, Leighton Colegrave and Marianne Hiley.
	• Work had progressed on the primary care strategic delivery plan (see agenda item PCB/41.1/23) and feedback from citizens would be welcome.
	• Access recovery plan: this was focused on general practice but also applied to dentistry.
	• Primary care digital road map: see discussion at agenda item PCB/41.3/23). A separate meeting would be held by the Digital Working Party to resolve any outstanding issues before the paper was submitted to the July ICB board meeting.
	• The first meeting of the medical workforce transformation team had been held; this covered primary care, acute and non-clinical staff.
	• Covid vaccination programme: spring boosters continued to be delivered, the uptake was not as good as had previously been the case particularly in the immune suppressed cohort. This was a reflection of the national picture.
	• Funding for research had been approved and work would commence with public health colleagues to analysis behaviour patterns of this cohort (this applied to all vaccinations, not just covid).
	• The risk registers had been aligned and would be shared with the ICB Board at its meeting on 26 May. The primary care team continued to review risks monthly, there were no current risks to escalate at this time.

36.2	Questions and comments were invited: • The mixed messages/comms re covid were raised; some citizens were confused, if covid was no longer a threat, why were vaccinations still needed etc. The need for vulnerable groups to maintain their immunisation levels was key and work was underway on this. • GP and community pharmacy delivery of the vaccination programme to vulnerable groups was essential; the fragility of the supply chain was raised by colleagues as well as the poor stock control by national/regional teams. It was suggested that the ICS should have its own stock of vaccinations. Examples were given of the difficulties

	sometimes experienced in ordering a specific number of doses, clinics having to be cancelled at short notice etc. This eroded public confidence. • It was hoped that improvements would be made to the distribution of vaccinations, which was centrally controlled, before the autumn programme commenced. • Workforce pressures existed in community pharmacy and HM hoped that an integrated discussion on workforce across all aspects of primary care would be held. • Workstreams were being overseen by the People Board covering all professions. • Regional differences within sectors were noted, e.g. recruitment of GPs in certain places was easier than others. • Further developments were suggested for the risk register in terms of identifying and addressing inequalities NB re access, use of digital, by cohorts and geographical areas. • An understanding of the current capacity of individual community pharmacy sites would be useful. GPs were directing patients to pharmacies, but did they have the capacity to perform these extra services? An example was given of slow service by a locum pharmacist which had frustrated members of the public waiting to be served. • Dental workforce was also an issue, there were opportunities for the sector to be more effective/innovative regarding the skills mix and the additional health care checks dental staff could potentially provide.
36.3	**The PCB noted the Directorate update**
PCB/37/23	**Primary Care Finance Report**
37.1	Alan Pond (AP) introduced the primary care finance report (see pages 33-40 of the document pack) highlighting the following points: • The 2022/23 out-turn for primary care services showed a small underspend offset by the overspend in prescribing. • 2023/24 allocation: funding levels would be maintained at 2022/23 levels with a small uplift and specific allocations based on 2022/23 activity and population growth areas. • All known costs within primary care had been identified. • Some monies had been ringfenced, e.g. fellowship/mentoring. • £2m transformation funding and £1.5m contingency were uncommitted within the primary care budget. Projects would need to be identified which will have impact and result in transformed services. All investment decisions would need to show better outcomes for patients. • Prescribing: the main challenges in this area would be the need to increase efficiency and reduce costs within the climate of rising prices and limited stock. Any underspend in prescribing would be ringfenced to the prescribing budget. • Dentistry and optometry were both underspent in 2022/23. • Optometry was driven by claims not commissioning. • Dentistry: main challenges – increase activity. • Pharmacy: overspent in 2022/23 because of transitional payments.
37.2	Questions and comments were invited: • Dentistry: 19% underspend nationally. This was the largest underspend since the dental contract had been introduced in 2006. Issues related to workforce and covid legacy; the need for greater IPC measures has reduced capacity. • The current dental contract was not attractive enough for dentists to consider an NHS route above a private route. This was being explored. The Primary Care team were building a picture of dental activity, data, and capacity with support from Public Health colleagues. • Inequalities of access to dental services would be identified during this piece of work. There were currently 241 dental contracts within HWE, but coverage was not equal and patients could easily be using services in a neighbouring county if they lived at the periphery of HWE. Research by Healthwatch had been commissioned. • All transformation funding would be non-recurrent.

	• How would the delivery of efficiencies be managed and monitored? All providers were responsible for achieving their own efficiencies, although this might have a knock-on impact in other areas of the system. Did all providers have a clear understanding of the efficiency requirements of them? • AP noted the danger of increasing funding without linking this to increased output. • PCB members stressed the need for spending decisions to be linked to the ICB's strategic priorities; to address health inequalities. • AS expected that the strategic delivery plan would provide the framework to do just that with input from all parts of primary care system. • Some funding decision would be driven by national asks and in response to unplanned events, e.g. the influx of refugees. • The primary care access strategy would require extra funding but this matter related to access within the whole of primary care and not just general practice. • There were tight controls in place to monitor prescribing, the price rises seen in 2022/23 were expected to continue and the supply chain remained patchy for some medicines.
37.3	**The Primary Care Board noted the finance report**
PCB/38/23	**Update from Healthwatch**

38.1	Neil Tester and Fergus Bird introduced this agenda item (see pages 41-54 of the document pack) which covered their early findings on:
	a. Adults with learning disabilities' experiences of accessing GP services and support in living a healthy lifestyle; and
	b. Public understanding on cardiovascular disease, and self-management.
	The following highlights were shared:
	• The LD research was entirely based on qualitative focus group feedback and interviews. The findings were powerful and highlighted the need for:
	  ○ Greater flexibility within general practice to support LD patients and their carers.
	  ○ The lack of access and the poor experiences all resulted in worse health outcomes for this cohort.
	  ○ Better training to achieve more positive interactions between LD patients and staff.
	• The COPD research findings were more straightforward and it was agreed that a more detailed discussion of the COPD findings would be held at the next meeting to allow more time to be dedicated to the LD discussion.

38.2	Questions and comments were invited: • The research highlighted the variation in service delivery across HWE. • In some practices, the LD cohort were supported by a dedicated LD practice nurse. Was it time to consider introducing a separate service for the LD cohort? Had the LD community been consulted about this? • The key message was the need for continuity of relationships, often LD patients were reliant on social services in how they accessed primary care. Some community services were not accessible by LD cohort. • AS reported that conversations were on-going with adult social services and how they could connect with the PCB. • The Healthwatch findings were being shared with mental health and LD teams and this research would link in with the next topic, neurodiversity. • Engagement with the wider partnerships of MH/LD teams was welcomed, were the access issues described in primary care similar to those experience in secondary care? • LD patients had complex and diverse needs and needed a personalised service. • A single point of access for LD patients within general practice would be welcomed and many practices would benefit from a LD champion.

	• A suggestion was made for a LD champion to be appointed to every PCN. • There was general agreement regarding the need for greater integration of services and improved access for LD patients, this could be an area where transformation funding was directed. • The benefit of a separate transformation project for a single cohort was challenged, there should be LD provision/recognition in every project business case/model. • All transformation funding decision should be viewed through the lens of inequality. • An integrated pathway to COPD was needed to ensure LD cohort access to this service. • Should each service delivery pathway be reviewed to judge the effectiveness or not of its integrated provision? • The LD cohort represented c5-10% of the HWE population.
38.3	**The PCB noted the interim findings of Healthwatch Hertfordshire and Healthwatch West Essex**
PCB/39/23	**Primary Care Access Recovery Plan**
39.1	Rachel Halksworth (RH) and Michelle Campbell (MC) presented this agenda item (see pages 55-104 of the document pack) and highlighted the following points: • Regular updates were being made to the plan in response to regional and national publications; the latest of which had been a checklist which had been received on Monday 22 May. The iteration shared in the document pack was still only a high-level summary with few details yet confirmed. The deadline for the report was 30 June. • Aim: create an accessible summary of the detail and processes needed for PCNs and practices to be able to deliver the plan covering training and financial support. This was a complex delivery plan which would span two years. • The plan would be published in coordination with the comms team to make sure there was a standardised form of wording for practice websites. • NHSE were hosting regular drop-in sessions to allow ICBs to provide feedback and escalate themes/issues. • A FAQ document would be created. • Baseline data was being collected, which showed the usage of digital tools. • GP appointment data was measured but this did not currently include appointments via the enhanced service or ARRs. Work was ongoing to ensure this was captured, currently all PCNs used different reporting systems. • The national ask was for 50m more appointments by March 2024 which equated to c1.5m more in HWE. • The compliance/enforcement role of NHSE was currently unknown.

39.2	Questions and comments were invited:
	• Methods to address and priorities inequalities were suggested:
	  ○ Identify areas with the lowest life expectancy; and
	  ○ Identify areas which had the least capacity in terms of primary care services.
	  ○ Avoid measures/spending initiatives which might widen these gaps.
	• PCNs would need to use public health management data to identify demand, gaps and needs. This response should be more than just increasing the number of appointments.
	• A questionnaire would be created for practices and PCNs to complete to evaluate the impact of the changes made and how this reduced inequality/barriers to access.
	• Appointments would be a mixture of face to face and digital and should be with the appropriate health care professional, this did not always have to be a GP.
	• IT system alignment was essential to save time, money and improve patient outcomes.
	• It was noted that some general practices were not yet operating collaboratively within their PCN, this would need to be addressed.

	• Could the digital front door identify how many patients were thwarted at their first attempt to access primary care. • The use of patient experience from Healthwatch research could be used to support the creation of a user-friendly patient interface. • There was a risk of potential overlap and overload of comms from national and local teams. • The extra paperwork involved for cross-border care was noted. • The recovery plan should be expanded to address the healthcare services provided in community pharmacy; see output from pilots in Dacorum and Hertsmere. • Clear comms to citizens was critical as well as better understanding by the public of the ARRs roles. • Potential barriers to the delivery of plan: estates - where would these appointments take place when many practices were already at capacity.
39.3	**The Primary Care Board noted the Primary Care Access Recovery Plan**
PCB/40/23	**Primary Care Transformation: Draft Strategic Delivery Plan**
40.1	James Gleed (JG) presented this agenda item (see pages105-135 of the document pack) and highlighted the following points: • Changes had been made to the previous iteration following discussions at the March ICB meeting. • Next steps: engagement and input from community pharmacy colleagues, more references to population health management and a greater focus on inequalities and prevention. • The document was a strategy not a guidance manual. • A high-level description of what a neighbourhood team should look like had been created. MOUs, terms of reference, governance structures and other standardised template documents would be provided by the ICB. • Transformation enablers were identified as: premises, workforce, data management and digital. • Acknowledgement that there would be different areas of focus in each place depending on local context.
40.2	Questions and comments were invited: • Effective estate management was essential; the current model was not working – when would this be addressed/discussed? • Clarity was needed on how the creation of integrated neighbourhood teams would work alongside the PCNs – which party would the ICB be working with moving forward? • The formation of integrated neighbourhood teams was not merely a group of practices but a team with representatives from other providers of health and social care in the neighbourhood. It should be considered as a collection of partners working together to improve population health management. • In its current format, community pharmacy did not have the capacity to engage; this has been eroded over time. • The LMC had not been included in the creation of this plan and could provide some recommendations. NW highlighted some mixed messages in the presentation and the need for clarity re same day access and enhanced access and between patient need and want. • Healthcare seeking behaviours varied dramatically across HWE. • Flexibility in the neighbourhood team footprint was encouraged, learnings from West Essex should be promoted. • Potential barriers to success: lack of budgetary control within the integrated neighbourhood team.

	• There was broad support for the plan but further work was required and input from LMC colleagues was welcomed.

40.3	**Primary Care Transformation: Digital Roadmap – strategy**
	Gopesh Farmah presented this agenda item (see pages136-182 of the document pack) and summarised the following points:
	• Digital strategic themes included:
	  ○ Digital collaboration
	  ○ Digital platforms
	  ○ Digital direct care
	  ○ Digital innovation
	  ○ Digital skills
	• Data highlighted the fragmented systems in use (EMIS and SystemOne) and the adoption of shared care across HWE.
	• The roadmap had been created within the remit of the national GP IT operating framework, the Fuller Stocktake and the delivery plan for recovering access.
	• Stakeholder mapping and engagement had taken place.
	• Digital inclusion was a huge consideration of the roadmap.
	• A list of digital “Must-dos” had been created.
	• Investment and delivery principles included:
	  ○ Prioritise the solutions that residents and staff need
	  ○ Optimise the potential of digital suppliers
	  ○ Set clear, realistic goals (S.M.A.R.T.)
	  ○ Invest in a dedicated, expert ICS Digital/Transformation team
	  ○ Think long term, deliver in the short term
	  ○ Use data and evidence to drive learning
	  ○ Adapt and change in response to challenges in order to maximise benefits
	  ○ Build trust in digital solutions and infrastructure
	• Risks and challenges identified were:
	  ○ Funding
	  ○ Resources
	  ○ Governance
	  ○ Duplicity of effort
	  ○ External influence

40.4	Questions and comments were invited: • All participants recognised that this was a massive undertaking, and that digital exclusion should not be underestimated. • How would patient feedback be incorporated; many elderly patients would not be able to engage with the digital front door; they must not be excluded. • There was a risk of overload and confusion by users; e.g. patients submit a repeat prescription request via the NHS App and then call the practice to chase it, phones were often blocked with patients chasing referrals and appointments from secondary providers. • Morale was reported as being particularly low in front desk staff. • Behaviour changes and better comms to patients was needed. • There was a risk that the app would provide too many different avenues of access to patients. • The team would need to understand and audit what is currently being used in community pharmacy, dentistry, and optometry before making changes. • The variety of digital access points was confusing for patients: 111, NHS app, direct access to GP surgery, system one online etc • Even IT literate patients struggle to download the NHS video app. • Self-referrals need to be seamless. • It was hoped that the long-term vision for digital remained a focus, to ensure that systems would have longevity. • Patients with multiple conditions should have a single point of access.

40.5	**The Primary Care Board noted the draft strategic delivery plan and approved the digital road map strategy**
PCB/41/23	**Update on primary care delegated functions:** **A: pharmacy, optometry and dental commissioning**

41.1	Rachel Halksworth (RH) introduced this agenda item and referred to the report at pages 183-187 of the document pack summarising the following points
	• The transfer in April had gone smoothy.
	• 20 staff have been successfully TUPE transferred to the ICB team.
	• Commissioning arrangements were in place for:
	  ○ 276 community pharmacists
	  ○ 225 opticians
	  ○ 243 dentists
	• HWE was providing the hosting arrangements for six other neighbouring ICBs in the East of England.

41.2	Questions and comments were invited: • It was noted that this would be an exciting opportunity for integration. • When would patients see the benefit from the transfer of commissioning of pharmacy, dentistry and optometry? • The dental workplan had a 6-12month timeline for improvement, with as many quick wins being made as quickly as possible.
41.3	**B: Dental services including areas of priority**
41.4	Michelle Campbell presented this agenda item and referred to the report at pages 188-193 of the document pack, highlighting the following: • The priorities for the first 7 weeks had been identified. • Contracts due for imminent renewal had been extended for the first 12 months of the delegation to provide time for better understanding of commissioning options. • The procurement hub meeting took place on 24 May. • Staff TUPE process went smoothly. • A PCB development session would be arranged to explain the contracts variations and differences for context. There were no questions/comments arising.
41.5	**C: Delegation of Primary Care Complaints Function**
41.6	Chris Harvey presented this agenda item and referred to the report at pages 194-204 of the document pack highlighting the following: • A task and finish working group had met w/c 22 May. • Two members of staff would be TUPE'd to the ICB by 1 July. • There were two ways of raising complaints; comms to the public would be arranged. • NSHE would create a template. • This would be rolled out to all stakeholders from July. • The detail of the process has not changed; the ICB had already revised its own complaints process last year so that it aligned with NSHE.
41.5	Questions and comments were invited: • Comms was needed on this for all system partners. Community pharmacy had leaflets in each pharmacy setting out how to complain for example, this would need to be changed. • Complaints were a useful element of feedback and could be used by the ICB to identify issues/trends. • Complaints were already analysed in this way by the Quality Board.
42.6	**The PCB noted the updates on primary care delegated functions**

PCB/42/23	**Reports/minutes from sub-groups**
42.1	The following reports were noted for information: • Primary care digital (pages 205-209 of the document pack) • Primary care workforce (pages 210-214 of the document pack)
PCB/43/23	**Reflections and feedback from the meeting**
43.1	Due to the overrunning of the meeting, the chair invited members to share feedback directly with him and/or Avni Shan via email. • Members noted and welcomed the strategic importance of the agenda items under discussion at today's meeting. • Representation from the pharmacy, dentistry and optometry sectors was welcomed. • The chair thanked the citizens for their contributions.
PCB/44/23	**Date and Time of next meeting**
44.1	Thursday 27 July 2023, at 9.30am
The meeting closed at 13:06.	

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Primary Care Board meeting held in Public				**Meeting Date:**	**27/07/2023**	
Report Title:	**Primary Care Transformation– Directorate Report**				**Agenda Item:**	**06**	
Report Author(s):	Avni Shah Director Primary Care Transformation						
Report Signed off by:	Avni Shah Director Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☒
Report History:	N/A						
Executive Summary:	Highlight Report provides a brief overview on the progress since last board meeting with a view of not duplicating areas of discussion on the agenda and to give a flavour of the forward look of some of the key areas of focus.						
Recommendations:	The Board is asked to • Note and discuss the key contents of the report						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			
	N/A						

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☐
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Primary Care – Directorate Report

Avni Shah, Director of Primary Care Transformation

Working together
for a healthier future

Vaccinations Update

Spring Booster

- In Spring 2023, 67.7% of the eligible Herts and west Essex patients received the covid booster (as of end of day on 30th June). The breakdown by eligible cohort is:

❑ Care home residents: 79%

❑ Aged 75+: 75%

❑ Immunosuppressed: 35%

- The current JCVI guidance for an autumn booster states that only the above 3 cohorts will be eligible, however we expect that this will be extended to those aged 65+, those at risk for their health condition or those that are health and social care workers (to align with the flu eligible cohorts).

MMR

- Generally HWE performs well and maximises uptake of childhood immunisations however uptake dropped recently and the 5 year MMR 2nd dose rate has fallen below the acceptable standard of 90% for the first time in a long time. This is a national problem and we are seeing cases and outbreaks of measles in Herts.

- Besides communications campaign with parents on social media/family centres to dispel myths, it is proposed do some targeted support with GP practices. Practices identified at where they are in deprived areas a face the health inequalities.

- This is joint piece of work with Public Health England, County Council Public Health and Primary Care and children community services teams and local districts.

Immunosuppresed Research Project

- The Covid Booster in Immunosuppressed research project is currently in the qualitative research phase. Interviews are being carried out with patients and acute hospital consultants.

- To date, 26 patient interviews have been completed against a a target of 30. A further 140 patients submitted expressions of interest, indicating interest in this research among patients. Similarly 5 consultants interviews complete against target of 8.

- The project team are taking an agile approach to analysing the interview transcripts to allow analysis of completed interviews to begin while the final interviews are being carried out. This approach allows us to remain on schedule to carry out the majority of the analysis of qualitative and quantitative research in early August with the proposed intervention design in mid and late August.

- As yet, there is no indication of early findings as the evaluation has not yet taken place. The project team are still committed to delivering the pilot intervention in September 2023, however due to the fast and agile pace of this project this is under regular review

Primary Care Workforce Priorities Aligned to ICS People's Strategy Workstreams

Integrated Workforce Planning

- Using NWRS data to support data collection for General Practice analysis of the data regularly
- Scope workforce data collection and reporting for dental/optometry and community pharmacy
- Based on development of PCN clinical strategy – develop robust workforce plans through skill-based for each PCN – progress through PCN education team
- Develop workforce planning skills in the directorate to support primary care providers
- Work with PCNs and Primary care providers to ensure workforce is a representative of our communities we serve

Innovation and New Ways of Working

- Continuously exploring new roles within primary care which support new ways of working and what the training hub can provide as support – enhanced fellowships – GP and nurses
- Improved collaboration with VCFSE with the recruitment of the navigator and personalised care roles and health coaches
- Empowering all primary care staff to empower patients and communities on self-care and prevention
- Skills mix in Community pharmacy with roll out independent prescribers, enhanced role of technicians
- Skills mix in Dental with Dental nurses and hygienists

Sustainable Workforce Supply

- Strong relationships with Universities on workforce supply chain
- Tested international recruitment
- Primary Care Careers Fair
- Training Hub support professionalisation and recognition of all roles
- All applicants treated equally

Staff Wellbeing and Experience

- Reduce turnover rates through PCN education teams
- Enhance Morale
- Access to wellbeing and psychological support
- Further work on access to Occupational Health for all primary care staff
- Equal access to education and training

Education, Talent and Leadership Development

- Embed a culture of training and developments across Primary care – PCN education teams, development of Community pharmacy Clinical lead per PCN
- Enhance apprenticeships in primary care
- Primary Care Awards
- Career Development and integrated roles development

Hertfordshire and West Essex Integrated Care System

Primary Care Workforce Update

HSJ Awards – Patient Safety Award 2023

HWE Training hub have been shortlisted for a HSJ Award for the 'Primary Care Initiative of the year' for the implementation of 35 PCN Training Teams across the ICB to support the delivery in four key areas of responsibility: workforce education, professional support and development, workforce sustainability and planning and future workforce training and education.

A presentation to the HSJ judging panel will take place on 31 July 2023 with the results of the winners taking place at the celebrating of achievements awards ceremony on 18 September 2023 in Manchester.

Primary Care Awards – HWE Celebrating Primary Care Achievement 2023

The awards ceremony will take place virtually on Wednesday **11 October 2023**, 7:00 – 8:30 pm. It is a celebration of excellence across Primary Care in Hertfordshire and West Essex. The aim of the awards is to recognise individuals, teams and practices/primary care providers and their exceptional contributions to Primary Care. This event is open to NHS Primary Care Providers (GP practices, Dental, Optometry and Community Pharmacy), Primary Care Networks and Federations

There are a range of categories including: Excellence in Supporting Staff Training and Development; Patient engagements, Leaders in innovation; transformation; digital transformation, Integration and Collaboration and teams of the years. Nominations are close 3 August 2023.

Primary Care Workforce Update

Progress of the Community Pharmacy PCN Clinical Leadership Role

- It is a local and a national priority for community pharmacies to be full partners within Primary Care Networks (PCNs), taking on expanded roles to protect public health and support urgent care and medicines safety.

- In Hertfordshire and West Essex (HWE) we want to do even more to have community pharmacies as full partners in Primary Care Networks. Therefore, we were successful in a proposal funded by Health Education England to trial having part-time community pharmacy integration leads within our 35 PCNs.

What are the responsibilities of the CP PCN Lead within their PCN:

- Building strong relationships with and between community pharmacies.
- Creating regular communication channels between PCNs, GP practices, and community pharmacies.
- Seeking to improve communication and collaboration between the PCN, GP practices, and community pharmacies.
- Aligning priorities and agreeing on ways to improve patient pathways.
- Communicating with relevant partners as appropriate to support implementation of changes and service development.
- Reaching consensus amongst community pharmacies on all decisions where possible.

To date 33 Community pharmacists have been appointed who are undergoing some training and development whilst also engaging with PCN/locality leadership to start building relationship and ways of working

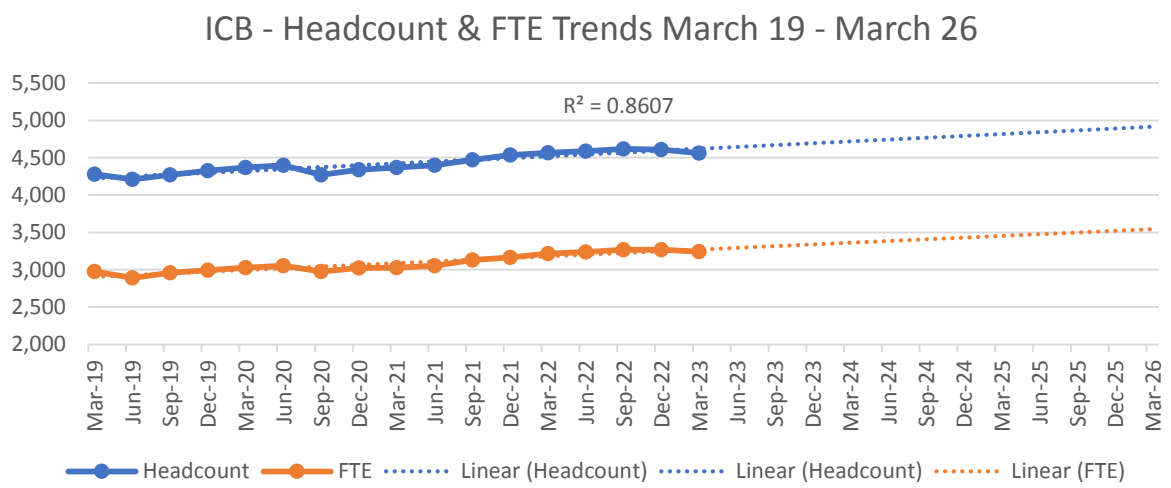
Primary Care Workforce Update

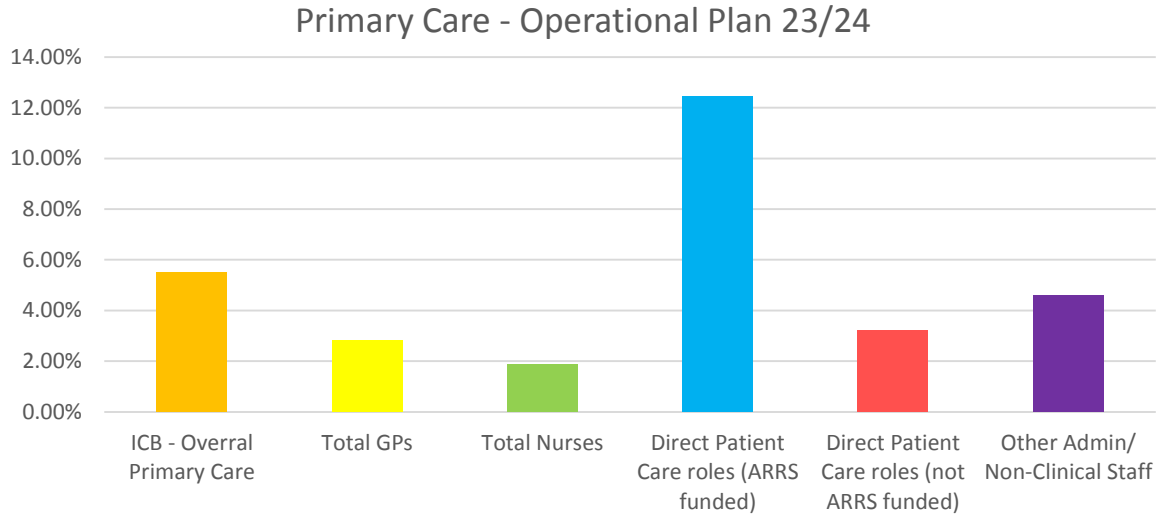
HWE Primary Care Careers Fair 2023

- Plans are in place for the HWE primary care careers fair to take place on 21 September 2023, 10:00 – 14:00 pm at The Fielder Centre, Hatfield, Hertfordshire.

- The event is to promote Primary Care as a first destination career. There will a variety of stalls showcasing a wide range of clinical and non clinical career opportunities and the opportunity to connect with Primary Care employers and hear about current open vacancies and future opportunities.

Performance against Operating Plan – showing a steady increase overall





Hertfordshire and West Essex Integrated Care System

Additional Roles by PCN across HWE

Job Role	ABBEY HEALTH	ALBAN HEALTHCARE	ALLIANCE	ALPHA	ATTENBOROUGH & TUDOR	BROXBOURNE ALLIANCE	CENTRAL WATFORD	DACORUM BETA	DANAIS	DELTA	EPPING FOREST NORTH	HARLOW NORTH	HARLOW SOUTH	HARPENDEN	HATFIELD	HERTFORD AND RURALS	HERTS FIVE	HITCHIN AND WHITWELL	HLH	HODDESDON & BROXBOURNE	ICKNIELD	LEA VALLEY HEALTH	LOUGHTON BUCKHURST HILL & CHIGWELL	MANOR VIEW	NORTH UTTLESFORD	NORTH WATFORD	POTTERS BAR	SOUTH UTTLESFORD	STEVENAGE NORTH	STEVENAGE SOUTH	STORTVALLEY & VILLAGES	THE GRAND UNION	WARE AND RURALS	WELWYN GARDEN CITY A
Advanced Clinical Practitioner Nurse																	0.5										0.6							
Advanced Paramedic Practitioner												2.0												1.0				1.0	2.0					
Advanced Pharmacist Practitioner	1.3			0.2			0.9	0.6	0.8	0.8						1.0	1.0						2.0	0.7										
Advanced Physiotherapist Practitioner	0.7			1.0				1.1	0.5	0.3																1.1								
Care Coordinator	0.3	4.3		3.0	1.7	0.6	3.9	4.9	1.1	1.5		1.0	5.8	2.8	4.5	7.5	28.0	8.2	1.2	9.5	4.8	3.0	3.0	6.5	1.2		6.1	1.6	13.9	6.2	3.6	7.1	2.0	1.6
Clinical Pharmacist		4.5	4.5	1.8	3.3	7.0	5.6	1.7	1.0	2.9	14.0	3.0	2.8	2.6	5.7	3.0	6.5	9.6	2.5	3.9	5.1	2.0	8.0	6.0	4.9	2.0	3.0	2.4	3.0	6.4	3.5	8.2	2.7	10.0
Dietician					0.5						1.0			0.5														1.0						
Digital and Transformation Lead	0.7	1.0				1.0			1.0	1.0	1.0				0.8	1.5		1.0	0.9	1.0	1.0		1.0	1.1	0.6			0.9	1.0	1.0	1.0		0.3	
First Contact Physiotherapist	1.0	1.4	1.0	1.6	1.2	1.0	2.0	0.5	0.3	1.7		2.0		1.0	2.0	1.3	2.0	1.9	0.9	0.9	1.7	2.0		2.1		1.8		2.0	1.1	3.0	1.6	0.4	1.0	1.5
General Practice Assistant		1.8	0.5	4.9					2.1	3.0		2.0					1.0		5.4			1.0	1.0						0.9		4.8	2.0		1.0
Health and Wellbeing Coach	0.9			1.0		1.0		1.0	1.0	1.0	1.0	3.0	1.0	1.0	2.0			4.0		1.2		0.4	0.5		2.6			1.0	1.0	1.0	2.4			0.6
Mental Health Practitioner Band 6															1.0	1.0								1.0								1.0		
Mental Health Practitioner Band 7		1.0		1.0	1.0			1.0	1.0	1.0		1.0		1.0			1.0	2.0	1.0	1.0					1.0	1.0	1.0	2.0	1.0		1.0			
Mental Health Practitioner Band 8a																																		1.0
Nursing associate							0.8		1.0				1.0				0.8																	
Occupational therapist																															1.0			
Paramedic		0.2		0.9	2.9	0.8			0.8		0.7			1.0		1.0	4.0						2.0	1.0		1.0	3.0	1.5		1.5	1.0	1.0		2.0
Pharmacy Technician							1.0	0.8			1.8				3.0	2.0	1.0		1.0		2.0		1.0	1.0					1.8	2.0	1.0	1.0	1.0	1.0
Physician Associate		1.5		1.0			3.5	1.0		2.0				3.2			0.8		1.0								1.0	2.7	1.0	1.0	1.0	6.1		
Podiatrist										1.0																								
Social Prescribing Link Worker	0.9	1.0	2.0	3.9	1.8	3.0	1.0	3.9	1.5	2.0	2.0	3.0	3.0	0.9	4.0	4.0	0.9	1.4	2.0	5.3	2.0	1.0	1.0	2.4	2.8	1.0		1.8	2.0	4.0	4.0	3.1	4.0	3.5
Trainee nursing associate		1.2		1.6		1.0																							2.0			1.0	1.0	
Grand Total	**5.8**	**17.8**	**8.0**	**21.9**	**12.3**	**15.4**	**18.7**	**16.5**	**12.1**	**18.1**	**21.5**	**16.9**	**13.6**	**13.9**	**23.0**	**22.3**	**47.6**	**28.1**	**15.9**	**22.8**	**16.6**	**9.4**	**19.5**	**22.7**	**13.1**	**7.9**	**14.7**	**17.9**	**30.7**	**26.1**	**25.9**	**29.9**	**12.9**	**22.2**

Hertfordshire and West Essex Integrated Care System

Update on Pharmacy, Dental and Optometry

The transition of the Dental, Optometry and Community Pharmacy delegated functions and the associated NHSE Staff were transferred to the ICB on 1 April 2023. Since last month, recruitment underway for vacant post in Primary care Contracting team.

Pharmacy

- As reported last month, due to changes in the Pharmacy Regulations, fitness matters in relation to Pharmacy must now be heard at the Pharmaceutical Services Regulations Committee (PSRC). PSRC meets monthly and is hosted by HWE ICB on behalf of the 6 East of England ICBs.

- The Committee hears matters related to Market Entry and compliance with the Regulations and fitness matters in relation to the body corporate as a fit and proper person to hold a contract. It does not consider individual pharmacists' fitness to practice as this is covered by the General Pharmaceutical Council.

- The governance has transferred to PSRC from 1st of April 23 however, the work to support transfer of the administration, case work and clinical input is part of a transition process till 31 July 2023.

- Detailed work is underway with Dr Ian Gibson, Medical Director at NHSE, Direct Commissioning Team and us whilst also keeping all the other ICBs abreast of the position. Resources for a Band 4 administrator has been made available, however there is additional workload for case management where needed and matters of resilience and contingency which mean this is at present potentially under resourced. Similarly Pharmaceutical Advisors will be transferring over to the ICB from 1st August to support Pharmacy contracting and fitness matters to the ICB from NHSE.

Update on Pharmacy, Dental and Optometry

Engagement with Local Professional Committees

The ICB has met with the Local Dental Committees (LDC), Local Optical Committees (LOC) and Local Pharmacy Committees (LPC) for both Hertfordshire and West Essex, with regular meetings planned over the rest of the year.

The professional committees are invited to Primary Care Board, Primary Care Commissioning Committee and Primary Care Contracting Panel when there are agenda items for the relevant discipline.

Since last meeting, primary care teams have engaged with Dental contractors across HWE held in the evening and also presented at the LPC Annual General meeting in Hertfordshire.

We are waiting on confirmation of dates for the LPC AGM in West Essex.

LOC colleagues have proposed that rather than meet with all providers, we attend a joint Herts and Essex Local Optical Committee to meet the wider membership. This is currently being arranged.

We will continue to build on these good relationships over the coming months.

Update from each Primary Care Place Team

East & North Herts Place

- All PCNs have submitted a Primary Care Access Improvement Plan.
- 14 practices are still on an analogue telephone system but are on a priority list submitted to NHS England region to be moved onto a cloud based telephony system.
- Work is progressing at pace under the Health and Care Partnership's, Care Closer to Home working group in developing the framework for proactive management through the establishment of leadership at locality level and operational multidisciplinary team of an Integrated Neighbourhood Team and PCN level.
- Active discussions between Bridge Cottage Surgery with Hertford & Rurals PCN with a view to join them under their Primary Care Network agreement for 2023/24. This was the one remaining practice at place who were not previously a member of a PCN. The patients of Bridge Cottage Surgery were accessing PCN services under an arrangement with Hoddesdon & Broxbourne PCN in 2022/23.

Update from each Primary Care Place Team

South West Herts Place

- All PCNs have submitted a Primary Care Access Improvement Plan.
- 13 practices are still on an analogue telephone system but are on a priority list submitted to East of England region to be moved onto a cloud-based telephony system.
- Danais PCN which comprised of two practices (Bennetts End Surgery and Everest House) has been dissolved with effect from 30th June 2023. Bennetts End Surgery have moved to Delta PCN and following an assignment process Everest House was assigned to Beta PCN with effect from 1st July 2023.
- Herts Five PCN are currently using the population health management segmentation model working with partners on SMI to operationalise an Integrated Neighbourhood Team

West Essex Place

- All PCNs have submitted a Primary Care Access Improvement Plans
- There are only 2 practices on Analogue telephone system and are on the priority list to be upgraded to CBT.
- The 'Integrated Urgent Assessment and Treatment Centre' at PAH has now gone live (12/07/2023) for a new procurement. The aim/vision/model is to have a truly integrated Health Care Partnership approach to delivering this service.

Communications and Engagement Update

GP Access Comms and Engagement Plan

In line with the national delivery plan this plan aims to explain the modern general practice access approach and to empower patients by making them aware of new online and digital ways of accessing general practice and different routes for accessing care and support such as via community pharmacy. Teams are to:

- Develop improved information on practice websites
- Identify & share best practice – possible introduction of buddy scheme and support
- Develop GP practice resources available key topics
- Educate and Train for GP practice staff
- Ensure effective utilisation of ICB website

Promotion of ARRS Roles

- Working with practices to promote the importance and value of additional roles that are available within general practice. Develop a toolkit of materials, to include videos and website materials that practices can use to help promote these roles. Work with practices to develop case studies.

Promotion of different modes of access

- Promote different ways that patients can contact their general practice with a particular emphasis on promoting and increasing the take-up of online services. Aim to share these with the board at the next meeting

Questions

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☐	*Meeting in private (confidential)*	☐
	NHS HWE ICB Primary Care Board meeting held in Public		**Meeting Date:**	**27/07/2023**
Report Title:	ICB Primary Care Digital Priorities		**Agenda Item:**	**8.1**
Report Author(s):	Trudi Mount,			
Report Presented by:	Trudi Mount, Dr Gopesh Farmah – ICB Primary Care Clinical lead for Digital Dr Parul Karia- ICB Primary Care Clinical Lead for Digital			
Report Signed off by:	Avni Shah, Director of Primary Care Transformation			
Purpose:	**Approval / Decision** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
Which Strategic Objectives are relevant to this report **[Please list]**	< Please identify from the five ICB Strategic Objectives and list below > ▪ to increase healthy life expectancy and reduce inequality ▪ to improve access to health and care services ▪ to increase the numbers of citizens taking steps to improve their wellbeing			
Key questions for the ICB Board / Committee:	▪ Do these priorities deliver the needed transformation in Primary Care ▪ Do these priorities support the Primary Care Access Recovery Plan ▪ Are the plans realistic			
Report History:	Original direction of travel and stakeholder feedback shared remotely to DTB members, discussed with Primary Care Board and all various primary care place leads meetings and patient group across HWE.			
Executive Summary:	The paper describes the key priorities for Primary Care Digital as part of the System Development Fund. It outlines main tasks and deliverables with indicative funding suggestions. The paper also shows links to broader primary care digital projects and links with other providers.			

Recommendations:	Members are asked to discussed and endorse the direction of travel for primary care aligned to the ICS Digital Strategy and Primary Care Strategic Delivery plan.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☐
Implications / Impact:				
Patient Safety:	*By looking to make digital inclusion a priority we are seeking to make primary care inclusive and accessible by all*			
Risk: *Link to Risk Register*				
Financial Implications:	*Budget via ICB SDF Funding*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	< N/A >		
	Quality Impact Assessment:	< N/A >		
	Data Protection Impact Assessment:	< N/A >		

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Herts and West Essex ICB – Primary Care Digital Priorities

July 2023

Working together
for a healthier future

Herts and west Essex – Primary Care Digital

This presentation provides an outline of the key digital priority areas in Primary Care that will enable delivery of the Primary Care Access Recovery plan and support the delivery of Primary Care transformation as outlined the Primary Care Strategic Delivery Plan across the ICB and align Primary Care digital with the overarching ICS Digital Strategy. The priorities are based on feedback from key stakeholders, initiatives derived from recovery plans and local needs.

Herts & West Essex ICB (HWE ICB) service a diverse population across Hertfordshire and West Essex. HWE ICB commissions local hospital services, primary care, mental health services and community services. Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry services.

Digital Technology is a key enabler to ensure that Primary Care can meet the challenges it faces in delivering that 'front door' service and is vital to help with the 4 key themes of the recovery plan of:-

- *Empowering patients*
- *Implementing Modern General Practice Access*
- *Building Capacity*
- *Cutting Bureaucracy*

Following extensive engagement with all stakeholders, the priorities identified in this plan align with the overall strategic direction for Primary Care Transformation including three key objectives around same day access, prevention and reducing inequalities and proactive management including establishment of integrated neighbourhood teams and to theme identified in the ICS Digital Strategy. They have been selected based on their ability to maximise benefits across the system for both providers and patients while providing value for money

Stakeholder Engagement

We engaged with a various groups and organisations within the Primary Care landscape on the content and priorities to be included. Engagement initially took place between Jan 2023 and March 2023 with a wide group of stakeholders. The document has then been continually refined through engagement with Primary Medical Care Providers via each place and other system partners to ensure it appropriately reflects and is aligned with our key stakeholders' direction of travel at that time. It is noted that further engagement will be required in the future because opinions and perspectives are changeable.

We have also engaged with patients and citizens through engagement forums and also by seeking feedback on the delivery plan via the website.

These priorities emerged from those themes although there were other areas also identified which we will need to address longer term.

Organisations / Groups Involved
Essex LMC
Bed and Herts LMC
Primary Medical Providers via place, Practice Manager groups, PCN Managers and Primary Care Leadership Groups
Primary Care Digital Forums
Digital First Primary Care
Digital Clinical Leads meeting
Essex Local Dentistry Committee
Essex Optometry Committee
HealthWatch - Herts
HealthWatch - Essex
Herts LPC - Community Pharmacy
Essex LPC - Community Pharmacy
Pharmacy & Medicines Optimisation Team
Practice Nurse Committee
Hertfordshire Partnership Foundation Trust
HWE ICB - Community
HBL ICT
HWE ICB Digital Team
Patients/Citizens

Landscape of HWE Primary Care

Overall

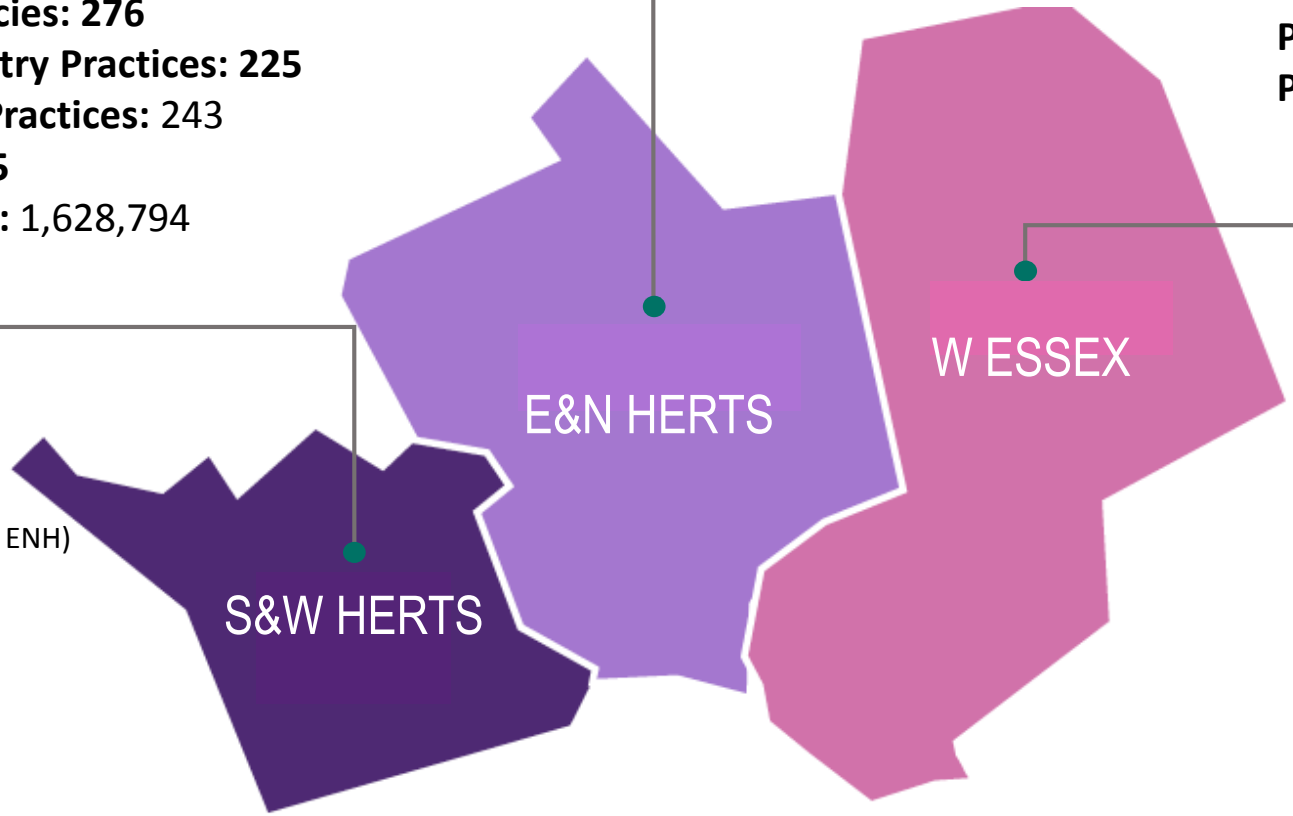
Practices: 130
Pharmacies: 276
Optometry Practices: 225
Dental Practices: 243
PCNs: 35
Patients: 1,628,794

East & North Herts

Practices: 50
Pharmacies: 240 (Inc SWH)
Optometry Practices: 186 (Inc SWH)
Dental Practices: 208 (Inc SWH)
PCNs: 13
Patients: 622,283

South & West Herts

Practices: 50
Pharmacies: 240 (Inc ENH)
Optometry Practices: 186 (Inc ENH)
Dental Practices: 208 (Inc ENH)
PCNs: 16
Patients: 677,780



West Essex

Practices: 30
Pharmacies: 50
Optometry Practices: 34
Dental Practices: 41
PCNs: 6
Patients: 328,731

Hertfordshire and West Essex Integrated Care System

Achievements To Date

Since the Covid pandemic much has changed in how primary care services are delivered. HWE have looked to ensure that new ways of working are supported by digital tools.

Recent achievements include:

- Online/Video Consultation software – deployment of choice of 2 systems for all practices for online and video consultations
- Integrating Total Triage with Digital Front Door - making systems work together and combining with workforce transformation to maximise benefits of systems and people
- Further development of VDI option allowing secure access to clinical systems from personal devices to support remote working
- Worked with LPC to deploy CPCS software to support referrals and information flow between GP (EMIS) and Community Pharmacies for relevant conditions
- Supported Cloud Based Telephony systems to be deployed to practices

  "The new phone system has enabled the practice to know our true demand each day which is helping us ensure we are offering our patients the best service we can. Since having the phone system in place, we have been able to see what hours our peak times are and can make sure we have enough admin members on the phones during these hours.

- Rolled out Windows 10 and Office 365 giving all practices access to MS Teams nd Office 365 functionality
- Creation of Digital Innovation Group to help share best practice across the ICB
- Deployment of Ardens to give practices access to reports and templates in clinical systems – enhances data quality

Priorities

- We have identified 7 priorities to form a programme of work as part of System Development Fund (SDF) which supports delivery of the Primary Care Access Recovery plan and the delivery of Primary Care transformation as outlined the Primary Care Strategic Delivery Plan across the ICB and aligns Primary Care digital with the overarching ICS Digital Strategy
    - Digital Inclusion
    - Advanced Telephony
    - NHS App
    - Automation
    - Digital Workforce
    - Community Pharmacy Integration
    - Infrastructure

Priority 1 – Digital Inclusion

Recovery Theme – Empower Patients/Implementing Modern General Practice Access/Building Capacity

ICS Digital Strategy Theme – Digital Skills

Problem

- A report commissioned by the ICB shows that many of our citizens either do not feel they have the skills to interact with Primary Care through digital tools or do not have access to tools because of lack of broadband, suitable devices or mobile data. This can cause some to be disadvantaged by the shift to a digital front door.

What we have already done

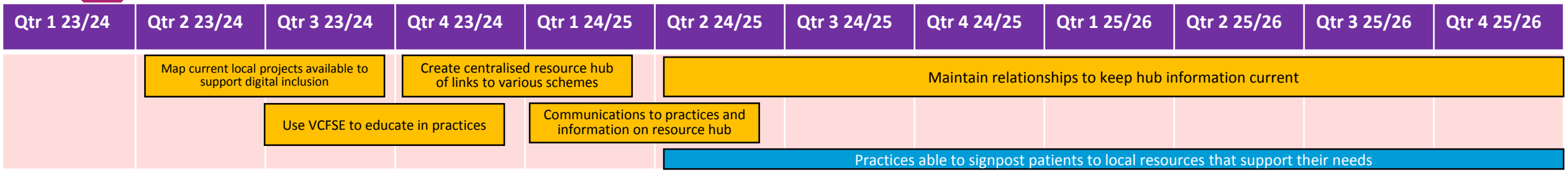
- Commissioned report via external company to understand challenges and public perception of digital front door – completed via previous DFPC programme

What we will do

- Work with partner organisations, such as local authorities and VCSFE organisations, who have programmes specifically aimed at either helping people become digitally skilled or can help with equipment or access to the internet.
- We will look to create a resource hub for primary care that will allow them to signpost patients to appropriate services.
- Look to fund resource via VCFSE to work in practices and other locations to offer digital training/NHS App Registration

Benefits

- Practices able to sign post patients to local services easily
- Practices have more capacity as patients 'self serving' via digital when possible
- Patients able to access digital services with confidence
- Patients able to be referred to suitable local services that can help with digital inclusion



Priority 2 – Advanced Telephony

Recovery Theme – Implementing Modern General Practice Access

ICS Digital Strategy Theme – Digital Platforms

Problem

- Issues with patients being able to contact their practices by phone at 8am to secure an appointment. Practice telephone systems do not always have the functionality for call back or call divert calls so people unable to get appointments when they most need them. Demand for appointments on any particular day is unclear so difficult to plan workforce and capacity to try and match this demand. Not all practices utilising CBT functions and maximising potential benefits.

What we have already done

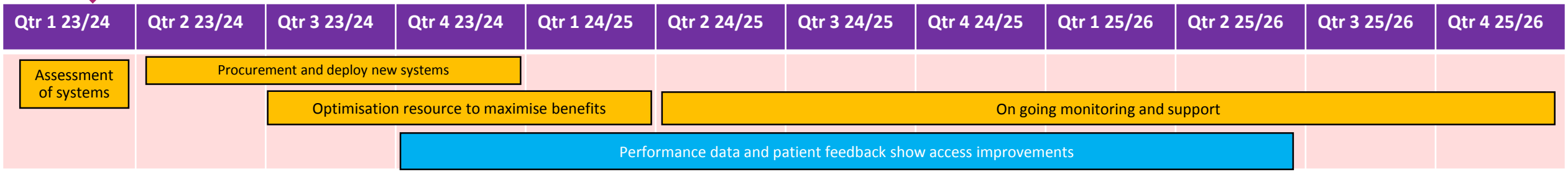
- 97 HWE practices already have some Cloud Based Telephony systems. Of which, over 40% have advance Cloud based telephony system Prioritised 28 more practices to be part of NHSE CBT funded programme and move from analogue systems.

What we will do

- There is now further national money available to deploy this system into more practices (against an agreed ICB priority list). We will support that process.
- We will ensure that practices have support in maximising the benefit of these systems by putting in place a resource within the ICB who will work with practices on optimising system functionality to suit their business model. They will also produce a report on benefits realised.

Benefits

- Patients able to contact practice easily by phone/improved experience with call back facility
- Practices able to manage/understand demand through access to data on call patterns/volumes which supports workforce planning
- Integration with clinical systems making easier and quicker to contact patients
- Opportunity to scope PCN telephone hubs through PCN Cloud based system with sharing of back office staff.



Priority 3 – NHS App

Recovery Theme – Empower Patients/Implementing Modern General Practice Access/Building Capacity

ICS Digital Strategy Theme – Digital Platforms / Digital Direct Care / Digital Collaboration

Problem

- Patients can interface with practices via various Apps, telephones, websites and face to face. The NHS App is now viewed as the future gateway to all NHS services. During Covid many people downloaded the NHS App for the Covid passport but there is now much more functionality within the App that we need to utilise. The NHS App can be used to make/amend/cancel GP appointments, view GP record, order and manage repeat prescriptions, use the NHS symptom checker, manage ERS referrals, manage organ donation preferences and data sharing preferences.

What we have already done

- Started to communicate about NHS APP in suitable forums
- Looking at options to integrate with existing systems e.g. Accurx and eConsult
- To note HWE have an average of 59% of the population (over 13 years old) registered for the NHS App against a national average of 54% registered but this does vary from area to area.

What we will do

- Develop a communications campaign, in line with national programme, to help practices inform patients of the benefits of the NHS App
- Make sure practices optimise their interfaces with the NHS App so that any options for automation/integration are applied.
- Attend any suitable forums (e.g. PPGs) to promote NHS App and integrate with existing practice systems to enable NHS app to be the main source of information
- Ensure this is also connected to the system digital work through hospital outpatient and integrate patient portals so it is all in one app as a system

Benefits

- Patients able to better manage their own condition
- Patients no longer need to contact practice for test results, info from GP Record
- Practices have capacity to do other tasks as less patients contact them for information
- Patients start to get one gateway to all NHS Services consistently across all providers

Qtr 1 23/24	Qtr 2 23/24	Qtr 3 23/24	Qtr 4 23/24	Qtr 1 24/25	Qtr 2 24/25	Qtr 3 24/25	Qtr 4 24/25	Qtr 1 25/26	Qtr 2 25/26	Qtr 3 25/26	Qtr 4 25/26
	Develop public facing comms campaign	Campaign		Work with practices where uptake and benefits not seen							
			Monitor uptake of NHS App and impact on services and functional areas								
			Patients use NHS App and practices able to reinvest time saved back into face to face interaction with most needy								

Priority 4 – Automation

Recovery Theme – Empower Patients/Implementing Modern General Practice Access

ICS Digital Strategy Theme – Digital Platforms / Digital Innovation

Problem

- Many tasks in General Practice are manual repetitive tasks (registering patients, managing recalls for LTCs, filing documents). Time spent doing this is time taken away from more important work for all General Practice staff.

What we have already done

- Scoping what has worked or not across national

What we will do

- We will look to see which areas will get the biggest gain from automation using existing research
- Understand which practices have already invested in automation and outline benefits/dis-benefits seen
- Create portfolio of solutions and understand if possible to pilot some
- Make sure Primary Care EPRs are configured to automate as many tasks and processes as possible.

Benefits

- Practices able to release time from back office tasks to spend on other work
- Patients admin matters dealt with quicker

Qtr 1 23/24	Qtr 2 23/24	Qtr 3 23/24	Qtr 4 23/24	Qtr 1 24/25	Qtr 2 24/25	Qtr 3 24/25	Qtr 4 24/25	Qtr 1 25/26	Qtr 2 25/26	Qtr 3 25/26	Qtr 4 25/26
	Look at practices that have already automated and benefits gained.	Develop benefits profile for practices to be able to understand what this might deliver for them		Use evidence from other areas to develop automated tasks around clinical pathways		Look at where AI may be able to support direct care		Pilot AI on chosen pathway		Expand usage if pilot successful	
			Practices able to reinvest time saved back into face to face interaction with most needy								

Priority 5 – Digital Workforce

Recovery Theme – Empower Patients/Implementing Modern General Practice Access/Building Capacity

ICS Digital Strategy Theme – Digital Skills

Problem

- Varied levels of IT expertise in primary care including general practice/community pharmacy etc.
- Some PCNs have employed digital leads but not all.
- There are many initiatives across the country, region and local area that have digital elements. There is little opportunity to share best practice, develop digital skills or help practices optimise the solutions they already have.

What we have already done

- Started some engagement via Digital Innovation Group (DIG) for Primary Care as part of DFPC Programme

What we will do

- Identify and work with PCN Digital Leads to bring together best practice ideas and ensure that they understand how to work within the GP IT Operating Framework.
- Establish opportunities for learning from each other through user forums such as DIG
- Use MS Teams to create resource hub of useful information/case studies/contacts etc
- Consider staff training and support of digital skills to optimise the use of the digital tools available. This might be with support from the HWE Training Hub or 3rd party providers or national programmes. Work with Workforce Team.
- Scope the workforce needs in other primary care providers on digital front and what can be done to support them further in community pharmacy/dental with the changing workforce

Benefits

- Local network of informed Digital Leads in Primary Care working within and understanding broader ICB Primary Care Digital Strategy
- Access to shared learning and best practice across areas
- Digital workforce in practices that works with ICB to deliver transformation

Qtr 1 23/24	Qtr 2 23/24	Qtr 3 23/24	Qtr 4 23/24	Qtr 1 24/25	Qtr 2 24/25	Qtr 3 24/25	Qtr 4 24/25	Qtr 1 25/26	Qtr 2 25/26	Qtr 3 25/26	Qtr 4 25/26
	Understand current PCN Digital workforce	Create User Groups/resource sharing space									
		Understand current digital skill level									
		Map local PCN digital projects	Local network of informed Digital Leaders in Primary Care working within and understanding broader ICB Primary Care Digital Strategy								

Priority 6 – Integrating Community Pharmacy

Recovery Theme – Implementing Modern General Practice Access/Building Capacity

ICS Digital Strategy Theme – Digital Collaboration/Digital Platforms

Problem

- Successful initial pilot of Community Pharmacy Consultation Service (CPCS) in HWE with EMIS practices but less successful with SystmOne practices.
- We need to get to a point where community pharmacy and practices have similar opportunities and patients receive equitable services regardless of geography – New pharmacy services to go live in December
- Need information flows between pharmacy and GP systems to support patient care.

What we have already done

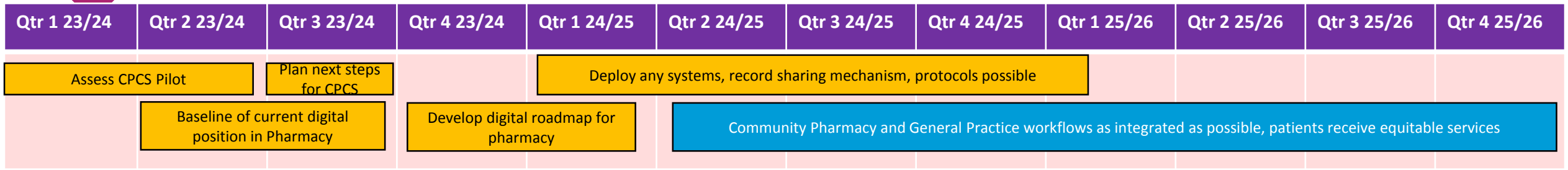
- Successful pilot of CPCS with EMIS practices via DFPC Programme

What we will do

- Working with community pharmacy PCN clinical leads and both LPCs look to understand where the current challenges are.
- Through appropriate channels look to deploy any systems that can facilitate flow of information and support general practice to community pharmacy work flows e.g. Shared Care Record link to Pharmacy systems but also when community pharmacy deliver services which include independent prescribing and how this flows back to the registered GP.
- Make sure we have resource to support implementation and utilisation of systems.

Benefits

- Integrated workflow between general practice and community pharmacy and vice versa
- Information passed electronically where possible
- Pharmacists able to see/treat patients and have access to patient records where appropriate
- Flow of data back to general practice to update them on treatments so have full information



Priority 7 – Infrastructure

Recovery Theme – Implementing Modern General Practice Access/Building Capacity

ICS Digital Strategy Theme –Digital Platforms

Problem

- General Practice is changing the way it works to meet increasing demands with a challenging diverse primary care workforce (move away from traditional GP nurse model)
- Need to ensure that the infrastructure supports this
- Some practices need more laptops but some have laptops that are unused
- We need to make sure we have a process for assessing need against options to support different ways of working of each practice

What we have already done

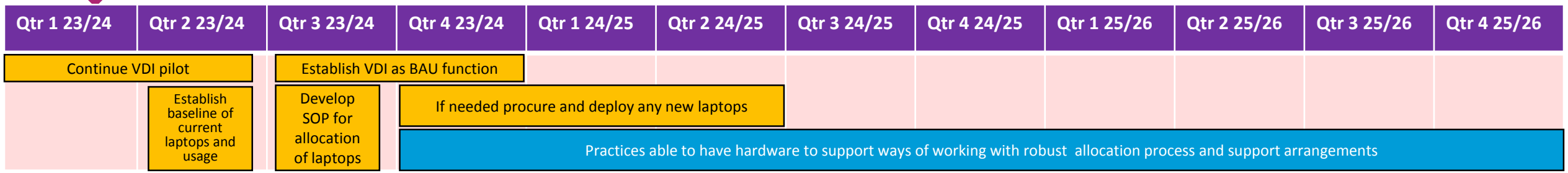
- Deployed laptops to the supporting expansion of ARRS staff across PCNs as well changing operating model with more remote working to meet the demands – this is where funding allowed
- Developed VDI (Virtual Desktop Infrastructure) option for use on personal devices

What we will do

- Working with our HBLICT our GP IT delivery partner, and review the total provision of hardware – desktop and laptops currently deployed and those in use and in line with the PCN clinical strategy/operating model
- We will develop a standard policy for how laptops are managed and allocated in line with the changing model – within budgets available
- We will develop the 'VDI' option which allows access to clinical systems on personal devices so that general practice staff are supported to work in an agile way that doesn't need them to be 'in the office'

Benefits

- General Practice staff able to work in an agile way
- Premises can be used optimally to support new ways of working
- Staff able to have work life balance if home working an option
- Patients better supported by workforce that have access to technology and



Broader Programmes

- As well as the SDF work we continue to work on other projects and workstreams. These are outlined on the following slides – they have touch points with the main priorities and support those but also tie in with other programmes and are not exclusively funded by SDF

Broader Primary Care Programmes

Key to Primary Care but not identified as priority

Primary Care Access

- Accelerating Patient Access to records – all practices to be enabled by October 2023
- Getting practices to enable online patient registration through national programme (16 live to date)
- Websites – working with practices utilising WGLL recommendations from NHSE

Care Homes

- Proxy Access - Work with Social Care to facilitate Care Homes to be able to order repeat medications on behalf of residents
- Look at access to clinical systems for Care homes learning from work done in practices who have piloted this already

Social Prescribing

- Social Prescribing
  - Understand how to facilitate data flows between primary care and social prescribing
  - Look at Social Prescribing systems to maximise integration and use of data across ICS

Population Health Management

- Implement a PHM approach and use population segmentation and risk stratification to help identify those most likely to benefit from care – work underway to support the delivery on MDT Integrated neighbourhood teams
- Use PHM data to work with social care on targeting appropriate cohorts for assistive technology working closely with County Council/Districts and VCFSE

Broader Primary Care Programmes

Primary Secondary Care

- Digital Solutions to reduce bureaucracy between primary and secondary care interface i.e Electronic Sick note and prescribing
  - *Work with partners to understand current position, options and impact on Primary Care (budgets, patient records etc.)*
  - Onward referrals within secondary care
    - *Understand current processes, options and how information sharing and patient and primary care updates can work*

Patient Portals

- NHS App interface with patient portals
  - Tie into broader communications on NHS App so patients getting consistent messages and primary care aware of impact on patients

Remote Monitoring

- Remote monitoring and resident-owned devices
  - How we can use primary care data to inform patients who might benefit, how we share feedback

Dental and Optometry contractors

- Understand challenges
- Look to see if any ‘quick wins’ possible
- Develop longer term strategy

Resource

The overall delivery of the plan is under the Primary Care Strategy and will be the responsibility of the Head of Primary Care Digital Services integrated with Primary Care Directorate.

It is proposed to bring in an FTC Senior Project Manager (8a) for 12 months to do the main project management. This is proposed from the Primary Service Development Fund for Primary Care Transformation money and will support the work across all primary care digital projects.

To drive Cloud based Telephony utilisation and integration within the practice operational model and benefits realisation we will bring in an FTC Band 6 For 12 months to work with practices to maximise benefits but also train PCN Digital Leads to be self reliant in this area moving forward which include providing hands on operational support and QI approach to integrate operational systems at practice and PCN level. This will be funded from Primary care Service Development Transformation money.

We will need input from ICB Communications teams and Engagement, especially around the NHS App priority and Workforce Teams to help with a resource hub around Digital Inclusion this will be integrated with the ask on communications across Primary Care Delivery plan – some funding to be aligned to provide that support to the ICB team to enhance this.

Review of the HBL ICT specification to deliver the core and enhanced GPIT model as a key partner in providing end to end support in delivering this programme on all workstreams

Update on Current and Proposed Funding for Primary Care GPIT

ICB 2022/23 (July 22 to March 23)

The GPIT budget had a significant overspend due to changes to ways of working, new services coming on stream or some things no longer being centrally funded. Additionally, since COVID, there has been an increase in remote working and/or non-face to face consultations leading to a significant increase in software licences and SMS Messaging costs. There were also increases in HBLICT charges.

For the period from July 2022 to March 2023 the ICB GPIT Budget reported a significant overspend to the ICB Primary Care Board of £814k against a budget of £6.3M

ICB allocation for 2023/24 is £7.2M which includes

GPIT Funding allocation for core systems

This remains at £1.70 per patient and is used to fund core clinical systems such as EMIS, SystmOne, Ardens, Docman and Eclipse. Any shortfall in this is met from main GPIT budget (eg DXS)

From 2023/24 onwards there will be an additional 93 pence per patient for procuring of Digital Pathways and Primary Care Support Solutions – this is 'Simpler online requests' and 'Faster navigation, assessment and response' which we currently use eConsult and AccuRx for. We will work with the procurement hub to ensure we utilise that funding appropriately.

PCN Hub money

As updated at a recent regional meeting we are awaiting more information on solutions and funding for Extended Access Hubs and will progress this as more information is available which will support hub delivery of primary care but also further clarification sought whether this is to support integration with wider partner to deliver integrated neighbourhood teams as a key objective

Primary Care SDF Funding Estimates (to be refined during implementation plan phase)

Band 8a Senior Project Manager (working across all projects) – 12 months £80K	Band 6 Utilisation Lead (Cloud Based Telephony) – 12 months £60K	Telephony (further support for national programme) - £200K	Automation – possible pilots £100K
Communications Materials (NHS App/Access) £10K	Infrastructure £200K	Pharmacy, Dentistry, Optometry Integration £250K	VCFSE (Digital Inclusion etc.) £100K

Total: £1m

Next Steps

- Discussion and agreement to progress with the detailed implementation plan for the priority areas identified in Primary Care Digital plan aligned to the ICS Digital Strategy
- Embedding of the priority areas in the overarching Primary Care Strategic Delivery plan for ICB Board Approval July 2023
- Business case development of key areas including recruitment to project management support – August 2023.
- Detailed transformation proposal on automation for discussion at DTB in line with the time line outlined
- Regular progress report of delivery quarterly at DTB and Primary Care Board.

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐				
	NHS HWE ICB Primary Care Board meeting held in Public				**Meeting Date:**	**27/7/2023**		
Report Title:	**HWEICB Primary Care Strategic Delivery Plan**				**Agenda Item:**	**8.2**		
Report Author(s):	Avni Shah - Director of Primary Care Transformation, HWEICB James Gleed - Associate Director Primary Care Strategy and Transformation, HWEICB Emily Perry - Primary Care Manager Strategy and Transformation, HWEICB Input from Primary Care Clinical Leads; Respective Senior Leads from Estates, Digital, Primary Care Transformation, Contracting, Communications and Engagement, Quality, Medicines Management, Finance etc							
Report Presented by:	Avni Shah – Director of Primary Care Transformation, HWEICB							
Report Signed off by:	Avni Shah - Director of Primary Care Transformation, HWEICB							
Purpose:	**Approval / Decision**	☒	**Assurance**	☐	**Discussion**	☐	**Information**	☐
Which Strategic Objectives are relevant to this report	▪ *Improving outcomes in population health and healthcare* ▪ *Tackling inequalities in outcomes, experience and access* ▪ *Enhancing productivity and value for money*							
Key questions for the ICB Board / Committee:	Following various discussions at the Board and Board development over last few months, Board is asked to ▪ Discuss and endorse the objectives outlined including the high level deliverables across each area including enabling workstreams ▪ Note deliverables in relation to new delegated responsibility of dental, optometry and community pharmacy which is integrated in the plan with high level milestones building on the work to date ▪ Endorse the approach used for Primary Care Service Development Fund for 2023/24 to pump prime the transformation and integration of primary care into the wider system with delivery through Health and care Partnerships							
Report History:	Deep dive on Primary Care – March 2023 Primary Care Strategic Plan at Board Development – April 2023 Primary Care Board – January/March/May 2023 All four Health and care Partnership Boards; Practice Managers, PCN managers, Place Primary Care Clinical leads, Locality Boards, Public							

	Health Colleagues, Patients and Public events, Community Pharmacy, Dental and Optometry engagement.
Executive Summary:	The HWEICB Primary Care Strategic Delivery Plan outlines the direction of travel for primary care transformation (general practice, pharmacy, dental and optometry) across Hertfordshire and west Essex from 2023-2026. The plan encompasses the key recommendations from the Fuller Stocktake Report and recently published NHSE Delivery Plan for Recovering Access to Primary Care, and also aligns with a number of local strategies and priorities as outlined within the document. The plan sets out three key transformation objectives; ➢ Continued focus on prevention and health inequalities ➢ Proactive care – Person centred, team based approach to Chronic Disease Management and Complex care management through establishment of integrated neighbourhood teams (INTs) ➢ Simplifying & enhancing access for urgent primary health needs It is believed that focusing time and resource in these areas will have the greatest impact on the sustainability and resilience of primary care services and wellbeing of the workforce. These objectives will be supported by a number of key enabling workstreams as outlined below: ➢ Patient empowerment and education and communications ➢ Workforce – clinical and non-clinical ➢ Premises – one estate ➢ Data, information, and digital technology ➢ Investment and contractual levers The document provides an outline of both recent achievements as well as key areas of priority to focus on over the next three years within each of these enabling workstreams. Mindful that funding is only available planned as an annual cycle with our allocation. The strategy has been input from a range of colleagues, partners and patients across Hertfordshire and west Essex as part of an extensive engagement plan. The plan will be delivered through collaborative working between the ICB, primary care and the wider system and work is already happening at place level to make this possible. In line with the direction of operating model, delivery is through Health and Care Partnerships system oversight and where appropriate design once and share good practice across. Once the plan is signed off, we will work with the ICB Communications Team to ensure everyone, including those with sensory or cognitive disabilities can access and are able to understand the key information contained in the document.
Recommendations:	▪ To discuss and approve the Primary Care Strategic Delivery Plan for 2023-2026

	Indirect	☐	***Non-Financial Professional***	☐

Potential Conflicts of Interest:	***Financial***	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A It is plan. Detail spending will be going through appropriate governance to manage the conflict.			
Implications / Impact:				
Patient Safety:	*To be evaluated individually as part of delivery related to specific projects to transform access and service provision*			
Risk: *Link to Risk Register*	*To be evaluated individually as part of delivery related to specific projects to transform access and service provision. Risk of not investing in priority areas will risk the ICB achieving its objectives with already a tired*			
Financial Implications:	*The paper outlines the number of areas where funding has been committed previously which support direction of travel through regular review of the various schemes.* *The paper also provides a high level summary of proposed allocation of Primary care Service Development Funds for 2023/24 in line with the proposed direction of travel set out in the plan*			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		Yes - EqIA was approved by HWEICB Equality and Diversity Lead on 18.7.23 and is attached to this submission. It will be key to ensure that further EqIAs are completed where required when objectives from the strategic delivery plan are implemented in each of the three places.	
	Quality Impact Assessment:		Confirmed by HWEICB Deputy Director Quality Improvement and Patient Safety that a QIA is not required, however it may need to be undertaken as part of the individual transformation projects during implantation of the plan.	
	Data Protection Impact Assessment:		Confirmation from HWEICB Head of Information Governance and Risk that a DPIA is not currently required – however it will need to be undertaken as part of the individual transformation projects where appropriate/relevant.	

Hertfordshire and
West Essex Integrated
Care System

Hertfordshire and west Essex Integrated Care Board

Primary Care Strategic Delivery Plan

2023-2026

Working together
for a healthier future

Introduction

Primary Care includes general practice, community pharmacy, dental and optometry (eye health) services. These services provide the first point of contact in the healthcare system, acting as the front door of the NHS. General Practice has historically fulfilled a unique role, with patients (and often several generations of their families) developing close, trusting relationships, solidified over many years. We are now contending with spiralling demand on all healthcare services and regrettably many GP practices often feel unable to provide the responsive, personalised care that has been valued so highly over several decades.

At a time when everyone is working harder, under more pressure and often longer hours than ever before, it perhaps feels unreasonable to set out a strategy for transformation and change - yet more work. However there is good reason to do so - evidence suggests that attempting to simply expand the current model of primary care will not bridge the widening void between the needs of patients and service capacity. We firmly believe that it is possible to narrow this gap and to do so in a way that re-establishes fulfilling careers and enhances staff wellbeing.

Transformation change requires some upfront funding which is recognised nationally with the allocation of some service development fund for primary care. What the delivery signals is areas of priority for which we are seeking to align the primary care service development funds which will aim to deliver the ICB set strategic objectives and continuous improved experience and outcomes for our population. The delivery plan with the strategic priority areas are proposed to be the our guiding principle for investment over the next 3 years.

Our Strategic Primary Care Delivery Plan supports a number of other key strategies across Hertfordshire and West Essex including the 10 year Integrated Care, Urgent and Emergency Care (UEC), People Plan, Quality Strategy and the ICS and Primary Care Digital Roadmap. The plan also encompasses the recommendations from the Fuller Stocktake Report and key requirements of the NHSE Recovering Access to General Practice plan. We have set out 3 key transformation objectives:

- Increase our focus on prevention: we must reduce people developing lifestyle diseases and experiencing exacerbations from long-term conditions
- Establish Integrated Neighbourhood Teams (INTs) across all of Hertfordshire and West Essex
- Simplify how patients with urgent health problems receive the right help

By focusing on these areas, we can better meet the needs of *all* service users for example by managing urgent health problems differently we can devote more capacity for people suffering with chronic long-term conditions or to ensure that carers' health and support needs are fully understood.

We are not starting from a blank page, there are many examples where exciting innovation has improved access and services for patients. We will continue to celebrate and share these important successes.

All local partners and stakeholders, including patients have been engaged in the development of this plan and we would like to express our sincerest thanks to everyone that contributed.

The ability to turn strategic objectives within the plan, into tangible changes of course hinges on the health and social care system moving forward in a new, truly integrated way of working. This plan supports primary care integrated further with our four Health Care Partnerships with primary care providers an equal partner in system planning and operational delivery through each place or across places.

As primary care leaders on the ICB Board, we will be doing everything we can to make these plans come to fruition and we ask the same of all our colleagues across Hertfordshire and West Essex – to play your part in creating a better health and care system for everyone.

Dr Prag Moodley - ICB Primary Medical Partner Lead for Primary Care Transformation
Dr Nicolas Small - ICB Primary Medical Partner Lead Primary Care Workforce
Dr Ian Perry - ICB Primary Medical Partner Lead for Primary Care Digital and Estates

Stakeholder engagement

We have sought views from local stakeholders, including patients as part of developing our strategy. These include the following:

General practice colleagues across Hertfordshire and west Essex	Patient/Public feedback via ICB website and engagement events across HWE	East and North Hertfordshire NHS Trust
West Herts Teaching Hospitals NHS Trust	Royal Free London NHS Foundation Trust	The Princess Alexandra Hospital NHS Trust
East of England Ambulance Service NHS Trust	Healthwatch – Essex & Hertfordshire	Essex Local Medical Committee
Bedfordshire and Hertfordshire Local Medical Committee	Public Health (Herts County Council and Essex County Council)	Essex Partnership University Hospital NHS Trust
Hertfordshire Community NHS Trust	Community Pharmacy Essex, Community Pharmacy Hertfordshire - and contractors	Hertfordshire County Council, Essex County Council
Hertfordshire Partnership University NHS Foundation Trust	HUC	Central London Community Healthcare NHS Trust
Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations	Hertfordshire Local Optical Committee, Essex Local Optical Committee	Local Dental Committees and contractors

Primary Care Services – Hertfordshire and West Essex

A snapshot of organisations in our Integrated Care System area – Who Are We?

1.6 million people

1 Integrated Care Board
1 Integrated Care Partnership
3 Health and Care Partnerships
1 Mental Health, Learning Disability and Autism Collaborative

1 Voluntary, Community, Faith & Social Enterprise (VCFSE) Alliance, representing thousands of local organisations

2 county councils and 13 district/borough councils

4 mental health and community providers

3 acute providers

8 GP federations - 3 in South & West Herts, 2 in West Essex and 3 in East & North Herts

130 GP practices; 35 Primary Care Networks (PCNs)

276 community pharmacies

225 opticians

243 dental practices

Our integrated care board (ICB) is one of two key components of the Hertfordshire and West Essex Integrated Care System (ICS).

- The ICB is the local NHS organisation that plans and oversees how NHS money is spent and makes sure health services work well and are of high quality.
- The second is the integrated care partnership (ICP). They work closely together. Overall it is designed to improve the general health and wellbeing of residents, tackle the inequalities which affect people's physical and mental health, get the most out of local health and care services and make sure that they are good value for money and help the NHS to support social and economic development in west Essex and Hertfordshire.

Hertfordshire and West Essex Integrated Care System

Alignment with local strategies / key priorities

The Primary Care Strategic Delivery Plan aligns with local strategies including:

Delivery of the six strategic priorities from **the 10 year Herts and west Essex Integrated Care Strategy,** these are:

- Give every child the best start in life
- Support our communities and places to be healthy and sustainable
- Support our residents to maintain healthy lifestyles
- Enable our residents to age well and support people living with dementia
- Improve support to people living with life-long conditions, long term health conditions, physical disabilities, and their families
- Improve our residents' mental health and outcomes for those with learning disabilities and autism

The **Hertfordshire & West Essex Integrated Care Board (HWEICB) Primary Care Digital strategy** (noting the importance that digital and technology plays in supporting the key objectives outlined in the primary care strategic plan, such as the establishment of a single fully joined up, interoperable landscape of local platforms, remote monitoring of patients where appropriate, use of the NHS App, supporting digitally excluded patients by utilising Voluntary, Community, Faith & Social Enterprise (VCFSE) and advance telephony.

The Urgent & Emergency Care (UEC) strategy (supporting the key stated objectives such as reducing demand for UEC, reducing ED attendances, reducing emergency admissions and supporting safe and effective discharge through taking a Population Health Management approach in INTs and improving same day access in primary care, and developing the role of social prescribing link workers)

The **Hertfordshire & west Essex Strategic Framework- 2022-2027 -** this strategy aligns to the Framework mission of '*Better, healthier and longer lives for all'*

Some of the key outcomes that will be delivered from the strategy include improved staff morale, improved recruitment and retention of staff – all of these align with the **Hertfordshire and west Essex Integrated Care Systems (HWEICS) People Strategy 2023-2025.**

Supporting the key **mental health priorities** such as new model development, access, integration with primary care, and early intervention with children and young people.

The strategy supports the **HWEICS Quality Strategy** – planning and delivering the best possible joined-up and high-quality and safe services which promote equal access, positive experiences and good clinical outcomes.

This strategy also aligns and **supports delivery of key children and young people (CYP) priorities** including areas of focus such as community paediatrics and neurodiversity, diabetes & epilepsy, asthma transformation and co-production and engagement.

NHS England delivery plan for recovering access to primary care – key messages

The NHSE Delivery Plan for Recovering Access to Primary Care was released on 9 May 2023 and has a focus on four key areas:

Empower patients to manage their own health including using the NHS App, self referral pathways and through more services offered from community pharmacy – launch of the pharmacy first scheme via national contract; create options to enhance access to digital tool but also reducing digital exclusion through integrating with the community and VCFSE.

Implement 'Modern General Practice Access' to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment, so patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message.

Build capacity – develop primary care workforce.

Add flexibility to the types of staff recruited and how they are deployed.

Changing to training, recruitment, retention and opportunities of skill mix

National Long term Workforce Plan 2023.

Cut bureaucracy

Reducing the workload across the interface between primary and secondary care such as how we can use digital technology for prescriptions, increase self referrals for a range of services; onward referral from specialists and maximising the use of shared care records to obtain the relevant information to support triage.

Our primary care strategic delivery plan picks up the key requirements of the NHS England recovery plan

HWEICB Primary Care Transformation objectives

The Delivery Plan has 3 key transformation objectives; **proactive management to support routine and complex care through establishment of Integrated Neighbourhood Teams (INTs), simplifying and enhancing access for urgent primary health needs** and **continued focus on prevention and health inequalities - helping people to stay well for longer. At all times the patient/citizen is at the centre of care**.

Prevention and Health Inequalities

Proactive Care – A person-centred, team-based approach to Chronic Disease Management and Complex care through Establishment of Integrated Neighbourhood Teams

Simplifying & Enhancing Access For Urgent Primary Health Needs

Key enabling workstreams

- Patient empowerment and education and communications
- Workforce – clinical and non-clinical
- Premises - one estate
- Data, information and digital technology
- Investment and Contractual levers

Improving outcomes, better care, integration of services, improving referral pathways and efficiency and cutting bureaucracy, reduce unwanted variation apply throughout the strategy

Prevention and Health Inequalities

Prevention and Health Inequalities

"Primary care has an essential role to play in preventing ill health and tackling health inequalities, working in partnership with all health and care including VCFSE partners to prevent ill health and manage long-term conditions" – Fuller Stocktake report (May 2022)

Primary Care providers has been pivotal to delivery of key aspects on prevention and inequality agenda. In collaboration with range of health and care partners examples below are to be built to continue focus on delivery of primary/secondary and tertiary prevention

Population Health Management (PHM) – using data and intelligence to identify need at system/place/locality and network level with a view to reducing variation and reducing inequalities examples include work on migrants, veterans, travellers communities, diabetes in BAME communities, outreach support LD/SMI for healthchecks including vaccination

Enhanced Commissioning Framework (ECF) for General Practice – Commissioning consistent approach across all practices including case finding; Secondary prevention in CHD; disease staging and enhanced proactive management – carers register and carers health checks and also where appropriate to prevent tertiary conditions – e.g. Referring eligible patients to weight management

Continue to grow the personalised care approach – Through social prescriber/health & wellbeing coach, and care-coordinators. E.g. Prevention from an early age in Children and Young People – including working with local authority partners to promote access to healthy lifestyle and physical activity programmes, such as via Healthy Hubs. Opportunity through personal health budgets

Community pharmacy and Optometry - Supporting self-care, health promotion; role in prevention including smoking cessation; identifying conditions such as hypertension;

Secondary prevention - Cholesterol and blood pressure monitoring.

Access for minor eye conditions, secondary prevention through screening

Voluntary, Community, Faith and Social Enterprise (VCFSE) - Strengthen the role of the VCFSE sector in:

- prevention
- community resilience
- co-design and
- identify pockets of inequalities

e.g. investment in VCFSE to support delivery of blood pressure monitoring; reduce digital exclusions

Dental - Addressing the impact of social inequality for not only dental decay, but also tooth loss, oral cancer, oral health and on people's quality of life particularly in early years under 5. Joint work with both Public Health leads across HWE.

Given the ageing population, high quality oral health care and attention for all those living in care homes or requiring care in other domiciliary settings is key priority to build on

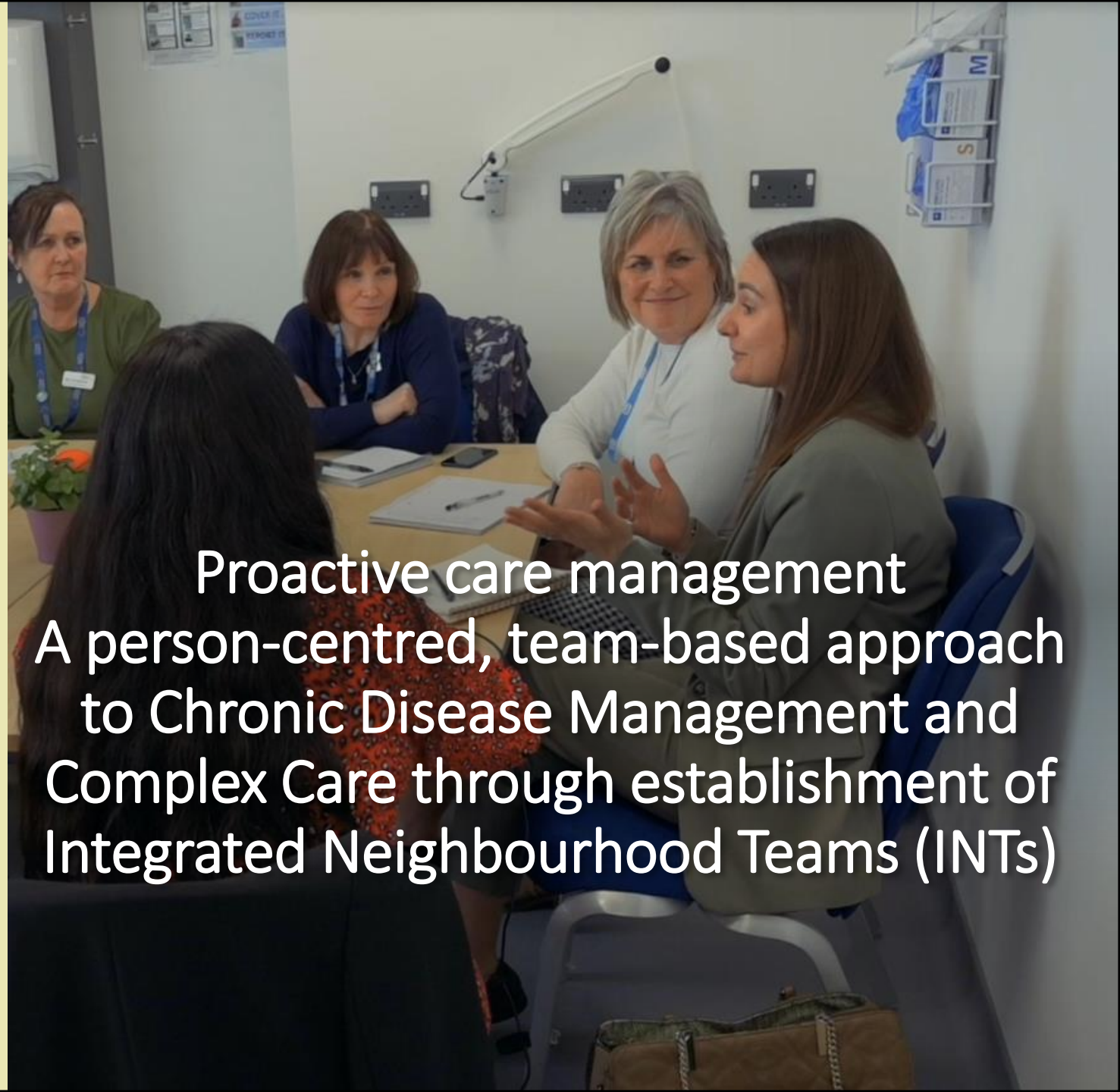
Priority two:
Integrated Neighbourhood Teams

Primary Care Network (PCN)

- Social Prescriber
- Healthy Hubs
- Social care
- Vol orgs
- Providers of care
- Community nursing & therapy
- Mental health
- Hospice

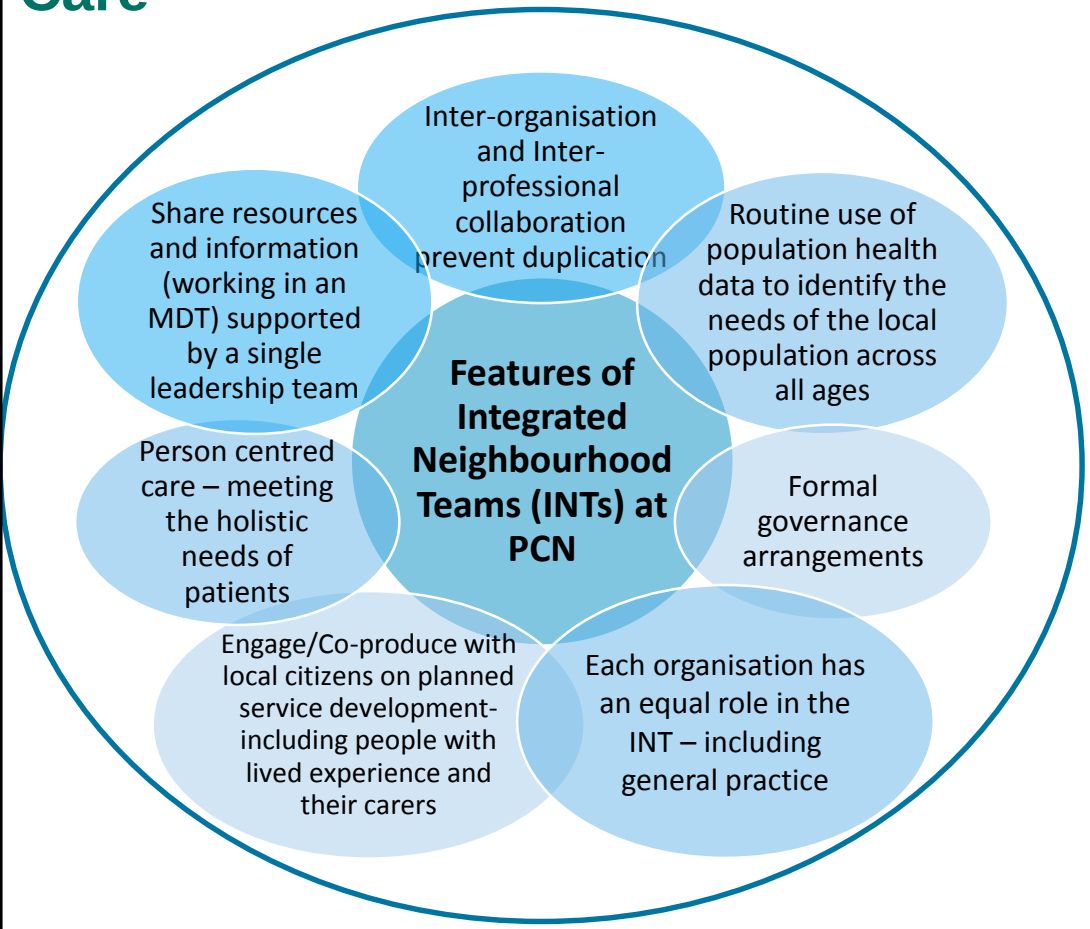
Patient supported by multi-disciplinary team delivering proactive case management

Working together as an Integrated Neighbourhood Team to improve people's outcomes and experience by meeting the health and social care needs of the local population



Proactive care management
A person-centred, team-based approach to Chronic Disease Management and Complex Care through establishment of Integrated Neighbourhood Teams (INTs)

Proactive Care Management - Establishment of Integrated Neighbourhood Teams (INTs) - a person-centred, team-based approach to Chronic Disease Management and Complex Care



Locality Leadership with PCN delivery of INT through collaboration in the Health and Care Partnerships

INTs core characteristics:

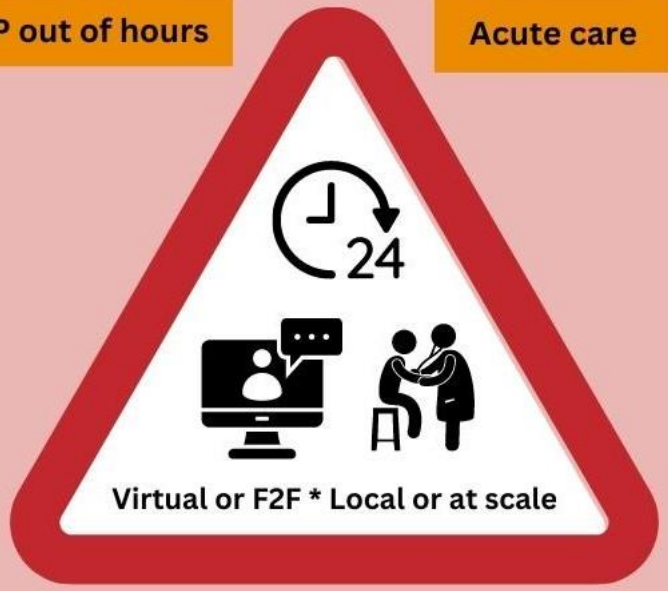
- INTs are the delivery vehicles at PCN level to have multidisciplinary approach for case management
- Supported through locality senior leadership from range of partners who are able to create conditions to enable professionals to be released to develop the INT at PCN level with a common purpose/vision/goal.
- Each INT will bring together a skilled workforce of professionals across health and care sector supported by a single leadership team to promote multi-disciplinary problem solving and utilisation of all available community assets to improve the outcomes and experience of the local population.
- Clinical leadership – both GP and Community pharmacy key feature
- Priorities informed by Population Health Management (PHM) - start small and identify how the team will work best to create a shared vision for the identified cohort
- INT/Multi Disciplinary Team (MDT) to have a lead care – coordinator (Connector roles) (example using ARRS role flexibly where possible or additional resources through transformation) and deliver proactive care through MDT approach with a named lead professional
- The teams enable collaborative, flexible working with simple care pathways that prevent duplication
- Build from existing structures - not creating new
- INTs will record and monitor outcomes with oversight via the senior leadership through locality
- Membership from all local stakeholders
- Clear governance including Terms of reference; Memorandum of Understanding and Risk sharing agreements would enhance decision making and cross organisational working

Integrated Neighbourhood Teams Vision Statement:

"Working together as an Integrated Neighbourhood Team to improve people's outcomes and experience by meeting the health and social care needs of the local population"

Priority three:
Simplifying and enhancing access for urgent primary health needs

- NHS 111
- Same Day Emergency Care
- Mental health crisis
- Community care
- GP out of hours
- Acute care



Timely access to:

Dental
Pharmacy
Optometry

Simplifying & Enhancing Access For Urgent Primary Health Needs

Simplifying & Enhancing Access For Urgent Primary Health Needs

The establishment of new access models for those (of all ages) who have an urgent primary healthcare need, led by a multidisciplinary team of colleagues will be key to ensuring the national direction of travel is implemented across Hertfordshire and West Essex (HWE). Enhancing and changing the model of access for urgent healthcare needs applies to all providers including; general practice, dental, pharmacy, optometry, community, acute, UTC, Integrated Urgent Care, mental health, community care – e.g rapid response/ virtual ward, social care, VCFSE and self referral.

Improving the pathway for those with urgent healthcare needs will free up capacity and time to see those who have routine healthcare needs.

Address variation through building on our existing **General Practices and Primary Care Network based service models** evolving across HWE

Facilitative support using QI methodology to support operational change at practice/PCN – national and local support

Test new models including telephony/e-consultation hubs; possible integration with NHS111/Community Care-coordination/enhanced care navigation/testing of AI in navigation and referral direction. Expansion of 111 service to include a greater range of clinical advice.

One of the key aspirations for the future of community pharmacy in HWE is that **Community Pharmacy is integrated into primary and community care, often being the first point of contact for patients, supporting better access** and improved outcomes for patients and the population for a range of minor conditions.

The ICB will capitalise on the skills within community pharmacy and how community pharmacy also develop and work in collaboration with others in the same area.

Dental in hours – analysis of urgent/same day demands versus provision to commission the appropriate capacity. Key is to ensure urgent access not at the detriment of routine/proactive dental care to create a balanced service provision

Dental out-of-hours – review dental out-of-hours services underway including data from NHS111 and A&E. Data not robust; however need to ensure a service is in place for winter to support ongoing future model of care across urgent care services.

The ICB will be reviewing urgent and emergency eye services over the coming 12 months, taking into account the pilot results from the Minor Eye Conditions Service (MECS) service to form new commissioning plans

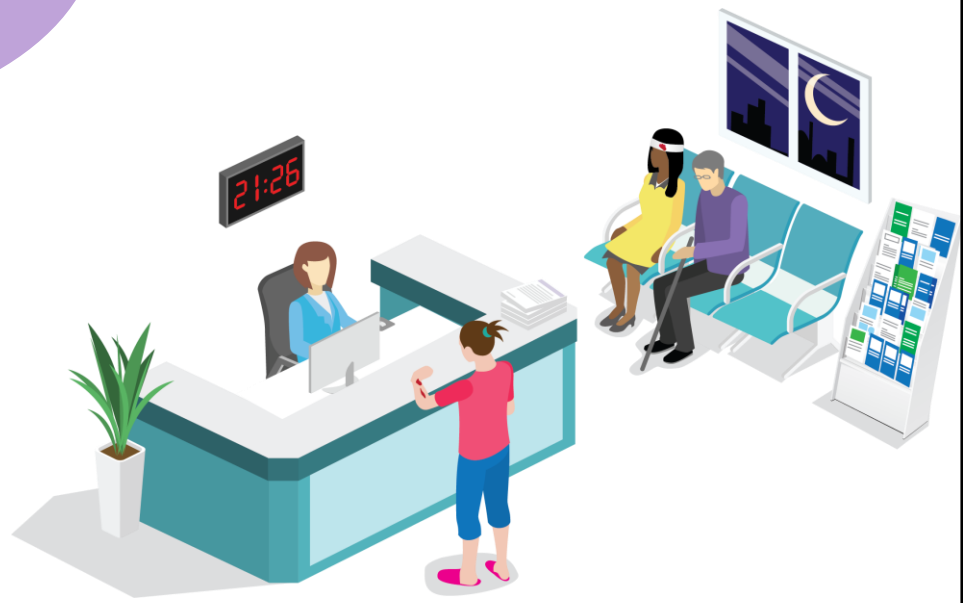
We will continue to work towards the implementation of Eyes-eRS to facilitate a direct referral pathway from **Community Optometrists** to Ophthalmology services to support on the day eye management.

Simplifying & Enhancing Access for Urgent Primary Health Needs: Defining Features

Features of Simplifying & Enhancing Access For Urgent Primary Health Needs

- Increased use of non-medical healthcare professionals, non-registered workers and voluntary sector
- System is easy to navigate for patients; *consolidate points of access; safe redirection from Emergency Department (ED); enhance use of digital and automation (AI)*
- ▪Patient empowerment / education and coproduction
  ▪(Self care/self referrals)
- Access is non-discriminatory and takes into account the needs of all service users
- Access is needs-led and the assessment of need is holistic

Case study: The following video showcases the urgent on the day service that Stort Valley and Villages PCN have implemented and how this is supporting both patients and staff:
Click here to see the Stort Valley and Villages Urgent on the Day Service video



Key transformation objectives – timelines

Key transformation objectives – timelines – 2023-2026

Prevention and Health Inequalities

Year 1 – 2023/24	Year 2 – 2024/25	Year 3 – 2025/26
2023/24 - Enhanced Commissioning Framework for GP practices as lever to commission general practice in prevention – primary/secondary as build on the work to date Dental – commission enhanced oral support; scope plan with education and public health (health visitors) Scope and commission outreach to care homes across HWE Scope future opportunities through prevention programme including lifestyle interventions and opportunities with districts to reach pockets of hard to reach communities and patient groups	**2024 – 25** - Development of a digital solution to capture outcomes and impact of personalised care on population health outcomes and work with ARRS and VCFSE to support digital solutions.	

2023 -2025 - Development of personalised care and social prescribing for children and young people - the ambition is that each PCN across HWE will have a Children and Young People's Social Prescriber / personalised care practitioner by end of 2024/25.

2023-2026 - ongoing training and development of the 3 personalised care roles (social prescribing link worker, health and wellbeing coach and care coordinators) and investment in the VCSFE in prevention and reducing inequalities including digital and how VCSFE are embedded in INT.

2024-2026 - The ICB will commission healthy conversations training via Public Health to enable both clinical and non-clinical staff to develop their skills in behaviour change in order to support the prevention agenda.

Key transformation objectives – timelines – 2023-2026

Proactive Care, Chronic Disease Management and Complex Care through Integrated Neighbourhood Teams (INTs)

Phased implementation from Year 1– 2023/24 to Year 3 2025/26

By March 2024 – Implementation of the Asthma Hubs at PCN/locality level
April –June 2024 – Scope test other chronic disease at scale

September 23 to July 24 – Hertfordshire and West Essex will have INT coverage at PCN level through;

- Establishment of locality leadership board
- Recruitment of overall lead
- Documents to support establishment of INTs (such as: Terms of reference, Memorandum of Understanding and risk sharing agreements) will be drafted by the ICB for INTs to use
- Commencement of Organisational Development (OD) programme to support leadership of the INT.

May 2024 onwards in a phased way - All INTs will have identified a population cohort that would benefit from a joined-up approach

- PHM data will continue to be shared by the ICB with INTs
- Each INT through collaborative approach identify the interventions and deliver with the Health and Care Partnership

September 23 onwards - completion of OD programme.

Ongoing evaluation to understand impact and using quality improvement methodology to continuously show improvement.

Key transformation objectives – timelines – 2023-2026

Simplifying & Enhancing Access for Urgent Primary Health Needs

Improving the pathway for those with urgent healthcare needs will free up capacity and time to see those who have routine healthcare needs

Year 1 – 2023/24	Year 2 – 2024/25	Year 3 – 2025/26
September 2023 - ICB working with PCNs with their core practices and non-core members will have mapped all access points and reviewed relevant data to determine where access is most challenged – *through Support level Framework/GP Intensive support national programme* **October 2023 onwards** - Plans implemented for one or more initiatives that are expected to improve access in a key area where there is the greatest potential to have a positive impact on access. **December 2023 -** implementation of national community pharmacy first across HWE from December 2023	**From November 2023** – Test new integrated, multi-provider service models where there is highest need with deprivation (UEC priority areas) . **April 24-June 24** Review of MECs Service and develop options working with Planned Care **Jan 2025** – evaluation, write up of pilots and explore opportunities to make new models business as usual.	**2025 -2026 -** Continue to embed new models as business as usual. **July 2024** – improved patient experience reporting, improved patient reported outcomes; impact on urgent care outcomes including A&E, increase in self care

August 2023/24 – Extend current urgent in and out hours dental services contracts whilst preparing the commissioning model of care aligned to the UEC strategic outcomes and ICB and Primary care objectives of same day access or urgent primary care (dental needs)
April 2024/25 – Commission a urgent dental care providing equality access across HWE whilst addressing the health inequalities identified in deprived areas

Impact on Planned Routine Access
General Practice – through improvement patient access for routine care
Dental – through improvement in planned dental activity and proactive care reducing need for urgent on the day
Community Pharmacy – Increased use of Electronic Prescription Service, integrated chronic disease management pathways with community pharmacy with New medicines review, monitoring of conditions – Hypertension etc.

Enabling Workstreams – key achievements to date

Key achievements to date

A number of key achievements have already taken place in our enabling workstreams – some of these are outlined below:

Patient empowerment and education

A workshop took place, led by the Patients Association, in June 2023 to support practices and patient groups in the use of social media, particularly Facebook. Another workshop was also run in early July 2023 about how patient groups can support the reduction of health inequalities.

Three patient representatives were appointed to the ICB primary care board in May 2023.

The first Patient Engagement Forum meeting took place in June 2023 – this forum provides assurance to the ICB Board on levels of patient and community involvement and participation. Patient representatives were appointed from a range of committees, groups and local areas to ensure a broad representation. These patients also link into other community networks.

Toolkits on the role of receptionist for practices to use now developed, next stage to share with reader panel for views.

Five practice websites created and in operation in the area of end of May 2023, template content to be shared wider. User testing and feedback being used for improvements.

The ICB has been working with the Patient Association (PA) since Autumn 2022. The focus on this work has been to support the development of GP practice patient groups across Hertfordshire and west Essex. This involves offering one to one support, developing a patient led 'buddy' scheme, sharing resources including a number of workshop videos, including one on social media and health inequalities. As part of this work the ICB has developed their patient network which now numbers approximately 500 people.

Workforce

Primary Care Networks Training Team implementation across all 35 PCNs – supported with detailed workforce data pack including headcount/full time equivalent; number equivalent per registered population; potential number of future retirements; number of training placements and how population needs data through PCN data pack reflects the number and type of range of professional to be recruited.

Shortlisted for HSJ Patient Safety Awards 2023 – category Primary Care Initiative of the year (PCN Training Teams implementation)

Recruitment and implementation of the 33 out of 35 PCN Community Pharmacy Liaison Leads across all PCNs

2 year New to Practice Programme – 6 GPs in year 1 and 16 GPs in year 2. The programme supports newly qualified GPs and GPNs. The programme supports portfolio working and learning and development opportunities.

18 GPNs undertaken the Professional Nurse Appraisal Pilot Project. The project focus is to train nurse appraisers to support the GPN appraisal process.

Apprenticeships – 16 Nursing Associates currently on programme. 2 qualified in February 23

Monthly lunch time and evening virtual Educational webinars – over 100 primary care staff join with numbers increasing each month.

Monthly PCN Protected Time to Learn Events – Learning opportunity for all practice staff and platform to interact with providers/partners and learn together. All PCN/Practices engaged.

Increased recruitment to multidisciplinary roles in PCNs/Practices through range of ARRS roles projected to ensure budgets are maximised

Key achievements to date continued

Data and Information

We have Primary Care data flowing into the ICB data environments to support Population Health Management (PHM) models and workstreams (including transformation).

We are piloting Machine Learning on the ICB Population Health Management (PHM) model to create bespoke practice searches to identify patient at risk on an A&E admission. – currently being tested in Uttlesford and Hertsmere

The use of the Ardens manager dashboard is in place for all practices in the ICB for Quality and Outcomes Framework (QOF), national and local Enhanced Services - improved performance on LD/SMI healthchecks, 8 care processes for Diabetes, Enhanced management of Frailty/EOLC etc

We have access to high level Dentistry, Optometry and Community Pharmacy activity data. Further scoping to be done how this data flows into the future ICB data warehouse and how we triangulate information

We are ensuring General Practice appointment data is pulled into the Patient Access dashboard and triangulating this with other data sources including workforce to provide better support to practices.

We have created an internal resilience Index dashboard to support the Primary Care team in order for them to support Practices accordingly (this includes appointment capacity, estates, workforce, CQC visits etc)

Digital technology

Procured a number of SystmOne Hubs to enable at scale delivery of a variety of clinical services by PCNs; provided extensive ongoing support for this technology.

Roll out of Virtual Desktop Infrastructure (VDI) which enables clinicians to access clinical systems from any device, any time anywhere. We have c. 400 regular users and will extend this over the coming year. – Impact on need of clinical space/eventual cost of hardware.

In September 2022, all GP practices were offered an online consultation solutions to support digital front door. In this time, we have had approaching 80,000 digital consultations in total across our patch.

Under recent nationally led telephony programmes, *Surgery Connect* advanced telephony system has been deployed in 36 practices. Across HWE 101 practices now have a cloud-based telephony system. We continue to support remaining practices to move to a cloud-based solution. Whilst enhancing and integrating the cloud-base into the practice clinical system

A Virtual Chronic Kidney Disease (vCKD) review service has been implemented between general practice and the East & North Herts Hospitals Trust. This has increased the number of patients being reviewed and reduced the potential for patients to develop chronic disease. The service is currently being extended to GP EMIS practices.

Premises and sustainability

Concluding the projects where the capital funding was sourced by NHS England under the Estates and Technology Transformation Fund (ETTF) programme, which had originally launched in 2016 - many projects that have benefitted thousands of patients and staff to receive and deliver healthcare from improved premises.

Lloyd George Digitalisation of patient notes - over 280,000 patient records were digitised and to date has created 56 desk spaces and 3 new consulting rooms, providing additional services/support

Improved engagement with the 13 Local Planning Authorities (LPAs) covering Hertfordshire and West Essex and a better understanding of housing trajectories from the LPAs who have advanced their Local Plans; emerging work with others.

Successful development of 35 PCN Clinical Strategies – National programme to identify estates change requirements in order to be able to deliver care to address their local population's health needs and priorities; support the development of the workforce; and plan for future service needs.


Enabling Workstreams -
areas of focus over the next 3 years

Patient empowerment and education - key areas of focus over the next 3 years

Year 1 to year 3 – 2023 - 2026

May 2023 onwards - ICB communications team to support development of local patient survey questions that GP practices/PCNs can use to survey their patients to measure improvement in patient experience

Proactive ICB wide series of patient feedback working with Healthwatch Hertfordshire and Essex

April 2023 onwards - GP Practice Website Support - Develop a model GP practice website to best practice standards defined by NHSE. Clear content and task-based navigation that enhances patients' experience of services by highlighting online access and new ways of delivering services including additional roles and different types of appointment.
Phase 1 was to pilot model website with 5 practices in ENH – this took place end of May 2023
September 2023 onwards -Phase 2 roll out model website content across HWE practices in a phased way to support practices.

Promotion of range of roles in Primary Care
Working with practices to promote the importance and value of additional roles that are available within general practice. Develop a toolkit of materials that practices can use to help promote these roles. Work with practices to develop case studies for use, in video form as well as non-digital channels.

- July/August 2023 - Promote the role of the reception staff in directing people to appropriate services
- August/September 2023 - Focus on key roles within practices with case studies and toolkits

Promote different ways that patients can contact their general practice with a particular emphasis on promoting and increasing the take-up of online services.

- October 2023 - National online access campaign promoted locally
- November 2023 - Day in the life of a practice – full range of work. Help with understanding of pressures on practice and routes in to support

Promotion of preventative and self care options – linking in with the ICS 'Lifestyle medicine' workstream for improving overall wellbeing as well as promoting screening, vaccination-take up etc, particularly amongst those who experience health inequalities. Linking with work below to involve PPGs and VCSFE in this work to boost self-care and wellbeing.

Continue support development of GP practice patient groups at practice/PCN and Place through Health and Care Partnerships delivered alongside the National Patient Association - the ambition is that patient groups will be able to link in with their local communities and support patient empowerment and education by running sessions such as Cancel out Cancer talks, patient led webinars and condition specific support groups (e.g diabetes). Resources to support PPGs will be developed building on the content to date who are producing 'how to' guides and training materials on engagement - It will be important to ensure that pharmacists, dentists and optometrists are linked into patient groups to support community primary care engagement.

Workforce - key areas of focus over the next 3 years

Year 1 - 2023/ 24

Emerging Leaders Programme – establish links between primary care and the system's leadership programme
Implementation and Evaluation with a view to evolve the Community Pharmacy PCN Liaison Leadership Role across 35 PCNs

- June 2023 – Leadership Training event for appointed Community Pharmacy Leads
- April – March 2024 – Project Evaluation

Enhanced workforce data collection and reporting across PCNs and General Practice and evaluation of training programmes

- June 2023– Develop a schedule of evaluations of training and development initiatives reporting
- July 2023 onwards – Production of monthly workforce data reports using NWRS national data and intelligence from quarterly PCN education team reporting
- August 2023 onwards – quarterly reporting on training and development initiatives, projection to operating plan workforce for primary care for General Practice/PCN

Clinical placements and work experience

- Increase undergraduate pharmacy clinical placements capacity & quality of placements across all pharmacy sectors, other roles such as paramedic, podiatry, physician associate, nurses. HWE ICB (in conjunction with University of Herts) ran a successful training event for potential placement providers in March 2023, this work continues with the development of 'champion roles'.
- Increase school work experience opportunities in primary care through the education sector working via County Council

Develop system-wide pharmacy/dental and optometry recruitment & retention plan including skill mix

- October 23-Jan 24: Map the gaps against the operation programme of work for each sector (including intra-professional collaboration & safe staffing levels), & develop a process at regular time periods to update, particularly at the point that supports winter planning – this will be with HEE
- Jan 2024 - Develop a system-wide recruitment and retention programme across all sectors (Primary/community and where appropriate acute) for this group of professionals

Retention Pathfinder – engagement with system's pathfinder programme exploring areas of support such as flexible working, onboarding and career development pathways.

Apprenticeships – April 2024 - review opportunities to establish the new health and wellbeing level 3 apprenticeship to support community wellbeing

Equality, Diversity and Inclusion – align activity in primary care with the wider ICS to support and achieve the high-impact actions identified as part of the national EDI improvement plan, and supporting the region's commitment in delivering the anti-racism strategy

Workforce continued - key areas of focus over the next 3 years

Year 1 to year 3 – 2023 - 2026

PCN Training teams continue to support the recruitment and retention of the Primary Care workforce and the protected time to learn events

- 6 Monthly feedback reports to reflect on events that have taken place and to support making future improvements and the sharing of learning opportunities that may be beneficial to PCNs
- Encourage PCN to be become learning organisation
- Jan 24-March 24 Evaluation of the PCN Training Team with a view to expand the role and remit and embed them for a longer term contract.

Training Hub to have a comprehensive array of multi disciplinary programmes for all primary care disciplines and at all career stages

- July 2023 – March 2024 – exploring roadmaps and training and development opportunities for the new roles in Primary care
- Ongoing career clinics for all staff to discuss training and development opportunities

Supporting the upskilling of existing community based Optometrists to become independent prescribers

- Engagement and promotion
- Course intake January and September

2023 – 2024 – plan / 2024– 2025 implement: Staff wellbeing & experience

- Implement strategies to promote job satisfaction, work-life balance, & a positive work environment.

September 2023-March 2024 – Develop of skills mix and scope the development of dental workforce, including upskilling dental nurses and therapists and integrated roles between primary/community and acute.

Cross sector working /Career pathways development

- Increase number of rotational & hybrid roles working across secondary care, community pharmacy and PCNs. Workstream to include facilitation, e.g. governance, access to IT hardware & systems.

Pharmacy: Independent prescribing

- Maximise the value of independent prescribers (including through commissioning) in all pharmacy sectors in preparation for 2025/26, when all new pharmacist graduates will be Independent Prescribers. The aim is to facilitate the implementation of innovative clinical practice and service delivery models.

Premises and sustainability - key areas of focus over the next 3 years

Year 1 – 2023/24

Deliver the HWE ICB/ICS Infrastructure Strategy

- Working as a system to make best use of estates to support delivery of care – ensuring optimum use of all existing public sector estates
- NHS England seek completion by December 2023, all system partners engaged. Primary Medical Care key partner to this development across the system

Year 1 to year 3 – 2023 - 2026

2023 – 2025 - Continued work is taking place to digitise the Lloyd George Patient Records of EMIS practices and to store the records of Systm1 practices off site in order to repurpose the space where it can usefully be repurposed into clinical or administration space for primary care. Resource identified from the Primary Care Team to support the premises team and aim to conclude this in 24/25.

2023- 2026 - ICB continue to work to reduce void costs on NHS Property Service assets by using the voids for occupation by primary care – especially to assist in accommodating ARRS staff and where possible to create additional clinical/consultation rooms**.** On-going and already achieved a reduction from £1.1m - £370k.

2023 -2026 - The ICB Premises Team continue to work with many practices and PCNs across the ICB on a variable range of premises projects. This is developed through the priority list which will be reviewed as year on year with changing circumstances and opportunities developing through evolving model of care, thinking differently for education and training opportunities.
Ongoing although the market conditions high inflation, increased borrowing costs, increased cost on labour and materials are causing viability issues on projects across the country.

2023 -2026 - From 1 April 2023 the ICB Premises Team have taken on the reimbursement scheme from NHSE and have already had positive feedback.

All system partners are working towards the 2040- 2045 Net Carbon Zero Agenda. To ensure we meet this nationally set timeline, we will continue to focus and plan to deliver on this agenda - supporting the development of sustainable, resilient, energy and cost efficient buildings (whether it be new builds or by the upgrading of existing estate - including the Boiler Upgrade Scheme where practices, dentists, optometrists and pharmacists could qualify).

Data, information and digital technology- key areas of focus over next 3 years

Year 1 to year 3 – 2023 - 2026

Advanced Telephony - work to be undertaken as part of the Primary Care Recovery plan initiative will identify, validate, and prioritise (against an agreed ICB priority list) those practices that still have an analogue system. This list will be submitted to NHSE Region for funding to be considered. Once confirmation and approvals are received, work will be undertaken to deploy Cloud-based Telephony to those practices. We will support the process and will ensure that practices have support in maximising the benefit of these systems by putting in place a resource within the ICB who will work with practices on optimising system functionality to suit their business model.

- April – June 2023 – Assessment of systems
- July 23 – March 2024 – deploy new systems
- October 23 – March 24 – **Optimisation and integration of resource to maximise benefits**
- July 24 – March 26 – ongoing monitoring and support
- January 23 – September 25 - Performance data and patient feedback show access improvement

NHS App The NHS App, with its full functionality, is now viewed as the future gateway to all NHS services and we need to work with practices and patients to make that the expectation. The NHS App can be used to make/amend/cancel appointments at a patients GP practice, view GP records (where enabled), order and manage repeat prescriptions, use the NHS symptom checker, manage and make secondary care appointments from a referral, manage donation preferences and data sharing preferences. We will develop a communications campaign, in line with any national programme, to ensure practices can inform patients of the benefits of the NHS App and that we use all avenues (other appointments with providers etc.) to inform patients of the NHS App and its uses. **We will work with practices and system partners to optimise their interfaces with the NHS App so that any options for automation/integration are applied.**

- July – September 2023 - Develop public facing communications campaign
- October 23 onwards – run campaign ongoing to support cultural change across population through all networks
- January 24 – December 24 - Monitoring of uptake of NHS App and impact on online services, ERS usage and access to record
- January 24 – December 24 - Use Digital Leads and delivery partners to work with practices where uptake and benefits not seen
- January 24 – June 25 - Patients use NHS App and practices able to reinvest time saved back into face to face on need and patient experience and patient reported outcomes

Automation - Working with Herts Beds Luton ICT (HBLICT) and practices, and taking learning from other areas, we will look to develop a suite of automation tools that tackle both back-office tasks but also some of the administrative components of clinical tasks around Long Term Conditions. Part of this should be making sure Primary Care Electronic Patient Records (EPRs) are configured to automate as many tasks and processes as possible.

- July – September 23 - Understand processes most suitable for automation and what practices may already be doing
- October – December 23 – Look to share learning from others and develop ways practices can use automation
- April 24 – September 24 - **Use evidence from other areas to develop automated tasks around clinical pathways such as follow ups and bid to fund to test where AI may be able to support end to end clinical pathways tasks but also support in front end direct care. This is to be tests in conjunction with appropriate system partners**
- April 25 – September 25 - Expand usage if pilot successful
- January 24 – March 26 - Practices able to reinvest time saved back into face to face interaction with those who require it
- April 25 onwards -Scope the learning from automation to other primary care contractors – community pharmacy, dental and optometry

Data, information and digital technology- key areas of focus over next 3 years continued

Year 1 to year 3 – 2023 - 2026

Digital Workforce - We will identify and work with PCN Digital Leads to bring together best practice ideas and ensure that they understand how to work within the GP IT Operating Framework. Establish opportunities for learning from each other through user forums. Share resources via MS Teams, workshops and other mediums. Create easy access to ICB Digital Leads to help with ability to work together across all partners. In addition, we need to consider staff training and support of digital skills to optimise the use of the digital tools available. This might be with support from the Herts and west Essex Training Hub or 3rd party providers.

- July – September 23 - Understand current PCN Digital workforce and skill level
- October – December 23 - Map local PCN digital projects
- October 23 – June 24 - Create User Groups/resource sharing space
- January 24 – September 25 - Local network of informed Digital Leaders in Primary Care working within and understanding broader ICB Primary Care Digital Strategy

Digital Inclusion - Work with partner organisations, such as local authorities and VCSFE organisations, who have programmes specifically aimed at either helping people become digitally skilled or can help with equipment or access to the internet. We will look to create a resource hub for primary care that will allow them to signpost patients to appropriate services.

- July 23 – December 23 - Map current local projects available to support digital inclusion
- October 23 – March 24 - Create centralised resource hub of links to various schemes and look to run digital education sessions in practices to help patients
- January 24 - June 24 - Communications to practices and information on resource hub
- April 24 – March 26 - Maintain relationships to keep hub information current
- January 24 – March 26 - Practices able to signpost patients to local resources that support their needs

Community Pharmacy - Look to understand where the current challenges are in terms of pharmacy and digital position. Through appropriate channels look to deploy any systems that can facilitate flow of information and support general practice to pharmacy work flows. Make sure we have resource to support utilisation and uptake of systems. Scope current/future advances that will impact pharmacy over the next 5 years, to permit pharmacy teams to be part of a digitally connected, wider multidisciplinary team providing opportunities for targeted interventions to improve individual patient and population health.

- July 23 – December 23 - Baseline of current digital position in Pharmacy in view of new initiatives underway including pharmacy first and pathfinder of independent prescriber.
- January 24 – June 24 - Develop digital roadmap for pharmacy including how systems can be streamlined for community pharmacies and integrated with practices and acute partners in first instance
- April 24 – February 25 - Deploy any systems, record sharing mechanism, protocols possible
- January 24 – March 26 - Community Pharmacy and General Practice workflows as integrated as possible, patients receive equitable services

Data, information and digital technology- key areas of focus over next 3 years continued

Year 1 to year 3 – 2023 - 2026

Infrastructure Working with our GP IT delivery partner, HBL ICT, we will do a thorough review of all the laptops currently deployed and those in use. We will develop a standard policy for how laptops are managed and allocated. This must all be managed with the budget available to us so may require a bidding type process. We will continue to look to develop the Virtual Desktop Infrastructure (VDI) option which allows access to clinical systems securely on personal devices so that general practice staff are supported to work in an agile way that doesn't need them to be 'in the office':

- April 23 – September 23 - Continue VDI pilot
- July 23 – September 23 - Establish baseline of current laptops and usage
- October 23 – December 23 - Develop Standard Operating Procedure for allocation of laptops
- October 23 - March 24 - Establish VDI as business as usual function
- January 24 – June 24 - If needed procure and deploy any new laptops
- January 24 – March 26 - Practices able to have hardware to support ways of working with robust allocation process and support arrangements

Access to GP records – this is a national programme that is now part of the GP contract, and practices must enable this functionality by end of October 2023. This will allow patients to have prospective access to their records - only data from the date the practice goes live and moving forward will be visible. 19 GP practices across HWE ICB are live so far and we will work with practices to support them to enable this function over the coming months.

2023 – 2026 - a new data platform system will provide clinicians with a range of tools to manage patients and improve outcomes, significantly strengthening our Population Health Management approach. The platform links data from Primary Care, Acute, Mental House, Community and social care for every person registered to a local practice and staff will be able to identify patients, where clinically appropriate. This data will be available at practice and PCN level along with a wide range of reports and dashboards to help providers understand more about the local population. In addition, PHM tools such as population segmentation and risk stratification will enable teams to identify people who are most likely to benefit from care. The system will also allow the ICB to provide Population Health Management support to clinical teams to design and manage care according to local health needs.

Dental and optometry -
September 23 onwards – ensure digital is key enabler as we progress with the dental workplan on procurement/commissioning of a number of areas including, in and out of hours urgent on the day, community dental services, domiciliary dental and optometry care.
October 24 –March 25 - work to understand the challenges being faced, look to see if any 'quick wins' are possible and develop a longer term strategy to digitally support these areas

Additional broader primary care programmes of work including reviewing digital solutions between primary and secondary care interface, NHS app interface with patient portals, onward referrals within secondary care and remote monitoring, and resident-owned devices will also be looked into over the coming 3 years.

Investment and Contracting

Contracting Options from Year 1

- Strategically where possible, we will seek alternative contracting mechanisms to APMS contracts for primary medical services, with a view to commission longer term contracts, increasing sustainability and allows the flex in partnership working
- We will explore different contracting models with the objective of increasing resilience, capacity and value for money - such as contracts held by incorporated PCNs, Federations and Partnership models such as Primary/community etc.
- Through our contracting approach we will aim to ensure consistency of service offer and access across HWE and does not create inequality
- A commitment to work with a wide range of providers to explore innovative solutions to service delivery that support our strategic plan for delivery of services, in an integrated way tailored to the local population
- We will ensure ongoing quality assurance of all primary care contracts through a standardised approach
- We will encourage providers to offer the full range of additional services within the national contracts and enhanced where commissioned beyond core contracts across all primary care providers as appropriate
- We will look at opportunities of how these new local contracts aim to address the inequality in health and care outcomes across pockets and how by integrating primary care, creates opportunities to develop commissioning and contracting options through a population health lens.

High level Areas of Priority in Primary Care where Funding is already committed

Areas of work – brief summary	Proposed £	ICB Objective/Outcomes
Primary Medical Care Service Workforce – Recruitment/retention and all initiatives such as PCN Training team, CPD, Enhanced Fellowships, Nurse development, Apprenticeships, ARRS development, practice resilienc	£1.3M (additional to ongoing Training Hub costs)	We will improve out Recruitment and retention objectives together improved well being of the workforce
Data, Information and Digital Technology – core GPIT, data quality and intelligence support through Ardens, EMIS enterprise, Online consultations – Accurx and E consultations; VDI. Practice supporting tools – Team net	£7.2M	We will continue to improve our data quality which support future commissioning, understanding our needs, reduce workload through ways of streamlining, integration of tools and systems and scope and test and use of AI
Enhanced Commissioning From Primary Medical Care Service Providers including ECF, enhanced services such as shared care, anticoagulation, care homes, asthma hubs, Migrant support (ARAP, Afghan etc), Additional winter support through PCNs NOTE - excludes national enhanced services as part of the core delegated national contract). **Dental Transformation Ring Fenced to Dental -**	£20M £2M (TBC)	We will continue to improve on our outcomes for management of patients with long term conditions; improve access; support unprecedented demands during winter, enhance the case finding/prevention and personalised care
Premises– Committed on agreed areas of priority to be developed ; follow through with digitalisation of notes or off site storage	£2.6M (TBC)	Key enabler to deliver strategic objectives including housing appropriate workforce.

Proposed new investment – Primary Care Service Development Funds

Areas of work – brief summary	Proposed £ FYE	Proposed Outcomes
Development of INT including • Primary Care Clinical Leadership (GP and Community pharmacy) • Co-Ordinator/convenor (across partners) at locality level • Organisation development – PCN/locality/Place • PCN Leadership and Management directly to PCN via PCSE	£2M £1M	• Improved quality of life of patients in receipt of INT services: Self-reported confidence, wellbeing, and independence • Improved clinical outcomes, for example: Reduction in exacerbations of Long-Term Conditions • Reduction in locally identified health inequalities, for example: Improved detection of specific conditions • Improved workforce health, wellbeing, and satisfaction Reduction in work-related stress • Reduction in utilisation of health and care services; Including all partners' services
On the day access – as outlined in UEC Opportunity of primary/community in collaboration with partners where most needed • Harlow • Stevenage • Hertsmere PCN innovative testing models Dental access (existing ringfenced dental funding)	£1.2M	• Easily accessible, when clinically required – improved experience and patient reported outcomes • Services will collaborate to optimise capacity within the system - ensuring all pathways are effectively utilised • Use of total triage systems will provide consistent messaging and will result in better patient awareness of services available, and ensure people are seen in the right place at the right time • Dental access – equity of access across whole ICB footprint for both in and out of hours
Primary Care Digital (beyond GPIT) includes project management, utilisation resources for fixed term 12 months; opportunity including Piloting automation; Enhanced VDI, Support the gap in national advance cloud based telephony, support digital infrastructure through Hubs	£1m	• Better patient access to services through different options, primary care workforce able to work in more agile way through infrastructure that supports them, automation of admin tasks to free capacity for staff to do other things, support with utilisation of new telephone systems to maximise benefits for patients and practice staff.
Prevention and Health inequalities – Support the work being undertaken in the VCFSE sector helping to reduce health inequalities, including reducing digital exclusion and development of personalised care roles.	£200k	• Improved data sharing between personalised care healthcare workers and wider system • Improve outcomes measurement of personalised care interventions • More patients able to confidently use digital interfaces with healthcare services and therefore be able to benefit from the widest range of access options offered by health services.
Communications/Engagement – including Healthwatch/ongoing work with Patients Association and communications development	£40k	• High quality clear and consistent practice websites • High levels of public confidence in new healthcare worker roles • Well functioning and impactful PPGs • Patients better able to find their own solutions where appropriate for their own minor health queries

Next steps / close

Every day I continue to be struck by the incredible professionalism, commitment and resilience demonstrated by colleagues working across all our primary care providers in collaboration with health and care partners, striving to deliver the best possible care in an enduring, testing environment. I'm also acutely aware of the toll this is taking on all our clinical and non-clinical staff and also of the frustration experienced by our citizens when services are not as easy to access as we would all wish. As a system we have made great strides to improve the quality and experience of care across all our sectors and I feel strongly that the areas of focus outlined in this plan provides a step change over the next few years to continuously improve the outcomes for our population whilst also creating a positive impact on our workforce across all our partners but also the wider community.

Within this document we have attempted to set out what we believe good looks like and also a firm commitment to change via the annotation of clear milestones, however we are mindful not to be prescriptive on the "how" as they need to be co-produced and implemented at network/locality/place level with the population we serve.

The idea of this plan is to ensure we don't duplicate/triplicate and where it is possible to provide the support once such as commissioning enhanced framework, designing the MOU/risk sharing for INT and governance of locality leadership we will support that. Aim of this is to be open and transparent on how primary care service development funding is being aligned to the priority areas within primary care but also where it pumps prime into multi-partner system collaboration too such as funding for a co-ordinator/connector to support the running of the INT or funding organisation development/cultural shift programme across all partners.

Each area will have its key requirement of how we measure benefits and see the impact both in terms of hard and soft lived experience hence continued active focus on the community/engagement investment. Next steps will be to build on the outline plan and develop detailed proposals with partners involved and provide progress via various forums with a view to embed the learning and show improvement in key areas through quantitative data but more importantly through lived experiences across our representative patient groups.

Would take this opportunity to thank everyone who has been involved in the development of this plan and your ongoing support in implementation and driving the change.

Avni Shah
Director of Primary Care Transformation
Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	NHS HWE ICB Primary Care Board meeting held in Public				**Meeting Date:**	**27/07/2023**	
Report Title:	**Primary Care Access Recovery Plan**				**Agenda Item:**	**9.1**	
Report Author(s):	Andrew Tarry, Head of Primary Care Contracting						
Report Signed off by:	Avni Shah, Director of Primary Care						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☐
Report History:	N/A						
Executive Summary:	0n 9th May, the National Delivery Plan for Recovering Access to Primary Care was published**.** This is the first step in delivering the vision set out in Fuller Stocktake and more importantly our local ICB wide plan for Primary Care integrating into our system with alignment of the priorities as a system and through each place. As outlined in recently published access recovery plan. At a high level the plan seeks to support recovery by focusing this year on four areas: • **Empower patients** to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice. • **Implement Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment. • **Build capacity** to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed. • **Cut bureaucracy** and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.							

	IIF Capacity & Access Improvement Plans (CAIP) - baselining and recovery planning – PCN AIPs submitted by 30th June. Further review underway to co-develop and for ICB to sign off. Summary of these will be shared with respective place UEC/SRG/Local delivery boards to support system discussion in August 23 Key updates are provided per place, however key include: Maximising the use of digital for triage; Identifying need for Cloud based telephony across practices; Acceleration of recruitment of ARRS roles; Identifying ways of streamlining working with Community pharmacies to take on CPCS and preparation when new community pharmacy services go live for winter 23; Cultural shift ongoing with patients/citizens ations as to how to access general practices/community pharmacy etc. Details of CBT support expected to be confirmed w/c 17th July, with 28 HWE practices prioritised The Board will receive a presentation as an update on the ICB work to date to support recover and the delivery of the access improvement plan.
Recommendations:	▪ The Board is asked to note the content of the paper

Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☒	***Non-Financial Personal***	☐
	None identified			☐
	GP members on the Board are conflicted; however as the paper is not seeking a decision, input into the discussion on the plan will be managed appropriately within the meeting.			

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A

Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒
	Enhancing productivity and value for money	☒
	Helping the NHS support broader social and economic development	☒
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☒

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Improving Access – Update of Primary Access Recovery Plan

Presentation to:
Primary Care Board

Thursday 27th July

Working together
for a healthier future

Delivery Plan for Recovering Primary Care Access

- Delivery Plan was published on 9th May outlining the core ambitions to support improving access and sustainability of general practice, underpinned by several supporting programmes either financial, training or transformational
- Checklist for both ICBs, practices and PCNs published on 19th May summarising the support offer with required actions and timelines
- The delivery plan covers 4 key areas:

1		**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy
2		**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity • Rapid assessment and response
3		**Build capacity**	• Growing multi-disciplinary teams	• Expand GP specialty training	• Retention and return of experienced GPs • Priority of primary care in new housing developments
4		**Cut bureaucracy**	• Improving the primary-secondary care interface	• Building on the 'Bureaucracy Busting Concordat'	• Streamlining IIF indicators and freeing up resources

Support Offer to Practices and PCNs

Area of Support	Detail	Timeline
Move to cloud-based telephony	Practices to indicate to ICB that it wants to move to a digital telephony solution	By 1 July 2023
Funding of Digital Tools	To provide functionality for online consultations, messaging, self-monitoring and appointment booking	By 31 August 2023
National General Practice Improvement Programme (NGPIP)	• Universal – online resources/webinars • Intermediate – targeted, hands-on support (up to 13 weeks) • Intensive – targeted, hands-on support (up to 26 weeks)	ICBs to nominate practices throughout 23/24 & 24/25
Transition cover and Transformation Support Funding	To support **qualifying** practices transitioning to "Modern General Practice Access Model"	Agreed with ICB throughout 23/24 & 24/25
Care Navigation Training	Practices can nominate **one member of staff** to undertake training	Throughout 23/24 & 24/25
Digital and Transformation Lead Training	PCNs can nominate **one member of staff** to undertake training	
Repurposed IIF Funding – Capacity and Access Support (CAP)	• PCNs receive 70% of the IIF funding unconditionally to support improving access and provide capacity for transformation – paid monthly from April 23 • Remaining 30% paid on assessment of improvement in access at year end	Ongoing in 23/24
Increase of ARRS flexibility and funding	• Increased cap on Advanced Practitioners from 2 to 3 per PCN (up to 99,999 population) • Reimbursement for FCP time to train to become an AP • Advanced Clinical Nurse Practitioner roles eligible for reimbursement as APs; • Apprentice PAs introduced • Cap removed on MH Practitioners – can now support some first contact activity	Ongoing in 23/24

ICB Baseline

- ICBs are required to provide baseline data to PCNs to support the development of the Access Improvement Plans (AIP) – *this has been provided and published onto Ardens Manager*

- **Digital Tools** – ICB has already rolled out Accurx and E-Consult to practices

Accurx

- 1,132,328 Communications
- 158,530 Questionnaires
- 33,841 Batch Questionnaires
- 98,623 Appointment Reminders
- 35,675 Patient Triage Links
- 60,138 Booking Links
- 347 Video Links

E-Consult

- 56 practices across HWE actively used E-Consult in April
- 21,097 E-consults submitted
- 4,808 related to “Administrative help”
- 1,459 related to “General advice”

- **NHS App**
  - 393,843 logins
  - 3,038 appointments booked
  - 50,611 Repeat Prescriptions Ordered
  - 1,377 appointments cancelled
  - 145,184 Summary coded Record views

Progress to date

IIF Capacity & Access Improvement Plans (CAIP) - baselining and recovery planning

- Access Improvement Plan (AIP) template developed and circulated to PCNs to capture all information required to support the Delivery Plan. Baseline data made available vis Ardens Manager

- AIP baseline to be submitted to ICB by 30th June; then by 31st July PCNs/ICB to co-develop and ICB to sign off PCN/practice access improvement plans. **Summary of these will be shared with respective place UEC/SRG/Local delivery boards to support system discussion in August 23**

- Key themes from PCN improvement plans include:
  - Maximising the use of digital for triage and where possible ensuring the priniples of triage are consistent across a PCN
  - Identifying need for Cloud based telephony across practices and how this is used to support the operational delivery including measuring demand vs capacity
  - Acceleration of recruitment of ARRS role based on PCN clinical strategy and current demands in general practice
  - Identifying ways of streamlining working with Community pharmacies to take on CPCS and preparation when new community pharmacy services go live for winter 23 to shift that activity within primary care
  - Cultural shift ongoing with patients/citizens with proactive video vignettes/communications as to how to access general practices/community pharmacy etc.

ICB Baseline continued…

- Other baseline data provided on Ardens Manager include:

  - GP Appointment Data
    - Appointments attended
    - Appointments DNA's
    - Appointment Mode – face to face, telephone, home visits
    - Accuracy of mapped appointments
    - Appointment Type – routine, urgent
    - Seen by GP
  - GP Patient Survey results
    - Good experience with booking appointments
    - Satisfied with appointment offered
  - Waiting time for appointments
    - Seen within 2 weeks
  - Workforce FTE
    - Admin/Non-Clinical
    - Direct Patient Care

Progress to date

Cloud Based Telephony transition support

- Collated an initial baseline of practices – 28 practices with analogue telephony systems prioritised. A further 51 practices are classified as low urgency (Systems not on framework or with only core functionality). 48 practice are complete in having advanced CBT
- Next steps;
    a) practice agreement in principal email between practices and ICB (rather than more formal MOU process)
    b) per practice baseline assessment to support governance and evaluation.
    c) Ongoing process to measure benefits as we move forward
- Details of support expected to be confirmed w/c 17th July

National GP Improvement Programme (NGPIP)

- Universal offer of webinars covering the 5 key priority areas and advice on how to make practical changes and improvements in general practice.
- Intermediate/Intensive support - hands on facilitated support. Place teams encouraging & prompting practice & PCN engagement.
- Care navigation training: every practice can nominate one member of staff to undertake training. Additional care navigation through PC Training Hub to be deployed to support general practice but also open up to other primary care staff such as front line community pharmacy

Progress to date

Support Level Framework (SLF)

- Self assessment tool delivered through a facilitated conversation with members of the practice team to support practices in gaining an understanding of what they do well, what they might wish to do better, and where they might benefit from development support. Aim for all practices to have had a facilitated discussion using the SLF during the year

Transformation support funding

- Indicative £13.5k per qualifying practice. Specific support for practices 'seeking to implement Modern General Practice Access model' – so temporary cover to support clearing of appointment books before transition.

Other

- Communications have been developed to support ICB and practice websites, media statements and communications for patients on the Delivery Plan

- Attendance at NHSE regional weekly drop-in sessions to escalate any issues or questions for clarification

ENH place – Key Highlights (1)

- PCNs have a focus within their Capacity and Access Improvement Plans on the training of reception staff for care navigation: enabling a better patient experience from receptionist through to ARRS/AHP/Nurse/GP.
- 2 GP Practices in the North Herts Locality have implemented a total triage model. In Hertford & Rurals PCN they have set up a hub that triages all of their E-consults for the PCN, a dedicated team has been set up. Work is underway to evaluate the impact and benefits of these service models with a view to sharing wider at place.
- The majority of our PCNs have a Digital Transformation Lead, for improved digital processes and for sharing good practice within place and across the ICB.
- Some PCNs are exploring a Quality Improvement Module of wellbeing – Stevenage South PCN are training two staff members as mental health first aiders and lifestyle medicine, and one staff member as a freedom to speak up guardian, they will share contact details for these staff members across the PCN as contacts for staff who may be in need of help and support.
- The 2 PCNs located in Stevenage locality are planning to implement a same day access hub to relieve pressure on A&E by reducing inappropriate, non-emergency attendance and accepting referrals from A&E for patients who can be effectively managed in primary care.
- Work underway to expand online consults and use of call back function to improve patient experience.
- Pilot underway of redesigned GP Practice websites supported by the ICB to develop and improve patient experience through online access.

ENH place – Key Highlights (2)

Summary below of no. of practices per PCN that:

1) Have been prioritised for CBT implementation (currently have analogue tel system)
2) Are or have engaged with the GP Improvement Programme or similar. Noting that Broxbourne Alliance are participating in the PCN-level Improvement Programme

PCN	CBT	GPIP or similar
Broxbourne Alliance	1	
Hatfield	3	
Hertford & Rurals	0	
Hitchin and Whitwell	2	
Hoddesdon and Broxbourne	1	
Icknield	2	1 - Accelerate
Lea Valley Health	2	1 - Intensive
Stevenage North	1	
Stevenage South	0	1 - Intermediate
Stort Valleys & Villages	0	1 - Intermediate
Ware & Rurals	0	
Welwyn Garden City	1	
	13	4

SWH place – Key Highlights (1)

- PCNs are fulfilling their workforce plans and embedding ARRS roles to address demand, for example GP Assistants
- Redesigning care pathways for management of long term conditions, with a strong focus on the training of reception staff: enabling better patient experience by allowing more seamless understanding of patient – receptionist – ARRS/AHP/Nurse/GP
- Several surgeries have already implemented a total digital triage or total triage model and more are planning to move to this model
- Some PCNs have a Digital Transformation Lead, for improved digital processes
- Some are exploring a Quality Improvement Module of wellbeing – this is in relation to the new QOF indicator, which is for workforce and wellbeing, patient experience and optimising demand and capacity
- PCNs are referring minor illnesses to Community Pharmacies Consultation Service and using social prescribers to ensure patients' non-medical needs are fulfilled, expanding care navigation to appropriately signpost
- Hertsmere locality have planned for a same day bookable minor illness hub to allow its patients to access a more local service
- Patient education about the Allied Healthcare Profession roles, for patients to get used to seeing clinicians other than GPs and for them to build a rapport with this workforce
- Expanding online consults and use of call back function to avoid long waits on the phone
- Some PCNs are allowing patients to self-book certain routine appointments, such as smear tests and vaccinations via AccuRx

SWH place – Key Highlights (2)

Summary below of no. of practices per PCN that:

1) Have been prioritised for CBT implementation (currently have analogue tel system)
2) Are or have engaged with the GP Improvement Programme or similar. Noting that 3 PCNs are participating in the PCN-level Improvement Programme – Grand Union, Halo, Harpenden

	CBT	GPIP or similar
Abbey	0	
Alban	1	
Alliance	1	1 - Intensive; 1 - Intermediate
Alpha	0	1 - Intermediate
Attenborough	1	
Beta	1	1 - Intensive; 1 - Accelaerate
Central Watford	2	
Delta	1	
Grand Union	1	1 - Intensive; 1 - Intermediate
Halo	0	2 - Intermediate
Harpenden	2	
Herts 5	1	1 - Intensive
MVP	0	
North Watford	1	2 - Intermediate
Potters Bar	0	1 - Intermediate
Rickmansworth & Chorleywood	1	1 - Intensive
	13	14

WE place – Key Highlights (1)

- PCNs are looking at their workforce plans and ensuring they making good efficient use of all available ARRS roles.
- Recognising the importance of the care navigator role and ensuring adequate training is being delivered.
- PCNs want to look and explore how interfaces and pathways can become a smoother process and reduce bureaucracy.
- Greater patient engagement and ensuring effective capturing of patient feedback through surveys or PPG's
- PCNs are showing a shift to want to understand their data and how this can aid in improvements and the direction of transformation.
- PCNs are looking to move to total triage systems which will start to build more consistent messaging to patients.
- PCNs want to learn more about the capabilities of the digital products they are now use. Ie CBT data can help plan rotas to assist with demand.
- Patient education through better website information and media messages.
- PCNs want to complete some work around a common approach to mapping appointment data.
- Identify staff training gaps and support staff in closing them.
- PCN have recognised the sharing of good practice and share challenges.
- Some PCNs are already Horizen scanning for what future digital technologies can support them with.
- An increased awareness and use of DOS for appropriate signposting to available services.

WE place – Key Highlights (2)

Summary below of no. of practices per PCN that:

1) Have been prioritised for CBT implementation (currently have analogue tel system)
2) Are or have engaged with the GP Improvement Programme or similar.

	CBT	GPIP or similar
Epping North	0	4 - GIRFT
Harlow North	1	1 - Intermediate; 1 - Accelerate
Harlow South	0	2 - GRIFT
Loughton, Buckhurst Hill, Chigwell	0	3 - GIRFT
North Uttlesford	1	
South Uttlesford	0	1 - Intemediate; 2 - GIRFT
	2	14

Empowering Patients - self-referral pathways

Have submitted to NHSE the Readiness Self-Assessment: Expansion of Self-referral Pathways on 17th July. Likely to be a monthly or quarterly requirement

- Confirmed that HWE expects to meet the requirement to have self-referral pathways in in place for all population to be able to access by 31 September 2023 – across the 7 services
- Have the ambition to meet the Access Recovery Plan estimate to increase self-referrals in the 7 services by 50% by 31 March 2024
- System task and finish group has been developed to support improving baseline information, improving access and to develop new pathways.
- Potential barriers include Financial, additional cost for an increase in referrals; possible additional use of a triage service to ensure patients go on a correct pathway; Most services are on a block contract may need increase in contractual activity/cost; Possible increase in waiting time in existing pathways; Capacity to see additional referrals, may need to undertake a demand and capacity review; Patient/carers - will require good engagement and communication to ensure uptake; Digital uptake – allowing for referrals to be made and tracked.

Reducing bureaucracy - plans for improving the primary–secondary care interface

SWH – The Primary and Secondary Care Consensus document has been created in collaboration with Clinical and Operational leadership from the following:
- Hertfordshire and West Essex Integrated Care Board (HWE ICB – South West Place)
- West Hertfordshire Teaching Hospital NHS Trust (WHTHT)

How did we achieve this:
- Through the Primary and Secondary Care Interface Meeting
- Face to Face meetings with Clinical Leads, LMC, GP's, Consultants, Prescribing and System Partner Leads
- Reviewed specific areas from Patient Letters, referrals documents, appropriate language and expectation of how we work together in a more joined up system approach

Socialising the document – this has been shared with Primary Care through various meetings – webinar's, Practice Manager's Forums and Locality specific forums.
Comments are being collated and will be taken back to the Interface meeting. Further discussions are needed to ensure other Trusts bordering South West (e.g. Royal Free)

ENH – The Primary and Secondary Care Consensus document is in final draft stage and has been developed in collaboration with Clinical and Operational leadership from the following:
- Hertfordshire and West Essex Integrated Care Board (HWE ICB – East & North Herts Place)
- East & North Hertfordshire Hospital NHS Trust (ENHT)
- This document has been developed through the Primary and Secondary Care Interface meetings and via engagement at various Primary Care meetings
- The purpose of the document is to cover expectations of how we work together in a more joined up system approach.

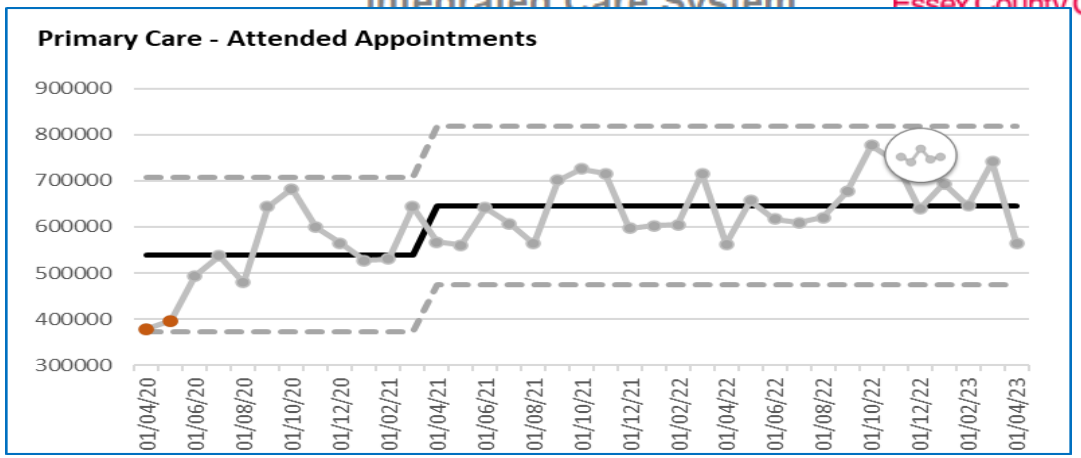
- The final version of the document will be signed off in September 2023 with a copy shared for inclusion within the Trust contract with the ICB for information.

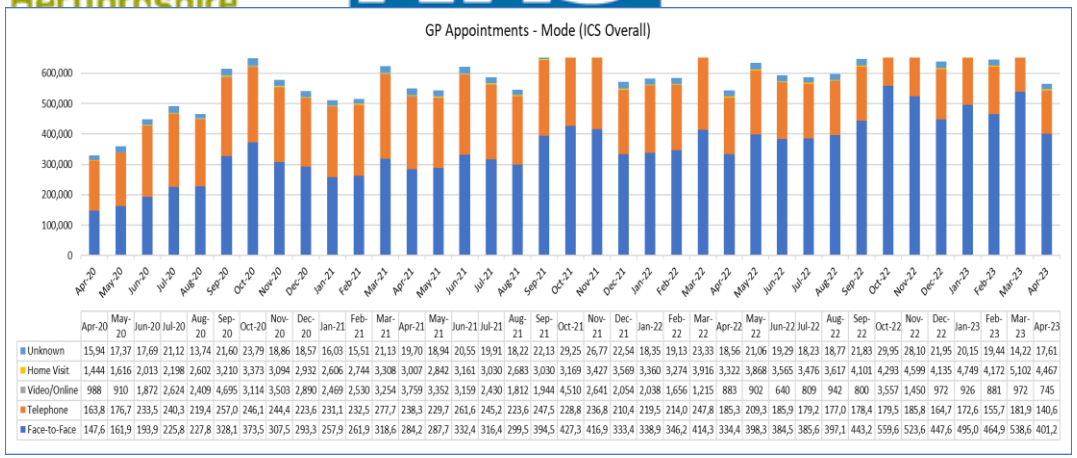
WE - The West Esses Health Care Partnership Interface group is now well established; Reps from the ICB, PAH, EPUT, PCN's, HCT, CYP are all members
- The group meets monthly with a structured agenda.
- Case studies are invited to be shared (in advance) to demonstrate where process have not worked as expected and the group aides to identify the issues and actions given to members to make appropriate changes.
- Members are given the opportunity to update on partners top two issues relating to interface issues and again gives a platform for sharing and identifying solutions as a collective.
- This group allows PC to raise issues identified through other groups such as duplications in the systems, discharge and referral letters.
- Some further work is needed to ensure fair challenge is given across all providers.

Empowering Patients - self-referral pathways

Service	Total numbers of providers (in area)			
	Providing the service with or without self-referral	Providing the service and offering self-referral	Expected to provide the service and offer self-referral next month (i.e. previous column plus providers beginning to offer self referral next months)	Expected to provide the service and offer self-referral by Sept 2023
Community Musculoskeletal Services	2	2	2	2
Audiology for older people including hearing aid provision	1	1	1	1
Weight Management Services (Tier 2)	1	1	1	1
Community Podiatry	2	2	2	2
Wheelchair Services	2	2	2	2
Community Equipment Services	2	2	2	2
Falls services	2	2	2	2

Primary Care





	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Unknown	15,94	17,37	17,69	21,12	13,74	21,60	23,79	18,86	18,57	16,03	15,51	21,13	19,70	18,94	20,55	19,91	18,22	22,13	29,25	26,77	22,54	18,35	19,13	23,33	18,56	21,06	19,29	18,23	18,77	21,83	29,95	28,10	21,95	20,15	19,44	14,22	17,61
Home Visit	1,444	1,616	2,013	2,198	2,602	3,210	3,373	3,094	2,932	2,606	2,744	3,308	3,007	2,842	3,161	3,030	2,683	3,030	3,169	3,427	3,569	3,360	3,274	3,916	3,322	3,868	3,565	3,476	3,617	4,101	4,293	4,599	4,135	4,749	4,172	5,102	4,467
Video/Online	988	910	1,872	2,624	2,409	4,695	3,114	3,503	2,890	2,469	2,530	3,254	3,759	3,352	3,159	2,430	1,812	1,944	4,510	2,641	2,054	2,038	1,656	1,215	883	902	640	809	942	800	3,557	1,450	972	926	881	972	745
Telephone	163,8	176,7	233,5	240,3	219,4	257,0	246,1	244,4	223,6	231,1	232,5	277,7	238,3	229,7	261,6	245,2	223,6	247,5	228,8	236,8	210,4	219,5	214,0	247,8	185,3	209,3	185,9	179,2	177,0	178,4	179,5	185,8	164,7	172,6	155,7	181,9	140,6
Face-to-Face	147,6	161,9	193,9	225,8	227,8	328,1	373,5	307,5	293,3	257,9	261,9	318,6	284,2	287,7	332,4	316,4	299,5	394,5	427,3	416,9	333,4	338,9	346,2	414,3	334,4	398,3	384,5	385,6	397,1	443,2	559,6	523,6	447,6	495,0	464,9	538,6	401,2

ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• Total appointments dropped in April 23 compared to previous month; however the trend does align with the previous year • The proportion of face to face appointments continues at over 70% of all total appointments attended	• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • **Not all appointment activity is captured in the above data i.e PCN Hub activity, ARRS activity**	• NHSE extended the deadline for the submission of the PCN Capacity and Access Improvement Plans to 30 June • PCNs being supported to develop their plans and to understand their baseline data published via Ardens • Submission to NHSE on practices prioritised for funding to transition to cloud based telephony • Recovering Access programme overseen by the Access MDT group with monthly highlights reporting on progress of action/milestones • Practices offered an extended period (additional 3 months) in which to achieve their QOF targets to recognise the ongoing prioritisation of on the day demand over winter • Continued work to promote use of the Community Pharmacy Consultation Service (CPCS) • Offer of additional national support through National GP Improvement programme (NGPIP) for practices and PCNs • Offer of Service Level Framework discussions to identify areas of priority and offers for support	• Continue to support return of business as usual to General Practice through the relaunch of the ECF across the ICB, supported by investment reporting to free up practice capacity • QOF period extension means that some annual review actions for LTC will be reprofiled to spring and should have a benefit next winter • Continued access trend analysis in the 3 places to identify individual practices with poor access through complaints and patient contacts • PCCC and Primary Care Board oversight of the GPPS results, and action plan developed through the Access MDT Group • Recruitment & Retention of Primary Care Workforce –initiatives are offered to the Primary Care Workforce to support recruitment and retention which are supported by the HSE ICB Training Hub • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices continuing

Next Steps

- Ongoing support to practices and PCNs to finalise their AIPs for ICB agreement and continued support throughout 23/24
- Publicise and maximise practice/PCN uptake of NGPIP support offers
- Digital tools and implementation (including telephony, online consultation and messaging tools) – support CBT transition; support & promote practices/PCN to enable all four NHS App functions for patients
- Support PCNs to use their full ARRS budget to recruit to the enhanced workforce whilst continuously support recruitment and retention of GP/Nurses and front line reception/back office staff and
- Report to Board to include all aspects of implementing Modern General Practice Access; also
    - **System level access improvement plan -** develop plan to include summary of practice/PCN improvement plans, challenges, wider support needs and barriers and ICB actions; developing and implementing the same day access models across each place and where appropriate integrating with existing same day urgent care provision such as UTC/MIU/NHS111. This will be support through each place and reported through UEC and Primary care Board.
    - **Empowering Patients** - Establish all self-referral pathways (including MSK, audiology and podiatry) as set out in 2023/24 guidance, also ensure pathways are in place between community optometrists and ophthalmologists. This is being scoped through planned care programme and will be delivered through each place.
    - **Reducing bureaucracy** - plans for improving the primary–secondary care interface. Areas of remit being discussed at each primary/secondary/community interface where established.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☐	*Meeting in private (confidential)*	☒
	PRIMARY CARE BOARD		**Meeting Date:**	**27/07/2023**
Report Title:	**DENTAL UPDATE – WORKPLAN AND PROCUREMENT PLAN**		**Agenda Item:**	**9.2**
Report Author(s):	Michelle Campbell, Head of Primary Care Contracts			
Report Presented by:	Rachel Halksworth, Assistant Director for Primary Care Contracts			
Report Signed off by:	Rachel Halksworth, Assistant Director for Primary Care Contracts			

Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☐	**Information** ☒

Which Strategic Objectives are relevant to this report **[Please list]**	• Increase healthy life expectancy, and reduce inequality • Give every child the best start in life • Improve access to health and care services • Achieve a balanced financial position annually
Key questions for the ICB Board / Committee:	The Board are asked to: • Note the content of the paper
Report History:	N/A
Executive Summary:	This paper provides an update to the Board on the dental contracting and commissioning delegated functions. The paper also provides the Board with the current dental workplan and the developing procurement plan. Due to the transition of the delegated functions to ICBs from 1 April, an agreement was approved by NHSE that contracts that were due to expire on 31 March 2023 or during 23/24, to be extended to 31 March 2024 to enable the ICB to develop a plan on the long-term commissioning models. There are currently over 40 Contracts across 9 service lines that are due to expire March 24 and we have been engaging with Arden and GEM as our procurement support on how we can phase this programme from April 2024; whilst working with other ICBs in the region to identify where we could collaborate on a procurement process to share resources. In addition to this, the team have been working with both Community Dental Service providers, both Hertfordshire and Essex County Council Public Health teams as well as the NHSE Consultant in Dental Public

	Health to address some of the priorities and health inequalities across the ICB.			
Recommendations:	The Board is asked to note the content of the paper			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
Implications / Impact:				
Patient Safety:	Patient Safety Issues will be addressed within any business case that is developed for approval.			
Risk: *Link to Risk Register*	N/A			
Financial Implications:	Any financial implications will be identified in any business case that is developed for approval.			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***	N/A		
	Quality Impact Assessment:	N/A		
	Data Protection Impact Assessment:	N/A		

1. Dental Update/Progress so far

Dental Workplan

Since the ICB took over the delegated functions for dental contracting and commissioning, the Primary Care Dental Contracts team have been developing a workplan which identifies the BAU functions and additional areas of work to support commissioning needs and potential areas for transformation.

The team have been meeting with both NHSE and Local Authority Public Health Teams to start to assess the Oral Health Needs of the Population and a future paper will be submitted to the Committee to support future decision-making.

There have also been meetings with other stakeholders to address current contractual issues and gaps in service which have all helped to develop the Dental Workplan for future consideration. **See Appendix 1 for the Dental Workplan**

Dental Procurement Plan

Due to the transition of the Pharmacy, Ophthalmic and Dental delegated functions, approval was given by the NSHE Primary Care & Public Health Oversight Group to extend all PDS Contracts that were due to expire on 31st March 2023 for 1 year to enable ICBs to consider the longer-term commissioning options for each service.

For HWE, this means there are **48** contracts spanning **9 service areas** that are all due to expire on **31st March 2024**

The ICB has access to procurement support from Ardens and GEM Commissioning Support Unit for 23-24 for primary care contracting and we have met with the procurement team to talk through each of these contracts to identify potential further extensions to allow the ICB to do a full review of the longer-term commissioning options.

The proposed extensions have taken into consideration the following factors to assess the risk of challenge from the market:

a) Current service type i.e specialist or generalist
b) Inter-dependencies with other services or programmes i.e CDS or UEC
c) Potential regional / cross-ICB procurement where services cross ICB borders

It should be noted that the PDS Contracts for Orthodontic Services was agreed by NHSE to extend up to 2027 across the East of England.

In addition, we have recently met with ICB leads across the region to identify where we can align our processes to avoid duplication for the procurement hub and will also enable ICB teams to share resources and free up capacity. Initial discussions on the other ICB plans are aligned to the HWE plan and we are now working with Arden and GEM to complete a full,

detailed procurement GANTT chart that identifies key milestones for engagement and governance to allow those procurements to complete on time. (There may be further adjustments to the plan to phase some procurements on a regional basis.

Community Dental Service (Special Care Dental Service)

We have met with both providers of the Community Dental Services i(CDS) in Hertfordshire and Essex. We are aware there are some variances in the service specifications across the 2 services which means patients in Hertfordshire do not have access to the same level of services than those in West Essex. For example, the Hertfordshire service does not include a service for anxious children.

The Hertfordshire CDS has developed a pathway on anxiety management and provided data to support the number of children who should be seen within the service had this pathway been commissioned. The data also demonstrated that the funding for the Hertfordshire service is lower than neighbouring services such as Milton Keynes and Northampton, despite the population being significantly larger, meaning the service can see approximately 0.1% of all paediatric referrals compared to 0.7-0.9% in Milton Keynes and Northamptonshire respectively.

We are also aware that a large number of children are referred into secondary care due to the limited access to services within Hertfordshire. Data obtained by the Paediatric Managed Clinical Network Chair, indicated that in 19/20, 36% of referrals received by the UCLH were from East of England region, and all were for patients from Hertfordshire.

The CDS is also the provider of the domiciliary service that treats patients in nursing and residential care homes; however this contract is under-performing due to patients or their carers not willing to pay for their dental treatment.

We are currently working with the provider to understand where we may want to tighten up both the domiciliary and the CDS specification to ensure it meets the needs of our population using the surplus funding within the current contract envelopes; whilst we undertake a full review of both services to inform the new specification for the procurement which is likely to commence during 24/25.

In addition, we had identified that there is no access to a bariatric dental chair within the community in Hertfordshire and therefore had an interim arrangement with the Bedfordshire CDS Service to see Hertfordshire patients where eligible. Unfortunately, uptake of appointments within the Bedfordshire service was low as patients were not willing to travel.

We have since sought approval for funding to place 2- 3 bariatric chairs in locations that are accessible to both Hertfordshire and west Essex patients and are currently working with the provider to complete this work.

Working with Public Health teams

We have met both individually and jointly with Hertfordshire and Essex County Council Public Health teams and the work they are doing on oral health promotion.

Harlow District Council invited the ICB to attend a workshop to focus solely on how we address the oral health issues in children within the district. The workshop was attended by local school leaders and Harlow College, local organisations that cater for Children and Young People, Community Dental Service and the ICB. The workshop was intended to identify current activities/initiatives that are in place to support this and ideas on how we can build upon this collectively drive the improvement in children's oral health.

We are awaiting for the outputs and next steps from the workshop to start to look at how we can support increasing access to services in this area of high need.

There is a plan to have a follow-up workshop later this year which the team will engage in.

In Hertfordshire, we have attended the Oral Health Alliance which had a similar focus on identifying current oral health promotion initiatives already in place; the main issue that was identified was that the Hertfordshire CDS are not funded or commissioned to participate in the Epidemiology surveys of school-age children which supports the oral health needs assessment; unlike other CDS Services who are contracted to provide this service. Previously, NHSE did not approve the funding for the Hertfordshire service so there are gaps in the data for children's oral health.

In June 2023, we took a paper to the Primary Care Commissioning Committee (PCCC) to seek approval for funding for the 2023/24 survey of 5year olds which is due to commence in the Autumn; which was supported.

Oral Health Needs Assessment / Joint Strategic Needs Assessment

The Oral Health Needs Assessment for HWE is due to be updated by the Consultant in Dental Public Health in NHSE and will focus on looking at dental access in primary care and to understand the experience of vulnerable groups when accessing primary care dental services. The section on patient experiences has an agreed focus on people experiencing homelessness, asylum seekers and refugees and Gypsy, Roma and Traveller communities.

We will also receive an updated map of all our dental contracts so we can see where there are geographical gaps in access to services so we can focus our commissioning in areas of high need with low provision.

On 22nd June, the first meeting was held with Hertfordshire County Council for the development of an Oral Health Joint Strategic Needs Assessment (OHJSNA). The OHJSNA will analyse the current oral health needs of the population in Hertfordshire; identifying those affected by poor oral health and assessment of whether current services adequately meet those needs. The OHJSNA will make recommendations, based on evidence, which will inform strategic

planning and local service provision to reduce health inequalities and improve health outcomes in these cohorts.

BAU Functions

In addition to the above, the team receive, daily communications from providers with contractual queries which may include requesting an increase/decrease of the contract activity, changes to performers or even notification to hand back their contract. These emails average 9-10 per day.

In June, the PCCC approved the scheme of delegation that was proposed to support the primary care contracting panel in making decisions on dental contracts where there were requests to amend their contracted activity, either through an uplift in the value of their Units of Dental Activity (UDA) or an increase in the contracted level of activity etc. This is to avoid any delay in commissioning decisions due to the Committee only meeting every 2 months.

In June, the contracting panel also received a paper indicating that a provider had handed back their contract; which is of a significant size and the team are working on identifying where this activity can be dispersed to prioritise the areas of highest need and inviting provider to bid for additional activity.

2022-23 Year End Achievement

We are expecting the 22–23 year end achievement data by Friday 21st July. We are currently liaising with NHSE on the retention of the clawback monies, as it has been suggested that this will be returned to NHSE.

We are also looking at how we can maximise the delivery of contracts during 23-24 to avoid large clawbacks next year; which may mean reducing some contracts where they are regular under-performers and commission that activity elsewhere or by commissioning in a different way to complement the current contract and incentivise preventative work, urgent dental care and stabilisation.

Urgent Dental Care

To align with the Primary Care Strategic Plan, we are looking at the urgent dental care pathways, both in and out of hours to ensure that this pathway is integrated in to the ICB Urgent and Emergency Care Strategy. The team are currently collating and reviewing the urgent dental activity delivered under the current services, including 111 data to develop a pathway to support access during winter, whilst the integration with UEC Strategy is progressed.

2. Recommendation

The Board are asked to note the content of the paper.

Primary Care and Localities Work Programme: HWE ICB
Primary Care Contracting Team
1st April 2023 - 31st March 2024

PLEASE NOTE:
This column populates Gantt Chart - wording should be appropriate for Exec report

Ref No:	Lead Team/Area	Portfolio Area	Project Title	Project Description / Updates	Locality	Frequency	Start Date	End Date	Project Status	MoSCoW	Benefit Category	Timescale Priority	Risk Stratification	SRO	Contracting Project Lead	Contracting Project Manager	Contracting Project Support / Admin	Members/Involves	Updates/Next Steps June 2023	Actions	Primary Care Contracting Team Members: Rachel Hallsworth (RH)	Michelle Campbell (MC)	Andrew Tarry (AT)	Marion Jones (MJ)	Liz Milne (LM)	Ola Sijuwade (OS)	Band 8As	Sara Kumari (SK)	Kaye Childs (KC)	Teresa Trodd (TT)	Jenny Burke	Dean Wimpory (DW)
1	MC/AC	Commissioning	Review of 1a flexible commissioning (in hours urgent care) and provision of urgent care out of hours	Paper in progress to present to PCCC. Recommendation to procure a new urgent service working with the ICB to ensure it fits with plans for urgent care	HWE Wide		5/1/2023	6/30/2023	In Progress/On Track	Must Do		High	High								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title		Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title
2	KS/AC/MY	Contracts	Year end process (all dental contracts)	BSA will liaise with us to confirm the year end figures and who has underperformed. They will notify all providers and liaise with us for review of any contested figures, force majeure claims etc. Once agreed, all clawback figures are to be entered in to compass and approved.	HWE Wide	Annual	3/1/2023	9/29/2023	BAU	Must Do		High	Medium								Select Role Title	Select Role Title	Select Role Title	Project Lead	Select Role Title	Select Role Title		Select Role Title	Project Manager	Select Role Title	Select Role Title	Select Role Title
3	KS/AC/MY	Contracts	Mid Year Process (all dental contracts)	BSA coordinate the mid year plans from providers for the dental team to review. Contract decisions may need to be made at this point in terms of reductions or changes to the contracts.	HWE Wide	Annual	9/1/2023	11/1/2023	BAU	Must Do		Medium	Medium								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Project Lead		Project Manager	Select Role Title	Select Role Title	Select Role Title	Select Role Title
4	AC,KS, MC	Contracts	Contract review	Desktop review of contracts with BSA, expand/create data report with outliers and actions.	HWE Wide	Quarterly	5/18/2023		BAU	Must Do		Medium	Low								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title		Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title
5	MC	Contracts	Re-establish relationships with Dental Providers	Regular LDC meetings established, ICB dental inbox in place and contact details have been shared with providers.	HWE Wide	Ongoing			BAU	Must Do		High	Medium								Select Role Title	Select Role Title	Select Role Title	Project Lead	Project Lead	Project Lead	Project Manager	Select Role Title	Project Support	Project Support	Select Role Title	Project Support
6	MC, AC	Contracts	Identify all contracts on a low UDA rate - how can the ICB support these providers to mitigate contract handbacks	Policy book may provide all required information, the team are working through to ensure all aspects are covered.	HWE Wide	Ongoing			BAU	Must Do		Medium	Medium								Select Role Title	Select Role Title	Select Role Title	Project Lead	Select Role Title	Select Role Title		Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title
7	MC	Contracts	Clinical advisor - current offer from NHS E does not provide all that we need.	Offer for one year contract made and accepted. Consideration to clincial advisor beyo	HWE Wide		4/1/2023	3/31/2024	Completed	Must Do		Low	Low								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Project Lead		Project Manager	Select Role Title	Project Support	Select Role Title	Project Support
8	JC	Contracts	Data Migration files from NHSE	Initial meetings with NHSE in calendars, on track for deadline date.	HWE Wide	Ongoing	4/1/2023	7/31/2023	In Progress/On Track	Must Do		Medium	Low								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Project Lead		Project Manager	Select Role Title	Project Support	Select Role Title	Project Support
9	MC, PCCC	Commissioning	All PDS agreements for CDS, MOS, Sedation, RMS, OOH and Ortho expire March 2024.	Review to determine which ones we want to take forward like-for-like and which services need re-development. Create a gant chart plotting all procuremements taking capacity of dental team and Commissioning Support in to account along with our ICB counterparts	HWE Wide	Ongoing	4/1/2023		In Progress/On Track	Must Do		High	High								Select Role Title	Select Role Title	Select Role Title	Project Lead	Project Lead	Project Lead		Project Manager	Select Role Title	Select Role Title	Select Role Title	Select Role Title
10	MC/AC	Commissioning	Budget review and payments process for invoicing and Purchase Orders	Contracts paid through invoice are West Essex MOS. Providers have been given invoice process for HWE ICB. All others are paid through compass. Aim is to move West Essex providers to Compass, notice can be given upon varying their contracts to extend once extension term has been agreed and approved	HWE Wide	Ad Hoc	6/27/2023		In Progress/Slipping	Must Do		Low	Low								Select Role Title	Select Role Title	Select Role Title	Project Manager	Project Manager	Project Manager	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title
11	Liz Milne (GP Contracts)	Primary Care and Localities Work Programme: HWE ICB Primary Care Contracting Team 1st April 2023 - 31st March 2024	Occupational Health Contract for HWE.	Current agreement povided by Beds Hospital Trust covers GP and Dentists and expires in September.	HWE Wide	Ongoing	4/1/2023	9/30/2023	Ad Hoc	Must Do		Medium	Medium								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Project Lead		Project Manager	Select Role Title	Project Support	Select Role Title	Project Support
12	AC in conjunction with SNEE and MSE	Commissioning	Community Dental Services for West Essex contract split between HWE/SNEE/MSE	Provider in dispute over the contract split. Initial meeting has taken place and team are arranging a meeting with all ICBs involved to decide the best way to take this contract forward until it can be reprocured	West Essex		3/31/2023		In Progress/On Track	Must Do		Medium	Medium								Select Role Title	Select Role Title	Select Role Title	Project Lead	Project Lead	Project Lead	Project Manager	Project Manager	Select Role Title	Project Support	Select Role Title	Project Support
13	AC/MC	Contracts	Governance and scheme of delegation	Process of and agreed scheme of delegation to be put in place. Paper with a proposal will be taken to June PCCC	HWE Wide		6/6/2023	6/27/2023	In Progress/On Track	Must Do		High	High								Select Role Title	Select Role Title	Select Role Title	Project Lead	Select Role Title	Select Role Title		Project Manager	Select Role Title	Project Support	Select Role Title	Project Support
14	RH, MC, SC	Contracts	Managed Clinical Networks	Review of MCNs in terms of the geographical area they cover and timings. Some are EoE region wide, others are Hertfordshire and BLMK etc.	HWE Wide				Not Started	Should Do		Medium	Low								Select Role Title	Select Role Title	Select Role Title	Project Lead	Select Role Title	Select Role Title		Project Manager	Select Role Title	Select Role Title	Select Role Title	Select Role Title
15	RH, MC	Contracts	LDN Chairs	Current LDN Chairs (Tom Norfolk and Nick Barker) cover the whole of the East of England, this is in place until March 2024 whilst we decide how we want to recruit to this post (LDN chair to cover HWE and BLMK?).	HWE Wide				Not Started	Must Do		High	High																	Select Role Title	
16	FF	Dental Public Health	Updated needs assessment for all additional services/PDS agreements	Needs Assessments required for all aspects of additional services such as special care dentistry, sedation, orthodontics etc. Linking in with NHSE Consultant in Dental Public Health and LA Publich Health Teams	HWE Wide				Not Started	Should Do		Medium	High								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title		Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title
17	MC, KS, AC	Contracts	Assess gaps in dental provision (urgent, paediatrics, community etc),	Can we commission in the short term whilst we work out pathways and plans for services when we are ready to re-procure	HWE Wide		5/1/2023		In Progress/On Track	Should Do		High	Medium								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Project Lead		Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title
18	MC	Contracts	Lack of provision of Bariatric Chair in HWE	Community Dental Services in Bedford are supporting Hertfordshire Patients whilst we source mobile chairs. Patients in West Essex access services in Colchester. Plan to have 2-3 chairs spread evenly across HWE. Both CDS services are happy to support. Quote gathering in process.	HWE Wide		6/6/2023		In Progress/On Track	Should Do		Medium	Low																	Select Role Title	
19	MC, KS, AC, SC	Contracts	Dental contract reform	Implementation of the recent reform of the Dental Contract by the Office of the Chief Dental Officer and access recovery plan. We will need to put a plan in place in accordance with these documents.	HWE Wide	Ongoing			BAU	Should Do		Low	Medium								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Project Lead	Select Role Title		Project Manager	Select Role Title	Select Role Title	Select Role Title	Select Role Title
20	Dental Team	Contracts	Complaints / FOI / MP Queries	Ongoing support to provide responses and investigations	HWE Wide	Ongoing			BAU	Must Do		SELECT	SELECT								Select Role Title	Select Role Title	Select Role Title	Project Lead	Select Role Title	Select Role Title		Select Role Title	Project Support	Select Role Title	Select Role Title	Select Role Title
21	RH, MC, AC, KS	Commissioning	How much recurrent funding do we have from handbacks and how can we recommission at pace or utilise in the short term.	Team are looking at ways we can utilise recurrent funding to support Oral Health and Health inequalities initiatives such as fluoride varnish clinics, supporting the large numbers of seldom heard patients such as refugees/asylum seekers, the traveller community.	HWE Wide	Ongoing	6/1/2023		In Progress/Slipping	Must Do		High	Medium								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Project Lead	Project Manager	Select Role Title	Select Role Title	Select Role Title	Select Role Title
22	SC, AC	Contracts	Re-introduce routine and for cause practice visits	Spreadsheet to capture practice visits has been developed along with for cause criteria. Due to the number of contracts and size of the dental team we are unable to schedule in annual visits to all practices (would mean two full days per week)	HWE Wide	Ongoing	6/6/2023		In Progress/On Track	Must Do		Medium	Medium								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Contractual Lead	Project Manager	Project Manager	Project team	Select Role Title	Project team
23	KS, MY	Contracts	Create an action plan for mid-year, christmas, year end. Get ahead of what's coming and know where our peak outputs are.	Set in review dates, work up a process that can be easily followed.	HWE Wide				Not Started	Should Do		Low	Medium								Select Role Title	Select Role Title	Select Role Title	Project Lead	Project Lead	Project Lead	Project Manager	Project Support	Project Support	Project team	Select Role Title	Project team

24	**KS, AC**	**Contracts**	Regular comms and updates to providers	Introduce a bulletin for our dental providers, sharing information and updates	HWE Wide	Quarterly			Not Started	Could Do		Medium	Low								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title		Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title
25	**AC, SC**	**Contracts and Clinical advisor**	Review of pilots coming to an end	We have one practice in West Essex performing under the Endodontic and Periodontic pilot (expiring March 2024). We also have patients who are receiving treatment in Essex as part of the Trauma pathway pilot. Both pilots need a full service review to determine whether and/or how to procure moving forward.	West Essex				Not Started	Must Do		High	High								Select Role Title	Select Role Title	Select Role Title	Project Lead	Select Role Title	Select Role Title		Select Role Title	Project Manager	Project Support	Select Role Title	Project Support
26	**SC, MC, AC**	**Contracts and Transformation**	Dental Workforce	Dental workforce, training and upskilling in collaboration with the LDN	HWE Wide				Not Started	Should Do		Low	Medium								Select Role Title	Select Role Title	Select Role Title	Select Role Title	Project Lead	Select Role Title		Select Role Title	Select Role Title	Select Role Title	Select Role Title	Select Role Title
27	**MC, AC, SC**	**Secondary Care Contracts**	Review of secondary care services HWE and out of area	Analysis of service provision and levels of activity to be identified within HWE Acute Trusts and referrals out of area. Work with acutes to ensure appropriate clinical coding to ensure robust activity reporting. Current waiting times to be deteremined and any waiting list initiatives to support.	HWE Wide				Not Started	Must Do		Medium	High								Select Role Title	Select Role Title	Select Role Title	Project Lead	Project Lead	Project Lead		Project Manager	Select Role Title	Project Support	Select Role Title	Project Support
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Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	NHS HWE ICB Primary Care Board meeting held in Public		**Meeting Date:**	**27/07/2023**
Report Title:	**Reports from Healthwatch Hertfordshire -** **a. Report and Recommendations on Adults with Learning Disabilities' Experiences of Accessing GP Services, and Support in Living a Healthy Lifestyle** **b. Report and Recommendations on Public Understanding on Cardiovascular Disease, and Self-Management.**		**Agenda Item:**	**10.1**
Report Author(s):	Geoff Brown, Chief Executive, Healthwatch Hertfordshire Chloe Carson, Senior Research Manager, Healthwatch Hertfordshire Miriam Blom-Smith, Research Officer, Healthwatch Hertfordshire Asha McDonagh, Research Officer, Healthwatch Hertfordshire			
Report Presented by:	Neil Tester, Vice-Chair, Healthwatch Hertfordshire			
Report Signed off by:	Avni Shah, Director of Primary Care Transformation			

Purpose:	**Approval / Decision**	☐	**Assurance**	☐	**Discussion**	☒	**Information**	☐

Which Strategic Objectives are relevant to this report **[Please list]**	▪ Improve access to health and care services ▪ Increase the numbers of citizens taking steps to improve their wellbeing ▪ Increase healthy life expectancy and reduce inequality
Key questions for the ICB Board / Committee:	Following discussions at the previous meeting, how will the Board address the following points raised: ▪ Primary Care Board members had emphasised the importance between community and mental health services and supporting people with learning disabilities in primary care. Also that each Health and Care Partnership explores these issues.

	▪ Primary Care Board supported practical approaches to address issues of access and the additional time needed to meet the needs of the client group. ▪ Primary Care Board strongly supported the recommendation of having a named contact for people with learning disabilities. ▪ The meeting also supported the potential use of transformation funding to ensure services meet the needs of people with learning disabilities. How will the Board identify ways to support/enable GP practices to implement the recommendations? ▪ For cardiovascular disease, the findings clearly show disparity between demographic groups, both in terms of knowledge and management of conditions. What targeted action can be taken to address this?
Report History:	▪ Early findings from each report were presented at the Primary Care Board meeting in May. A positive discussion was had, particularly in relation to the Learning Disabilities report, with practical recommendations suggested by Board members. These have been addressed through the key questions and within the recommendations listed below.
Executive Summary:	Between February and May 2023, Healthwatch Hertfordshire carried out engagement exploring the following: ▪ Adults with Learning Disabilities ▪ Cardiovascular Disease **<u>Engagement with Adults with Learning Disabilities</u>** Through a focus group and one-to-one interviews, we spoke to adults with learning disabilities, carers and support workers about their experiences of accessing GP services, and how GP practices support them in living a healthy lifestyle. Key themes included: ▪ Difficulties accessing GP services ▪ The role and importance of Care Coordinators ▪ Lack of choice and flexibility when making appointments ▪ Cases of poor communication, and information not given in Easy Read ▪ Generally good support from clinicians on how to live a healthy lifestyle, though more information was needed particularly around cancer screenings ▪ Cases of thorough Annual Health Checks, while others received an inadequate examination **<u>Cardiovascular Disease</u>** Through an online survey, we engaged with people with a diagnosis of cardiovascular disease about how they self-manage their condition, and

	those without a diagnosis, about their understanding of the symptoms and risk factors. Key themes included: ▪ Clear disparities between demographic groups in regards to both knowledge and management ▪ Generally people with a diagnosis feel supported by primary care services and feel confident in managing their condition ▪ Limited number of people without a diagnosis have spoken to a clinician about their heart health ▪ Knowledge of cholesterol level and blood pressure needs improvement amongst people with, and without, a diagnosis
Recommendations:	**<u>Engagement with People with Learning Disabilities</u>** Recommendations focus on the following themes: access, choice, accessibility, communication, support in living a healthy lifestyle, and Annual Health Checks. A number of the recommendations are for GP practices, though we understand the pressures that are on primary care, and the impact this will have on being able to make changes quickly. <u>Access</u> 1. GP practices to continue improving telephone systems to reduce delays and waiting times for patients 2. GP practices to allow people with learning disabilities to contact their GP practice for a same day appointment outside of the 8:00am timeframe. This will allow people with learning disabilities to contact their GP practice when their carer or support worker is with them. 3. GP practices to have a Care Coordinator or a primary point of contact specifically to support people with learning disabilities in accessing their GP practice. o If a GP practice has this support available, they should ensure that people with learning disabilities registered at their GP practice are made aware of this. <u>Choice</u> 4. GP practices to allow people with learning disabilities to choose the type of appointment they have, and offering face-to-face appointments in the first instance. 5. GP practices to ensure that with learning disabilities can choose the time and date of their appointment, so they can make sure this is when their carer or support worker can accompany them.

6. If a telephone appointment is booked, a specific time slot is to be given rather than a large time window. This will enable people with learning disabilities to ensure they are (a) available to take the call (b) have their carer or support worker with them (c) be in a quiet area to have the consultation.

7. GP practices to ensure that people with learning disabilities can choose to see their usual clinician to provide continuity of care and familiarity.

<u>Accessibility</u>

8. Under the Health and Social Care Act (2010) GP practices are to be proactive in asking whether someone with a learning disability needs, or would like, any reasonable adjustments.
    - If reasonable adjustments are requested, they are to be recorded on the patient's medical records and implemented accordingly.

9. Under the Accessible Information Standards (2016) GP practices are to be proactive in ensuring that people with learning disabilities are communicated with in a way that is accessible to them.

10. GP practices to also ensure that information is provided in a range of formats, including Easy Read.

<u>Communication</u>

11. Clinicians to communicate directly with the person with a learning disability about their health and care, and not their carer or support worker.

12. Clinicians to avoid sharing information, such as test results, with people with learning disabilities by telephone. This can cause unnecessary concern and anxiety.

13. Clinicians and reception staff to treat people with learning disabilities with kindness and respect. Reminders and refresher training on engaging with people with learning disabilities should also be considered.

14. Clinicians and reception staff to never question whether a patient has a learning disability, and must meet their needs accordingly.

15. GP practices to deliver Customer Care training for reception staff to improve their customer service and communication skills.

<u>Support with Living a Healthy Lifestyle</u>

16. Clinicians to provide practical information about healthy eating, weight management and exercise, including meal and exercise plans.
    - Any information is to be provided in Easy Read and/or a format which is accessible to the patient.
    - Any support is to be tailored to their individual needs.

17. Clinicians to have regular discussions about mental health, sexual health, drugs, alcohol intake and smoking, and to ensure any support provided is personalised to their needs.

18. Clinicians to talk to people with learning disabilities about cancer screenings, ensure any relevant tests are carried out, and provide information on how to check their body for any signs of cancer.

Annual Health Checks

19. Clinicians to allow between 30 minutes to one hour for an Annual Health Check.

20. Clinicians to provide a full examination of the individual's physical and mental health. This is not to be carried out by telephone appointment only.

21. GP practices to ensure that people with learning disabilities are offered an Annual Health Check and reminded as to when their Annual Health Check is due.

Cardiovascular Disease

Recommendations focus on the following themes: signs and symptoms, risk factors, monitoring and management, support, and health inequalities. Although the recommendations are predominantly focused on the ICB taking action, there are opportunities for individual services to also address the actions on a local or targeted basis.

Signs and Symptoms

1. Increase awareness of the signs and symptoms of heart disease and its high-risk conditions.

2. Encourage residents to consider their heart health in their everyday choices, with a particular focus on supporting men, those aged 18-44, people with less disposable income, and people from White Other ethnic backgrounds.

Risk Factors

	3. Highlight the importance of age, gender and ethnic background as key risk factors, particularly to those they impact. 4. Increase understanding of the risk factors associated with heart disease, particularly amongst men and people from White Other ethnic backgrounds. <u>Monitoring and Management</u> 5. Promote opportunities for people to monitor their heart health outside of their GP practice, particularly emphasising the role of pharmacists. 6. Ensure residents feel confident in using at-home monitoring equipment. 7. Ensure residents are aware of their "ABC" numbers (atrial fibrillation, blood pressure and cholesterol). <u>Support</u> 8. Ensure people with a diagnosis feel confident in self-managing their condition, with a particular focus on improving confidence amongst those aged over 65, people who identify as White Other, people from an Asian ethnic background, and those with less disposable income. 9. Ensure people with a diagnosis are routinely monitored and given sufficient information and support to self-manage their condition. 10. Consider increasing emphasis on, and support with lifestyle changes in addition to medication, for example exercise and dietary advice or referrals. 11. Strongly encourage residents to take up their NHS Health Checks as soon as they are eligible, and ensure practice staff are aware of this entitlement. <u>Health Inequalities</u> 12. Further investigate the inequalities in diagnosis and management amongst different demographic groups. 13. Consider targeted interventions and engagement with particular demographic groups, including men, people of an Asian ethnic background, people of White Other ethnic backgrounds, those with less disposable income and those aged 18-44.

Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	N/A			
Implications / Impact:				
Patient Safety:	N/A			
Risk: *Link to Risk Register*	N/A			
Financial Implications:	N/A			
Impact Assessments: *(Completed and attached)*	***Equality Impact Assessment:***		N/A	
	Quality Impact Assessment:		N/A	
	Data Protection Impact Assessment:		N/A	

"You don't need to ask them, ask me" – Understanding how Adults with Learning Disabilities are Supported by GP Services

Engagement: February – May 2023

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Authors: Asha McDonagh and Chloe Carson

healthwatch Hertfordshire

Contents

About Healthwatch Hertfordshire

Healthwatch Hertfordshire (HwH) represents the views of people in Hertfordshire for health and social cared services. We provide an independent consumer voice for evidencing patient and public experiences and gathering local intelligence with the purpose of influencing service improvement across the county. We work with those who commission, deliver and regulate health and social care services to ensure the people's voice is heard and to address gaps in service quality and/or provision.

About the Hertfordshire and West Essex Integrated Care System (ICS)

The Hertfordshire and West Essex Integrated Care System (ICS) was established as a statutory body on 1st July 2022. Integrated Care Systems are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, coordinate and commission health and care services[1]. The Hertfordshire and West Essex ICS is made up of two key bodies – an Integrated Care Board (ICB) and Integrated Care Partnership (ICP).

Integrated Care Board (ICB)

The Integrated Care Board (ICB) is an NHS organisation responsible for planning and overseeing how NHS money is spent across Hertfordshire and West Essex, with the aim of joining up health and care services, improving health and wellbeing, and reducing health inequalities. The board of the ICB includes representation from NHS trusts, primary care and from Hertfordshire County Council and Essex County Council[2].

This report will be sent to the Hertfordshire and West Essex ICB Primary Care Board to inform how it can improve the support people with learning disabilities receive from their GP practice.

Integrated Care Partnership (ICP)

The Integrated Care Partnership (ICP) is made up of representatives from different organisations involved in health and care. This includes NHS organisations, local authorities and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. The partnership is responsible for developing an Integrated Care Strategy which will set out the priorities for Hertfordshire and West Essex for the next 10-20 years[3].

Hearing Patient Views about Primary Care in Hertfordshire and West Essex

Hertfordshire and West Essex have been commissioned by the Hertfordshire and West Essex Integrated Care Board (ICB) Primary Care Workstream to undertake a series of engagement projects. The aims of the engagement projects include:

[1] Integrated care systems: how will they work under the Health and Care Act? | The King's Fund (kingsfund.org.uk)
[2] Health and wellbeing decisions – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)
[3] Health and wellbeing decisions – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)

- Gathering lived experiences to feed directly into the Hertfordshire and West Essex ICB Primary Care Workstream
- Supporting and enabling the Hertfordshire and West Essex ICS to achieve wider participant engagement
- Engaging patients and the public on programmes covering key priorities and areas of importance at a regional and local level
- Making recommendations to the Hertfordshire and West Essex ICB Primary Care Workstream so improvements can be implemented

Using patient and public feedback, each engagement project will focus on improving the relevant service(s) within different areas of primary care by making recommendations to the Hertfordshire and West Essex ICB Primary Care Board.

From February to May 2023 the Director of Primary Care Transformation at the ICB requested Healthwatch Hertfordshire and Healthwatch Essex to explore the experiences of adults with learning disabilities in accessing GP services, and how they are supported by GP services to live a healthy lifestyle.

Background

There are approximately 1.5 million people in the UK who have a learning disability[4] and an estimated 21,000 people with a learning disability living in Hertfordshire[5]. People with learning disabilities tend to experience much poorer physical health outcomes and are more susceptible to a range of health conditions compared to the general population[6]. For example, rates of cardiovascular disease, respiratory disease, cancer, obesity and Type 2 Diabetes are significantly higher amongst people with a learning disability than the wider population[7].

As a result, people with learning disabilities are far more likely to have a lower life expectancy. In 2022, the Learning Disability Review of Mortality (LeDeR) found that the median age of death for people with learning disabilities in Hertfordshire was 58 years old[8]. This is considerably lower than the median age for the general population at 81 years old[9].

However, it is very important to recognise that these differences in health are largely avoidable, meaning that deaths and ill health could be prevented through the provision of good quality healthcare[10]. In Hertfordshire, 59% of the causes of death of people with a learning disability would be defined as avoidable causes of death, compared to 22% for the general population[11].

These figures show how crucial it is that the health needs of people with learning disabilities are addressed by clinicians early, and that they are given the appropriate care, treatment and support. A significant factor for this inequality is difficulty using healthcare services and barriers to accessing healthcare.

Barriers to Accessing Healthcare

Accessing Appointments

[4] How Common Is Learning Disability In The UK? How Many People Have A Learning Disability? | Mencap
[5] SEND news - (hertfordshire.gov.uk)
[6] NICE impact people with a learning disability
[7] NICE impact people with a learning disability
[8] LeDaR Annual Report 2021-22 (hertfordshire.gov.uk)
[9] Life expectancy for local areas of the UK - Office for National Statistics (ons.gov.uk)
[10] learning-disabilities-jsna.pdf (hertshealthevidence.org)
[11] LeDaR Annual Report 2021-22 (hertfordshire.gov.uk)

People with learning disabilities can face significant challenges in accessing health and care services. Many can find it difficult to make an appointment with health and care services, as online services are often difficult for people with learning disabilities to use and access, and visiting in-person can also be inaccessible due to factors such as money, location and transport. Long waiting times on the phone and speaking to a receptionist can provoke unnecessary stress and anxiety[12]. All of which can make people with learning disabilities feel hesitant to contact healthcare services, despite needing medical attention.

People with learning disabilities also tend to rely on their carer or support worker to help them make an appointment and to be in attendance. Flexibility around appointment times and dates is very important to ensure that someone with a learning disability can be supported by their carer or support worker. When this is not accommodated for, this can mean having to wait several weeks for an appointment[13].

Choice in the type of appointment is imperative, with most people with learning disabilities preferring to discuss their concerns in-person. Face-to-face appointments are also important, as people with learning disabilities can have difficulties communicating their health needs and whether they are in pain[14], which can lead to challenges identifying health conditions and delays in diagnosis and treatment. By seeing a clinician in-person, the patient can have a physical examination to ensure any concerns are addressed.

Similarly, being able to see their usual clinician is essential to people with learning disabilities, as this familiarity and continuity of care can help them to feel more comfortable and as such, help them to communicate their needs and symptoms with greater ease[15].

Communication Barriers

People with learning disabilities can find it more often to communicate, and health information in particular can be hard for them to understand and engage with[16]. Research has shown that not meeting their communication needs can lead to incorrect diagnoses, inadequate care and inappropriate medication given[17]. Despite this, clinicians often lack training, understanding and awareness as to how to communicate with people with learning disabilities in a way that is accessible to them.

Fear and Physical Environment

People with learning disabilities can feel scared speaking with clinicians. Fears include judgement over their lifestyle choices, blood tests and vaccinations, use of medical instruments and concerns around screening procedures[18]. It is also common for people with learning disabilities to find clinical environments or waiting rooms uncomfortable and distressing[19]. All of which can make people with learning disabilities reluctant to access healthcare services, and emphasising the importance of ensuring settings are made accessible and safe for people with learning disabilities.

Barriers in Living a Healthy Lifestyle

[12] Meeting in the middle: improving communication in primary health care consultations with people with an intellectual disability: Journal of Intellectual & Developmental Disability: Vol 29, No 3 (tandfonline.com)
[13] (PDF) What should dental services for people with disabilities in Ireland be like? Agreed priorities from a focus group of people with learning disabilities (researchgate.net)
[14] Pain and pain assessment in people with intellectual disability: Issues and challenges in practice - Doody - 2017 - British Journal of Learning Disabilities - Wiley Online Library
[15] Barriers and facilitators to primary health care for people with intellectual disabilities and/or autism: an integrative review - PMC (nih.gov)
[16] (PDF) What should dental services for people with disabilities in Ireland be like? Agreed priorities from a focus group of people with learning disabilities (researchgate.net)
[17] Why some adults with intellectual disability consult their general practitioner more than others - Turk - 2010 - Journal of Intellectual Disability Research - Wiley Online Library
[18] Barriers to healthcare: Instrument development and comparison between autistic adults and adults with and without other disabilities (sagepub.com)

Addressing barriers in accessing healthcare is important, however it is also imperative that GP services play an active role in supporting people with learning disabilities to live a healthy lifestyle, particularly given that they are far more likely to face poorer physical and mental health outcomes, as outlined below.

Obesity and Inactivity

People with learning disabilities are at an increased risk of being overweight or obese compared to the general population[20], with data identifying that 37% of people with learning disabilities are obese compared to 30% of people without a learning disability[21]. This is often due to poorly balanced diets and lower levels of physical activity. This risk increases the likelihood of a range of health problems, including heart disease, high blood pressure, stroke, Type 2 Diabetes, types of cancers and mobility difficulties[22].

People with learning disabilities tend to have poorer health literacy[23], and can find it more difficult to understand information about healthy eating, exercise and weight management, and the benefits of being active and making healthy choices[24]. They can also find it more difficult to cook and prefer healthy meals, often resorting to eating ready-meals which can be high in fats and sugars[25]. Lastly, exercise facilities such as gyms and swimming pools can be inaccessible, including difficult to travel to, expensive and unwelcoming[26].

Mental Health

People with learning disabilities are at greater risk of experiencing poor mental health, with severe mental illness 8.4 times more common in people with a learning disability than those without[27].

Research has also found that 36% of people with a learning disability felt lonely nearly always or all the time. 37% said they hardly ever or never go out to socialise, and 33% said they did not feel part of their local community[28].

Health and Wellbeing

Research shows that some groups of people with learning disabilities are less likely to partake, but are at an increased risk of smoking, drinking alcohol in excess and using illicit and/or prescribed drugs[29]. Such behaviours can lead to physical and mental health complications.

Although people with learning disabilities are less likely to be in a relationship and pursue sexual relationships, this remains an important matter as they are less likely to understand information about sexual health, including contraception, sexually transmitted infections and pregnancy[30].

Cancer Screenings

[20] Obesity and weight management for people with learning disabilities: guidance - GOV.UK (www.gov.uk)
[21] Improving the diets of people with a learning disability (learningdisabilitytoday.co.uk)
[22] The Medical Risks of Obesity - PMC (nih.gov)
[23] Improving the diets of people with a learning disability (learningdisabilitytoday.co.uk)
[24] Don't Mention the Diet! A health promotion initiative to support healthy diet and lifestyle decision-making by people with intellectual disability - Martin - 2021 - British Journal of Learning Disabilities - Wiley Online Library
[25] Adjusting a mainstream weight management intervention for people with intellectual disabilities: a user centred approach - PMC (nih.gov)
[26] Supporting people with learning disabilities to have a healthy diet and be active (publishing.service.gov.uk)
[27] Learning Disability - Health Inequalities Research | Mencap
[28] New report: "Lockdown on Loneliness" (learningdisabilitytoday.co.uk)
[29] Smoking and People with an Intellectual Disability | Intellectual Disability and Health
[30] Sexual health and people with learning difficulties factsheet.pdf (hscni.net)

Cancer is a leading underlying cause of death among people with learning disabilities and they are significantly less likely to receive NHS screening tests for cervical, breast and bowel cancer than those without a learning disability[31]. This is particularly concerning amongst women with learning disabilities, who are 45% less likely to be screened for cancer[32].

People with learning disabilities are less likely to express pain and/or report changes in their physical appearance, which can lead to delays in diagnosis and symptom presentation[33]. Other common barriers include invitations to cancer screenings not being in Easy Read, difficulties using appointment systems and accessing primary care services, and anxiety around attending screening tests.

Role of GP Services

The above has outlined the significant health inequalities people with learning disabilities can face, and emphasises the importance of GP services addressing and accommodating their needs.

Accessible Information

Under the Accessible Information Standard (2016) all NHS services are legally required to meet the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss[34]. This includes:

- Being able to contact, and be contacted by, services in accessible ways
- Receiving information and correspondence in formats they can read and understanding, including audio, braille, Easy Read or large print
- Being supported by a communication professional at appointments if this is needed
- Getting support from health and care staff to communicate, for example to lip-read or use a hearing aid

For people with learning disabilities, this often involves providing information in Easy Read. Easy Read information can give people with learning disabilities, choice, control and independence[35] and can help them to better understand health information. Despite this, research has shown that GP services are not always proactive in providing this information and/or in asking people with learning disabilities how they would like to be communicated with, creating another barrier in accessing health and care services.

Speaking slowly and clearly is also important for people with learning disabilities, however research has shown that both clinicians and receptionists can speak too quickly and use terminology which is difficult for people with learning disabilities to understand, again impacting their ability to access healthcare.

Reasonable Adjustments

The Equality Act (2010) states that the NHS must make reasonable adjustments to ensure that services are accessible to disabled people as well as everyone else[36]. According to Mencap's Treat Me Well campaign, common reasonable adjustments people with learning disabilities could ask for include[37]:

- Speaking clearly and using simple words

[31] Health_inequalities_cancer (1).pdf
[32] NHS England — South West » Study shows only 1 in 4 women with learning disabilities attend cervical screening in the South West
[33] Health_inequalities_cancer (1).pdf
[34] NHS England » Accessible Information Standard
[35] Why-Easy-Read-is-Important.pdf (peoplefirstltd.com)
[36] Reasonable adjustments: a legal duty - GOV.UK (www.gov.uk)
[37] https://www.mencap.org.uk/sites/default/files/2018-06/Treat%20me%20well%20top%2010%20reasonable%20adjustments.pdf

- Providing longer, or "double" appointments
- Working with family members, support workers and carers whilst still directly involving and speaking to the person with a learning disability
- Flexibility with appointment times
- Ensuring there are no physical barriers for people using wheelchairs or with mobility issues
- Providing quieter places to wait
- Providing written information in Easy Read format
- Asking people with learning disabilities what they need rather than making assumptions

Although the following, and more, should be put in place, Mencap state that NHS services are not doing enough to ensure reasonable adjustments are implemented for people with learning disabilities, to enable them to access the healthcare they need.

Staff Training

Reasonable adjustments also means providing policies, procedures and staff training to ensure that services work equally well for people with learning disabilities[38]. This has been further emphasised under the Health and Care Act (2022) which made it a legal requirement to provide staff training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability[39].

However, Mencap have found that one in four healthcare professionals have never been given training about learning disability, and that 50% of a lack of knowledge around learning disability might be contributing to the problem of avoidable deaths[40]. Mencap argues that it is imperative that healthcare professionals receive more training on how to support and communicate with people with learning disabilities, and felt this would help people with learning disabilities receive better quality healthcare.

Annual Health Checks

People with learning disabilities over the age of 14 should be offered an Annual Health Check by their GP practice. Annual Health Checks aim to improve the health of people with learning disabilities by identifying unrecognised medical conditions and implementing preventative measures such as screenings, vaccinations and blood tests to safeguard the health of people with learning disabilities[41].

A good quality Annual Health Check should take between 30 minutes and one hour, and include a thorough examination of an individual's physical and mental health, as well as their lifestyle and general wellbeing. Annual Health Checks should also include the creation of a Health Action Plan, a personalised plan developed by the person with a learning disability and their practitioner, outlining how they are to stay healthy[42].

However, from our own research, and national literature, there are many people with learning disabilities who are not offered an Annual Health Check, and there are many who are only receiving a basic examination of their health and wellbeing.

[38] Reasonable adjustments: a legal duty - GOV.UK (www.gov.uk)
[39] Training staff to support autistic people and people with a learning disability - Care Quality Commission (cqc.org.uk)
[40] 2017.005.01 Campaign report digital.pdf (mencap.org.uk)
[41] Annual health checks and people with learning disabilities - GOV.UK (www.gov.uk)
[42] NICE impact people with a learning disability | Reviewing the impact of our guidance | Measuring the use of NICE guidance | Into practice | What we do | About | NICE

Aims

The aims of this research include:

- To understand the barriers adults with a learning disability may face when accessing their GP practice.
- To explore whether GP services are providing reasonable adjustments to adults with a learning disability, and communicating in a way that is accessible to them.
- To explore whether adults with a learning disability feel supported and listened to by their GP practice.
- To investigate whether adults with a learning disability are supported by their GP practice to live a healthy lifestyle.
- To identify what additional support adults with a learning disability would like to receive from their GP practice to help them to live a healthy lifestyle.

Methodology

To achieve the aims of this engagement, we held in-depth one-to-one interviews and focus groups with adults with learning disabilities, as well as carers supporting an adult with a learning disability. We adopted a qualitative approach to enable us to understand the lived experience, views and perspectives of adults with a learning disability.

To promote the engagement and to ensure it was as accessible as possible, we created a number of Easy Read materials, including a flyer and promotional video which explained the purpose of the project and why it is important, how to get involved and how the information they share will be used and protected.

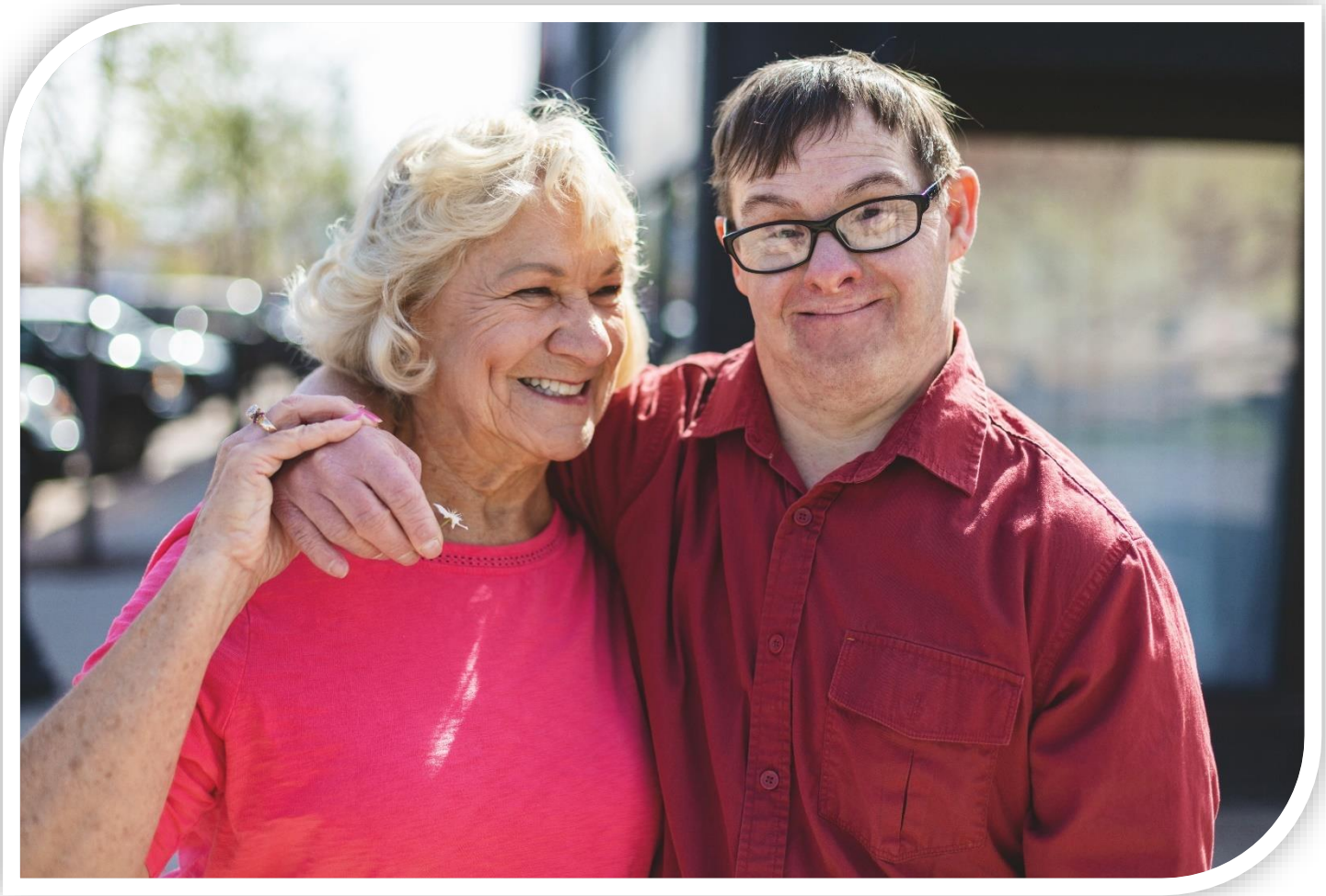
Participants could also choose the time and date of the engagement and whether it took place in-person, by telephone or on a video platform of their choice. Participants also had the option of bringing their support worker to help them share their experiences. This gave support workers an opportunity to share their views as well.

The engagement itself was made accessible through ensuring the questions used Easy Read language, and through using materials such as PowerPoint slides and interactive exercises to ensure that all participants could express their thoughts and feelings in a way that accommodated their communication needs and preferences.

The engagement period ran from 1st March to 2nd May 2023 and was shared with the NHS, Hertfordshire County Council, organisations supporting adults with learning disabilities and organisations supporting carers who look after an adult with a learning disability.

In total we heard from 15 people, which included two carers, four support workers, and nine adults with a learning disability.

Throughout this project we worked with Herts People First who provided excellent expertise and guidance on how to carry out the engagement, the creation of accessible promotional materials, and supported with the recruitment of participants.



Key Findings

Our findings demonstrate examples of best practice within some GP practices, however, concerningly, they also highlight the difficulties people with learning disabilities have faced in accessing their GP practice, and a lack of support around how to live a healthy lifestyle. Key issues include:

- Barriers in accessing their GP practice for an appointment, and the value of GP practices having a Care Coordinator to specifically support people with learning disabilities
- Lack of choice in regards to appointment type, time and date and choice of clinician
- Lack of understanding and awareness of accessibility and communication needs
- Lack of personalised, tailored information on living a healthy lifestyle
- Mixed experiences regarding Annual Health Checks, with concerns raised about the quality

**Please note that pseudonyms have been used throughout this report to protect the identify of our participants.*

Accessing GP Services

Making an Appointment

All of the participants primarily contact their GP practice by telephone, with all participants often having to wait a long time on the telephone before being able to speak to a receptionist. Occasionally, participants have visited their GP practice in-person with their carer to try and get the support they need.

> ***"If I have to make an appointment, I use the telephone and you usually join the queue but you get through eventually. It takes a long time and I try to ring as early as I can in the morning, but it doesn't make any difference."***

> ***"It takes at least half an hour on the phone and sometimes up to an hour. We went one time to get an appointment quicker."***

> ***"It can be quite a long time waiting on the phone or waiting for an appointment."***

It is important to note that all but one of the participants with a learning disability contacts their GP practice with the assistance of their carer or support worker. As such, participants are reliant on their carer or support worker to be with them when contacting their GP practice.

However, GP practice opening hours are often outside of their carer's or support worker's working hours. This is a significant barrier for people with learning disabilities and can exclude from being able to access GP services and from getting the care and support they need.

> ***"Usually I'm not here at 8:00am in the morning to make appointments for him. More flexibility would be great because he likes to have support in making his appointments."***

> ***"I'm only here 10:00am – 2:00pm and they say you have to ring at 8:00am in the morning or 2:00pm in the afternoon which doesn't work for us because I can't speak for her, so we struggle to get appointments."***

> ***"It's not easy a lot of the time because of the hours my support worker works. You know it's harder to get through because they say you can only call within these certain times."***

Difficulties in getting through to their GP practice and in accessing an appointment has made some participants reluctant to contact their GP practice, despite feeling that they need medical attention.

"Sometimes we access the GP and sometimes we can't because it is so difficult sometimes. I put it off which I shouldn't be doing."

"I have actively put that off because access and having a conversation with somebody that might not be taken in the right vein that's my judgment I don't know I think that is telling you a lot about how things have changed and how inaccessible it is now."

Support workers and carers also felt that receptionists can be reluctant to offer appointments, meaning they need to be assertive to ensure the person they support is seen by a clinician.

"You can get through to the GP surgery and convince them to see people. But they're still quite abrupt and reluctant to see people."

This was emphasised by a couple of participants, who shared that they have to be assertive with receptionists in order to get their needs met.

"It makes it more difficult and it makes you feel that you hope you don't have to speak to them that you get your regular receptionist. Yeah if it's someone that doesn't know me I get a bit worried."

"If you have a particular concern whatever that concern is if you can't get past the receptionist, it doesn't make a difference. It doesn't matter how urgent your concern is if they don't pick up the phone, they can't help you and I suppose there's no special number if you have a disability or need extra support when you go online there's no help pages if you needed to sign up there's no page to help you."

eConsult

As mentioned, all of the participants with a learning disability tend to contact their GP practice by telephone. None have used, or tried to use, eConsult to make an appointment or as a way of accessing their GP practice.

Carers and support workers in particular said that GP services are becoming too reliant on technology and as a result, are excluding people with learning disabilities.

"They encourage you to use online eConsult. How someone with special needs is meant to be able to use eConsult is beyond a joke. My son would not even be able to access it. This is a completely inaccessible system for people with learning disabilities."

"I'm concerned it's not just the NHS it's everywhere going online and I don't have a problem with it but some people don't know how to use it."

Care Coordinators: Example of Best Practice

Ben, Becky and Amy* are all registered with a Purple Star accredited GP practice. At their GP practices, they have a Care Coordinator who they can contact if they need support in accessing GP services.

"We met a Care Coordinator who we can text or call if we need an appointment."

The Care Coordinator will support them in making appointments, and will also work with them to ensure the appointment is at an appropriate time and with the clinician of their choice. Amy's Care Coordinator will also meet her outside of the GP practice and will accompany her to any appointments she has, including dental appointments.

"If I say to them I want my doctor then I see that doctor. They don't just give me Tom, Dick or Harry."

"She comes with me to appointments and she'll meet me outside so I don't have to sit in a busy waiting room and get nervous with everybody watching me and how to sign-in."

Ben, Becky and Amy used to find it very difficult to access their GP practice, so having a Care Coordinator has been invaluable.

"I am so happy that the Care Coordinator can text me or ring me. Or I can ring them. Now I don't have to ring the GP surgery I just communicate with that person if I need to."

Support workers also praised this initiative and felt that this support for people with learning disabilities should be offered at every GP practice.

"It's brilliant. We found out about the Care Coordinators recently in Stevenage and our recommendation is to get a Care Coordinator working just with people with learning disabilities at every GP practice."

However, is important to note that Becky and Ben only found out about the Care Coordinator at their GP practice by attending their GP practice's Patient Participation Group. Ben and Becky are concerned that other people with learning disabilities will be unaware that this support exists.

"It was purely because we are members of the Patient Participation Group. Otherwise we wouldn't have known about this person's existence. And so I'm very worried that people with learning disabilities in Hertfordshire will not know about it, it's like winning the lottery whether you know or don't know."

They are also concerned that Care Coordinators only work within the GP practice's opening hours, meaning that they still have to rely on out-of-hours support, which they have had difficulty accessing in the past.

"I think if the Care Coordinator is operating in what I would call normal working hours then essentially we've got access to support. But out of normal working hours we are on our own."

Choice

Appointment Preference

All participants prefer to have a face-to-face appointment with a clinician rather than by telephone or video call. Having an appointment face-to-face was important to people with learning disabilities, with many emphasising that this makes them feel more comfortable and an easier way of communicating their health needs and concerns.

> ***"I'd rather be seen face-to-face with a doctor, rather than him ringing me up saying you've got this, you've got that."***

> ***"I like face-to-face with a chat with the doctor in the surgery itself."***

> ***"I would like to see a doctor in-person. I find this is better for me because they can understand me better."***

Positively, most participants said that they can often see a clinician face-to-face if needed and/or requested. Some carers and support workers also acknowledged that the GP practice is accommodating in providing home visits to meet the person they care for's needs and preferences.

> ***"(Amy) has said very clearly it has to be face to face and they have always done that."***

> ***"He can't actually attend GP appointments at the surgery, his challenging behaviour is so much that is a real problem, and the GP overtime has understood this so will visit him in his own home. So that's really positive. They do accommodate him."***

However, a couple of participants have faced difficulties in accessing face-to-face appointments, with receptionists not acknowledging their choice and why this type of appointment is important for them.

> ***"It's not always easy to get a face-to-face appointment. I had a very bad cough and cold and asked if I could see someone. I had it for two days and didn't hear so I rang again on the Monday and had to speak to someone over the phone."***

> ***"Before COVID I used to go in. At the moment they ring me up now on the telephone. I can't remember when I last went in. I'd rather go in."***

Participants also emphasised that they would or have struggled to have an appointment with a clinician by telephone or video call. Reasons included difficulties using and accessing online technology and difficulties hearing and communicating.

"They need to hold the phone close. I had an Annual Health Check and the woman was holding the phone away from her and from that moment I refused telephone calls because of people holding the phone too far away and I can't hear them."

"I like seeing the doctor in person. I didn't like being on Zoom speaking to them. They would talk too fast or sometimes it would freeze."

"A lot of people use Teams a lot which I don't know how to use. It's not an option, I'm not an IT person. I don't know enough, I can't set my computer up."

In addition, some participants shared that having an appointment by telephone or video call can make them feel very anxious. It also means a clinician cannot physically examine them, which can also increase their anxiety.

"Normally I get quite anxious when it's by phone."

"Sometimes I want reassurance so it is better to see someone. I did find it hard during COVID when you just saw someone on Zoom. If you can't physically see the problem, how s a computer screen going to help if you can't touch the area that's painful."

Receiving test results and information by telephone or video call can also be difficult for people with learning disabilities, causing unnecessary concern and anxiety. One participant, Harry*, received a telephone call from a clinician to talk to him about his test results. Harry does not like speaking to clinicians over the telephone as this can make hm feel very anxious and distressed. Feeling overwhelmed, Harry had a panic attack and had to call the ambulance for help.

"About five months ago, Harry took a call from one of the doctors about his results and it got Harry worrying so much it led to Harry calling an ambulance to take him to hospital because Harry suffers from anxiety and he had a panic attack so I think it was poorly handled in that respect. I think they need to be more mindful when they're talking to people like Harry or someone with a disability. Sometimes it can be too much what they're saying and the information is quite confusing."

Carers and support workers also shared that the person they care for would need, or prefer, to be supported during their appointment, which is much easier to accommodate for when the appointment is face-to-face. They also stressed the importance of clinicians seeing people with learning disabilities face-to-face so they can be physically examined. They felt this is particularly important given that people with learning disabilities can find it difficult to communicate their needs, pain and symptoms.

"If it's only a phone call you can't see whether they have lost weight, you can't see if they're anxious, it has to be face-to-face. How can you diagnose a person with a learning disability or get to the bottom of what is wrong? My son can't articulate very well what his issues are."

Choice of Time and Date

When booking an appointment, most participants are given a time and date and are not able to choose this for themselves, which some participants can find difficult to fit around their own routine, schedule and activities. This lack of flexibility and choice also means that some participants have to wait several weeks before seeing a clinician.

> ***"He would find it very difficult on the phone. We have done video, but I've been there. I'm his main carer, how is he going to access this when I'm not here because he couldn't access that video call."***

> ***"They usually tell us a time and a date and sometimes we have to work around that or ask for a particular day and then sometimes that can be weeks away which isn't ideal."***

> ***"They give you a time and date and sometimes I'm busy, I'm working. I only work twice a week but I've got to work all of that out."***

Most participants prefer to have their carer or support worker accompany them at their appointments. As such, being able to choose a date and time when their carer or support worker will be available to attend with them was very important.

However, some GP practices do not always accommodate this. For example, Paul* and Mia* said that despite telling their GP practice that they can only attend appointments on the days their support worker is with them, their GP practices continually book appointments on dates and times that they cannot attend.

> ***"If we say to them I've got no one to support me, they should say that's fine we'll find another time, they make sure people have got their support. They say we can do this time or that time but no one is there to support me at that time."***

> ***"I tell them that I've got no one with me to help me, can we do another day? So they say can you do a day like tomorrow. I say we can only do it at this time. I don't think people understand that I need support."***

Support workers and carers find this equally frustrating and emphasised that this barrier can prevent people with learning disabilities from receiving medical attention in a timely manner.

> ***"I support (Harry) on Thursdays so he saves any letter he gets through the week. If he gets any then I try and get appointments for him when I'm with him on a Thursday. That's the only day he gets support so it would be problematic to rearrange appointments. I can't always be flexible because I have other clients as well so it can be problematic."***

"It's quite rare for him to get an appointment. It's quite difficult to get one on a day I'm here."

However, some participants said that their GP practice will try to be flexible where possible and will work with them to find a date and time that is suitable.

"Sometimes they tell me when the appointment is. I can tell them I can't make it and they will change it."

When having a telephone appointment, participants shared that they are given a large time window rather than a specific time slot. Participants said that they can find this very difficult as their support worker or carer might not be with them to help and/or they might be busy when the clinician calls.

"Sometimes they give a general time when they phone like a time between 12:00pm and 2:00pm so we want to do something and not wait about. So they have phoned us when we're out and about and you can't guarantee good reception or privacy. So any feedback would be to give more precise times when they contact you. Rather than a two hour slot, maybe a 20 minute slow so you can be somewhere quiet and take the call."

"It's when they do it and I have no one here I say to them can you ring 10-12 on a Tuesday or 9:30-11:30 on a Thursday when that time comes you have gone, and they ring. They sometimes ring later when there's no one there to help."

Choice in Clinician

Most participants prefer to see the same GP or nurse. This continuity is important to people with learning disabilities and helps them to build communication, trust and a rapport. It also means that they do not have to keep repeating their medical history, which they can find frustrating.

""You have to see whose there and not your regular GP which makes it difficult. Because I'm epileptic and I have a physical disability which is invisible I like to see my GP. She knows everything about me but nobody else does and that's the problem."

"I would like it if my regular GP could see me at least two or three times a year. I don't use my surgery that much to be honest. I would have seen them about the pain down below my waist. I didn't ring them because I only want to see my GP who I know."

"You're having to go through all your history to fill them in and it takes up time. And then when you see another person you have to go through the same thing all over again. If I see my GP then this doesn't happen."

However, most participants will often have to wait several weeks if they want to see the clinician of their choice.

> ***"They ask if you want to see a particular doctor, but you could be waiting for around three weeks. I could see the others face-to-face that were available, but I prefer to have my doctor."***

> ***"We have a really good GP. But it takes about two or three weeks until we can actually see our GP."***

Seeing the same clinician is important to carers and support workers too, who also appreciate the familiarity and assurance that the clinician has a good understanding of the person they care for's health needs.

> ***"If we get to see the doctor who has known him all his life then he is so well looked after, they have known him since a baby and we are very happy there are still GPs who know him, but it's an if."***

Communication

Attitudes of Clinicians

The majority of clinicians shared how "nice", "thoughtful" and "kind" clinicians are. Participants particularly appreciate are clinicians are patient and take the time to listen.

> ***"They listen to you."***

> ***"The doctor has been good at listening to our advice on how to support him but also treating him like a human being in his own right."***

> ***"They are fantastic, they are really switched on, they are really good at listening. We have to tell them things like use simple words, no chatter, don't make any noise, things like that, and they are brilliant with all that and listen to us."***

However, a few participants recounted experiences in which clinicians had a lack of understanding and awareness of their needs and in some cases, treated them poorly.

> ***"The person with a learning disability knows that they're not going to be listened to, they're not going to be taken seriously whatever problem they've got, they know what problem is not going get solved. We have to find our own coping strategies because we are fed up, angry and all the bad language you can put together of not being believed by healthcare professionals and this starts in GP surgeries."***

One participant, Claire* said that clinicians will often speak to her support worker about her health, even though she is in the room, which she described as "horrible" and "unkind."

> ***"It's not kind and it's not appropriate to talk to someone about you when you're right in front of the doctor. I think hello? Hello I'm here. You don't need to ask them, ask me. It makes me feel horrible and it's unkind."***

Other participants shared similar experiences, emphasising that clinicians will often speak to their carer or support worker, rather than the person with a learning disability, which makes them feel ignored and disempowered. If someone with a learning disability is non-verbal, support workers noted that they will often not be spoken to at all.

"People who are non-verbal are bypassed completely."

"Sometimes they don't speak to the person. If there is staff there they'll start talking to the staff."

"The system will often talk to parents first. They are very good at listening to parents. I'm not saying the views of parents aren't important, what I am saying, when you go to the GP surgery or you access the GP, the system is not good at listening to the voices and health needs of people with learning disabilities independently of their parents or whoever happens to be in the supporting role."

Communicating with Receptionists

Participants shared that they often have trouble communicating with receptionists and in some cases, were treated very poorly. For example, one participant, Becky* is told by receptionists at her GP practice that they cannot understand her and to "hurry up" when she is speaking, which Becky findings distressing and disrespectful.

"If I ring up they can't hear you and there are too many people in the background and they say I can't understand you, they say I don't understand you. They were saying hurry up. I feel like saying to them sorry I've got a disability and didn't choose to have a disability, I was born with a disability, how can I wipe it away."

On a separate occasion, Becky visited her GP practice in-person to speak to a receptionist and the receptionist called for her to be removed which Becky found offensive and inappropriate.

"I was at the GP surgery and they opened the door as I was talking and shouted "can someone come and get her!" and they were calling someone to get me out of the reception."

Participants Ben*, Daniel* and Fran* have had receptionists question whether they have a learning disability on several occasions, which they all find insensitive and rude, and often prevents them from getting the care and support they need.

"Sometimes, maybe because of the way I come across, I've been asked, do you have a learning disability?"

"I have to explain to them I have a learning disability. I had to keep saying I have a learning disability and I'm on the learning disability register."

"I'm quite high functioning so they don't see me as disabled."

In contrast, a couple of participants have had a positive experience when speaking with receptionists. For these participants, there is a receptionist at their GP practice who knows them well and knows how to communicate with them.

> ***"There's one who knows me on reception and is good. The others don't know me as well so it depends who I get."***

Accessible Information and Reasonable Adjustments

Reasonable Adjustments

Under the Equality Act (2010) the NHS must ensure that services are accessible to disabled people, including people with learning disabilities. This is called making reasonable adjustments[43].

However, some participants face physical and practical barriers when accessing their GP practice, with a number emphasising that they find waiting rooms uncomfortable, the sign-in process difficult to use, and the GP practice too busy, all of which intensifies feelings of anxiety and distress.

> ***"You go to the appointment and you sit and you wait and you've got the time but it takes a long time and I'm sat in the waiting room for a long time which I can find hard."***

> ***"I don't like going to the doctors when it's busy that makes me very anxious."***

One participant, Claire* has Cerebral Palsy and uses an electric wheelchair. Claire finds it difficult to visit her GP practice because it is not physically accessible for her. Fortunately, Claire's GP practice is often very accommodating in providing home visits when she needs medical attention.

> ***"I would love to go and be independent but it is a bit hard for me because going to the GP surgery you've got to think of the roads. For me that's quite difficult because I've got to think about my wheelchair about getting up the roads. I have been to the GP surgery but I would prefer to avoid it and have someone come out to me. It's hard for me to get to the surgery because of my electric wheelchair and the GP surgery does not have enough room for my electric wheelchair so it is hard to be there."***

Carers expressed that they have to constantly "fight" to get their child's basic needs met and to ensure that the reasonable adjustments their child needs are implemented.

> ***"I have to repeat this information every time and negotiate that every time. Even though it's on his file that message doesn't get through."***

> ***"You are continually fighting for different things for them. You have to fight for things and sometimes you're not listened to."***

[43] https://www.gov.uk/government/collections/reasonable-adjustments-for-people-with-a-learning-disability

For example, one carer, Nicole* cares for their adult child with a severe learning disability. Her child can only receive home visits which must be at a specific time to enable her child to be sedated beforehand. Despite this information being on her child's medical records, Nicole has to repeatedly remind the GP practice of this information and why it is so important.

> ***"I would say 80-90% of the time I have to explain the situation from scratch, and it doesn't particularly give us any support of fast track or any preferential access. I think the reasonable adjustments we have now, I think that's taken about 5 or 8 years to get right, it's just been a real fight. I don't think it's an admin error I think it's a cultural error, unless you ask, you're not going to be offered."***

Accessible Information

Under the Accessible Information Standard (2016) the NHS must ensure that it supports and addresses the communication needs and preferences of people with disabilities, impairment and/or sensory loss[44].

Providing information in an Easy Read format can help people with learning disabilities understand information more easily. However, this engagement found that some participants have never received information in Easy Read and in some cases, have been asked what Easy Read information is.

> ***"When we ask for accessible information, the standard response we get is I don't know where it is and where to go on the system. They say there isn't any."***

> ***"Often, we are told "what is Easy Read?" the only accessible information that we've received is from Herts People First."***

> ***"I've never had an Easy Read anything in my life."***

One participant, Daniel* has a mild learning disability. Daniel feels that because of this, he is never given information in Easy Read or an alternative format. Despite emphasising that he needs information in a different format, Daniel has never received this. As a result, Daniel can find it very difficult to get the support he needs.

> ***"I can't believe that I'm the only person in the world who has said "can I have it in a different format?" if you have a disability, you have the right to choose it in a different format that disabled people can actually read. It's just one size fits all. If you can't read the stuff, you just have to deal with that."***

It is also important that clinicians communicate with people with learning disabilities in a way that is accessible to them. However, some participants said that clinicians speak too fast and use words that

[44] https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/

they find difficult to understand. Participants tended to have a more positive experience when speaking to a clinician they know well.

> ***"I speak slowly and quietly and sometimes they don't wait for me to answer and sometimes they talk too quickly which is hard."***

> ***"Sometimes they speak too fast."***

> ***"They try to speak slowly but it depends on who. I know there are three or four GPs that are very good, then I would say that there are others who don't have a clue."***

Support in Living a Healthy Lifestyle

Healthy Eating and Weight Management

Positively, most participants with a learning disability said that a clinician has spoken to them about healthy eating, weight management and the associated health risks of being overweight and not eating a balanced diet.

> ***"The reason why we choose to see our GP is because the way in which Becky communicates, the GP gets it. The other doctors, one comes across impatient and the other one, although professional and kind, I think they feel a little out of in-depth."***

> ***"She sat down and told us what to eat and not what to eat. What to cut out and what exercises to do."***

> ***"We do get advice or guidance about healthy diet, high fibre diet, exercise."***

> ***"They told me if you're overweight you can get all sorts of illnesses like diabetes and stuff and that you are best to keep yourself healthy in the long run, and if you're not overweight you can do more things like sports and stuff."***

However, almost all of the participants would like more information about how they can eat healthy. Some participants specified that they would like Easy Read information which they can take home, as they find it difficult to remember the information and advice given during the appointment, particularly if they attended without their carer or support worker.

> ***"There could be more information and leaflets. There should be more Easy Read information for them about staying healthy. There's not been a lot of that."***

> ***"I would like more information about staying healthy and about food."***

> ***"I'd like more information, like your fruits and vegetables and everything like that."***

> ***"There is a problem in regard to remembering the advice you've been given because you haven't got the support to remind you."***

Some participants shared that although they have received information about healthy eating, they would like more guidance and support on how to put this information into practice, for example through the provision of meal plans and simple recipes.

> ***"A person can give healthy food information or a sheet where it says do this but what we don't actually have the support to implement that."***

> ***"I would like information on how to cook nutritious things. I want to know how to cook them like pasta or toad in the hole, how you actually do it. They could say here's what we think you could have and get you to try these recipes."***

In addition, a few participants feel confident in their knowledge about healthy eating, but would like more information on nutrition and how to maintain their weight.

> ***"We have the Slimming World microwave meals but I read that they are not good for nutrition so we need information about the types of foods to cook."***

> ***"The information I would like is about nutrition, that's a big thing for me because I have lost a lot of weight. I was 24 stone and now I'm 11 stone. I want information on nutrition because I've lost this weight but I want information on how I keep my weight down because that's what I'm finding difficult. I've got off my takeaway meals that was the hardest part, now I've got off that I'm struggling with other things because I've done everything I can."***

Other participants would like to have more regular conversations about healthy eating with a clinician and for this advice to be given face-to-face, rather than through leaflets or online resources.

> ***"I suppose he knows where to find the information if he wants to but it would be nice to hear it from a healthcare professional instead of reading it on a website."***

> ***"I think that speaking to someone about nutrition would be better for me."***

A few participants have been referred to weight loss programmes such as Slimming World and Weight Watchers. However, not all participants found this helpful as the programmes are not tailored to people with learning disabilities. As such, they are often not accessible, and the information given can be difficult for them to understand.

> ***"It's not personalised. None of it is personalised."***

One participant, Becky* asked if the Purple Star Strategy could educate Weight Watchers on how to support people with learning disabilities but she was told this could not happen.

"When Becky was overweight the standard referral was to Weight Watchers. Because of the experiences Becky had in regards to the programme, Becky recommended that the Purple Star Strategy could talk to Weight Watchers about health for people with learning disabilities. But Becky was told that couldn't happen because Weight Watchers is a private company. If GPs want to refer people and help people lose weight, eat well, then these private companies aren't right. They need learning disability awareness."

Support workers also mentioned that when a referral is made to a weight loss programme, there is no follow-up from a clinician to see whether they are attending and/or how they are getting on.

"There's no follow-up. They'll give a referral to Weight Watchers or Slimming World, whatever it happens to be, whether you turn up or not it doesn't matter so it's not that great."

It is also important to note that support workers and carers play a significant role in helping people with learning disabilities to stay healthy. It is often the support worker or carer who provides the information and explains how in practice they can eat a balanced diet. Without this support, participants would perhaps need more support from clinicians.

"My key worker has been helping me to lose weight."

"The support worker does meal prep and sorts the portion sizes and makes sure it is healthy."

"We try to eat healthy everyday. They have shopping lists and we try to work out a menu plan and we change up the meals. We've got noticeboards about healthy stuff and a folder all about healthy cooking."

Exercise

Most participants have received information from a clinician about the importance of exercise and keeping active.

"Got to do 35 minutes a day of fitness and they said to me you've got to walk or do something active once a day to keep yourself fit and stuff."

"They gave me information stuff about walking and stuff, which I didn't mind because walking is quite easy for me."

However, some participants said they would like further information about how to stay active and practical information and advice about the types of exercises they should be doing.

"I did try to do exercise but it's a tricky one for me. I would like a doctor or nurse to tell me what more can do."

"Before COVID I used to walk up and down in our bungalow. Now if you ask me now can you go again, walking in your bungalow, that confidence from before COVID has gone. I would need someone to help me [rebuild] that."

"How to keep fit. What exercises I could be doing and when."

One participant, Becky* was referred to a clinician to a local gym to help her with her mobility and to lose weight. However, the gym was not tailored to people with learning disabilities and had no awareness or understanding of how to support people with learning disabilities. This was inappropriate for Becky and meant she had some challenging experiences when attending.

"There was a link to the gym for Becky to go to but that's also tied in with people who have heart conditions, it's for everybody, not just people with learning disabilities. Because it's not specific, that meant that Becky actually had some unexpected and difficult experiences and had to come into contact with people who aren't learning disability friendly."

Again, it is important to highlight that carers and support workers play a key part in supporting participants to stay active and exercise. Those without this support might face more difficulty and need greater support from clinicians.

"My key workers help me a lot with keeping my weight down and doing exercises."

Mental Health

It is important that clinicians talk to people with learning disabilities about their mental health as well as their physical health. Some participants have had a clinician discuss their mental health and wellbeing, while others have not. However, most participants had only been asked about their mental health during their Annual Health Check, rather than during routine appointments and check-ups.

"Yes they did…there were pictures and stuff like ticks and smiley faces and stuff."

"It was part of their Annual Health Check to talk about feelings. The doctors and nurses don't ask in general appointments though."

"They have a few times but not lately."

Most participants were unsure whether they would like mental health support from a clinician, with many stated that they feel supported by their regular clubs, activities and groups.

"I go to my Soul class so I'm seeing and speaking to people. Might be helpful for others though."

"I'm not sure, I'm quite happy. Maybe they should ask me though."

One carer, Cath*, said a clinician has not talked about mental health with her son, but felt it would be valuable for her son to be told that his emotions are valid and not to blame himself for other people's emotions.

"I think it's about him understanding what sometimes not being happy is ok and sometimes not saying the right thing is ok."

One participant, Ben*, was referred by a clinician to take part in an online course to support with his mental health. The online course was not personalised for people with learning disabilities and was not accessible to Ben. Ben felt he was referred to this course because he has a mild learning disability and that the clinician made the assumption that he would be able to understand, which he felt was inappropriate.

"I was referred to a system which was this course online which didn't work. In my case, the way in which I was assessed with face-to-face but someone made the decision to put me on a course which was online. The actual information I couldn't take it and use it and I couldn't read it."

Another participant, Becky* spoke to a clinician about her anxiety. Becky received some information to support her, but it was not given in Easy Read, so she could not understand it.

"Becky has an anxiety disorder and the information Becky received gave a bit of information but wasn't in Easy Read."

Positively, one respondent, Fran* told a clinician that she was feeling lonely. The clinician referred Fran to a social prescriber who has been working with Fran to find some groups, clubs and activities.

> ***"Hopefully she will find something for me. I would like someone to come to me. The time I need it most is around Christmas because on Christmas Day I get very lonely and depressed, I have ended up crying and saying nobody loves me. That has happened once or twice. Especially Christmas Day. I can manage my depression very well otherwise through the year. At Christmas time everything is closed down. There's nowhere to go. In Hertfordshire there's not much around on Christmas day."***

Lifestyle and Screenings

Most participants have had their weight, height and blood pressure checked by a clinician. However, the regularity of this differed amongst participants.

> ***"They check it but not every time."***

> ***"I don't think I've been weighed or had my height checked for over 10 years."***

> ***"Yeah, [the GP] checks my weight and my height and my blood pressure regularly."***

The majority of participants have not been asked about whether they drink alcohol, smoke or use drugs. Most felt that because they do not engage in this behaviour, they do not need to speak to a clinician about it.

> ***"Yeah, they ask and I say on special occasions I drink alcohol."***

> ***"I will never smoke. You will never ever get me into smoking or alcohol. I don't like the taste of alcohol. I do take drugs, but they are not party drugs."***

> ***"They've asked me loads of questions but the answer is no, they haven't asked about that."***

> ***"No they haven't asked, I don't smoke, I don't drink and I don't take drugs apart from prescriptions."***

One participant, Harry* used to drink an excessive amount of alcohol. Although Harry has stopped drinking, he said that clinicians do not ask him about this alcohol intake, despite his history.

"I was in Lister Hospital; I was in the Drugs and Alcohol ward. She said what is that above your liver. I said I haven't got a clue. She said you'll be dead in 2 years; I didn't know I was killing myself. This was awhile ago. I had to make the decision to quit. They don't ask me about that."

Support workers also felt that clinicians should have more regular conversations with people with learning disabilities about the prescription drugs they are taking to ensure they have the right dose and are taking the medication correctly.

"It's important that doctors talk to them about the drugs they take because a lot of them are more powerful!"

In regard to sexual health, most participants have not had a clinician talk to them about this, although most felt that they did not need this information. Clinicians have spoken to Ben* and Becky* about sexual health, but they felt the information given needs to be updated.

"Based on what we were told, it needs a radical overhaul. It's coming from the starting point of the 80s and 90s and what to tell disabled people, if I put it like that."

Concerningly, the majority of participants said that a clinician has not discussed cancer screenings with them and how to check parts of their body for any lumps, discolouration and irritation. Some participants had no awareness and asked what cancer screenings were.

"I have cancer in my family, but I haven't been spoken to directly by doctors. So the answer is no."

"What's a cancer screening?"

"Have I been checked?"

"I haven't been told about any screenings."

Some participants were anxious about bowel cancer screenings and felt unsupported by carrying out the home test kit. One support worker shared that some people with learning disabilities can find it frightening to receive a bowel cancer screening test in the post, as they often do not understand the instructions and do not who to ask for help.

"The thing I'm not good at is doing the bowel cancer screening, that is something I fall down on."

> ***"They find it very frightening, they don't know how to do it and they don't know who to ask. So, some people do come to me and I try to get the learning disability nurse involved."***

Positively, one participant, Fran* had a learning disability nurse support her during their cervical cancer screening and helped them to feel more relaxed.

> ***"The learning disability nurse that day told me I could get a tablet that would relax me. It meant I wasn't pulling against the pain which was making it more painful. It worked for me."***

In terms of bowel and urine, some participants said a clinician has spoken to them about what their bowels and urine should look like, while others have received this information from elsewhere, such as Learning Disability Forums and Coproduction Board meetings.

> ***"They get the examples out at the County Council meetings sometimes and show us all."***

> ***"They always ask what colour is your wee and poo and if there has ever been blood in your poo."***

In contrast, one carer, Cath* felt that GP services need to prioritise ensuring that people with learning disabilities are accessing care and having their basic health needs met, before focusing on providing support for living a healthy lifestyle.

> ***"How can they have a healthy lifestyle when their underlying health needs that they were born with are not being monitored properly? GPs should know a healthy lifestyle should be about sorting what their main issues are, otherwise, they can't access a healthy lifestyle can they?"***

Annual Health Checks

Most participants have had an Annual Health Check, with some sharing that they had a good experience and praised clinicians for carrying out a thorough examination of their health and wellbeing and for their communication skills.

"It was a lady, and she was kind and patient."

"I had a really good time with my nurse. She's really nice."

"I would say 2 or 3 annual health checks, the doctor has been good at listening to our advice on how to support him but also treating him as a human being in his own right."

Annual Health Checks: Example of Best Practice

We spoke to a group of participants who live in a residential home. A female and male GP visited the residential home to carry out an Annual Health Check with each resident.

"We had a male doctor and a female doctor come in and we split the male doctor with the chaps and the female doctor with the ladies."

The participants received a thorough examination of their physical and mental health, and were asked questions about their general health and lifestyle.

"I told him about my mental health. I had a bit of a bad day and he got one of the mental health doctors to come and see me. He did my blood pressure too and did a blood test and he told me about losing weight. He told me about my relationship and talked to me about sex and he asked about smoking and he asked about drink."

The support workers noted that they spent a lot of time with each resident before the Annual Health Check to prepare them and to complete the relevant paperwork.

"We sat down with all the forms and we sat and talked about it at a meeting didn't we? Then you spent time with your key worker one-to-one to add more bits to the forms. So that helped the doctors focus on what to ask and helped to make the experience better."

Although a positive experience, one support worker felt that the examinations and questions asked during an Annual Health Check should happen throughout the year.

"Often all the questions happen at the Annual Health Check rather than throughout the year which would be better."

Some participants had a negative experience at their Annual Health Check, including receiving a short appointment (20-40 minutes), a basic examination of their physical and mental health, and having the appointment over the telephone rather than face-to-face. A few examples have been outlined below.

Ben* and Becky* had their Annual Health Check together but were only given 20 minutes between the two of them, when an Annual Health Check should take between 30 minutes to an hour per person. Part of the Annual Health Check was also carried out by telephone, which Ben felt was inappropriate.

> ***"We get 20 minutes between us. The time runs out fast. The last time we did our Annual Health Check we had a phone call from someone and they rattled through a very long list of questions. The purpose of the call was to give the doctor the information they would need beforehand because they wouldn't be able to ask them all face-to-face. I'm worried that if I'm struggling to cope with a phone call like that, I'm worried about other people with learning disabilities who can't articulate as well. I left the phone call burnt out."***

Paul* has only ever had an Annual Health Check completed by telephone. Not only is this inappropriate as a physical examination should be carried out, but Paul also often becomes anxious and distressed during telephone appointments.

> ***"The only Annual Health Check Paul has done has been over the phone, not in person."***

Fran* did not have her Annual Health Check with her regular nurse, and the clinician she had did not carry out a thorough examination of her physical and mental health. The clinician also did not ask Fran many questions about her health and lifestyle, and the appointment only took between 20 and 25 minutes. Fran also found it hard to communicate with the clinician because he was looking at the computer, rather than her.

> ***"I didn't get my regular nurse…it was a chap and basically he didn't ask any of the questions around cancer, about cancer checks, or anything which was a bit off and I had to ask him. We went through the regular blood test…he didn't weigh me. [The appointment] wasn't very long, like 20 minutes to 25 minutes, it wasn't as long as normal. He slipped right behind on all the questions he is supposed to ask me. He was looking at the computer and talking to the computer…I need the person to look at me so I can lip read."***

Fran also shared that her GP practice has not been using the term "Annual Health Checks" when corresponding with her, which she has found very confusing.

"The doctors use the phrase "people with long term conditions" instead of "Annual Health Checks" and also calling it other things as well. They are not using the term "Annual Health Checks" which everybody knows. When I rang up after I got a text, because the text said people with long term conditions, it was only through me asking, is this anything to do with Annual Health Checks. I could have ignored it. We've all been trained to use the term "Annual Health Check" and to use another term isn't helpful to anyone, me, you, no-one!"

Mia* received a basic examination at her last Annual Health Check and felt that the clinician was inpatient and did not take enough time to discuss her health with her.

"It weren't very good……. I don't think they have done what they call a full annual health check…… I haven't heard of anyone that has actually had a full check."

A couple of participants have never had an Annual Health Check or have not had an Annual Health Check in several years.

"I found out about three or four months ago that as a young adult with a learning disability he should have a general check-up yearly. I'll tell you that's not happened and it hasn't been promoted at any stage ever."

"I can't remember when my last Annual Health Check was. They don't send letters about them to me. I don't know."

One participant, Daniel*, has not had an Annual Health Check for a few years. At his last Annual Health Check, the clinician did not provide Daniel with Easy Read information, meaning that Daniel found it difficult to engage in the discussion and to follow-up on the information he was given.

"I once had an Annual Health Check two or three years ago. It was a bit hard to read. It all goes back to communication, so there's no point in the doctor printing me off stuff to go home and read if I can't read it, if it's not in a format that's accessible. I couldn't read it and I couldn't ask questions."

Conclusion

Overall, these findings raise concerns regarding the level of access people with learning disabilities have to GP services and the quality they are receiving. In terms of access, as with the general population, participants faced barriers such as delays in getting through to their GP practice and long waiting times for appointments. However, this engagement found that these challenges are clearly exacerbated for people with learning disabilities. Examples included restricted contact hours and lack of flexibility in appointments times preventing participants from accessing their GP practice, particularly as most participants are reliant on their support worker or carer being who available to help them. Best practice was shown amongst participants who had a Care Coordinator who could be their point of contact and support them in accessing GP services.

In terms of quality of care, choice was a significant factor, with many participants not able to choose the type of appointment they had, the time and date of the appointment, and the clinician they saw. Face-to-face appointments, flexibility in appointments times, and seeing their usual clinician was very important to participants, however in many cases, these needs were not accommodated.

Communication was another concern, with many participants recounting incidents in which clinicians and/or receptionists treated them poorly. This included clinicians speaking to their support worker or carer instead of directly to them, questioning whether somebody had a learning disability, and treating participants with disrespect.

Many respondents also did not receive information in Easy Read and were not communicated with in a way that was accessible to them. Reasonable adjustments were often not met, despite this being recorded on their medical records and repeatedly requested.

Positively, most participants felt supported by clinicians in living a healthy lifestyle, with many having received information on healthy eating and exercise. However, they felt that clinicians could provide more information on how to put this advice into practice, and to ensure that any support provided is personalised to meet their individual needs. It was also clear the clinicians need to do more to ensure that cancer screenings and mental health are discussed with people with learning disabilities.

In terms of Annual Health Checks, participants had a mixed experience, with some receiving a thorough examination of their physical and mental health, and others only having a basic examination and a short appointment, which did not sufficiently address all of their health needs.

Recommendations

Based on the findings outlined in this report, it is recommended that the Hertfordshire and West Essex ICB Primary Care Board should encourage GP practices to take forward the following recommendations.

Access

1. GP practices to continue improving telephone systems to reduce delays and waiting times for patients.

2. GP practices to allow people with learning disabilities to contact their GP practice for a same day appointment outside of the 8:00am timeframe. This will allow people with learning disabilities to contact their GP practice when their carer or support worker is with them.

3. GP practices to have a Care Coordinator or a primary point of contact specifically to support people with learning disabilities in accessing their GP practice.
    - If a GP practice has this support available, they should ensure that people with learning disabilities registered at their GP practice are made aware of this.

Choice

4. GP practices to allow people with learning disabilities to choose the type of appointment they have, and offering face-to-face appointments in the first instance.

5. GP practices to ensure that with learning disabilities can choose the time and date of their appointment, so they can make sure this is when their carer or support worker can accompany them.

6. If a telephone appointment is booked, a specific time slot is to be given rather than a large time window. This will enable people with learning disabilities to ensure they are (a) available to take the call (b) have their carer or support worker with them (c) be in a quiet area to have the consultation.

7. GP practices to ensure that people with learning disabilities can choose to see their usual clinician to provide continuity of care and familiarity.

Accessibility

8. Under the Health and Social Care Act (2010) GP practices are to be proactive in asking whether someone with a learning disability needs, or would like, any reasonable adjustments.
    - If reasonable adjustments are requested, they are to be recorded on the patient's medical records and implemented accordingly.

9. Under the Accessible Information Standards (2016) GP practices are to be proactive in ensuring that people with learning disabilities are communicated with in a way that is accessible to them.

10. GP practices to also ensure that information is provided in a range of formats, including Easy Read.

Communication

11. Clinicians to communicate directly with the person with a learning disability about their health and care, and not their carer or support worker.

12. Clinicians to avoid sharing information, such as test results, with people with learning disabilities by telephone. This can cause unnecessary concern and anxiety.

13. Clinicians and reception staff to treat people with learning disabilities with kindness and respect. Reminders and refresher training on engaging with people with learning disabilities should also be considered.

14. Clinicians and reception staff to never question whether a patient has a learning disability, and must meet their needs accordingly.

15. GP practices to deliver Customer Care training for reception staff to improve their customer service and communication skills.

Support with Living a Healthy Lifestyle

16. Clinicians to provide practical information about healthy eating, weight management and exercise, including meal and exercise plans.
    - Any information is to be provided in Easy Read and/or a format which is accessible to the patient.
    - Any support is to be tailored to their individual needs.

17. Clinicians to have regular discussions about mental health, sexual health, drugs, alcohol intake and smoking, and to ensure any support provided is personalised to their needs.

18. Clinicians to talk to people with learning disabilities about cancer screenings, ensure any relevant tests are carried out, and provide information on how to check their body for any signs of cancer.

Annual Health Checks

19. Clinicians to allow between 30 minutes to one hour for an Annual Health Check.

20. Clinicians to provide a full examination of the individual's physical and mental health. This is not to be carried out by telephone appointment only.

21. GP practices to ensure that people with learning disabilities are offered an Annual Health Check and reminded as to when their Annual Health Check is due.

Heart Health:

Views and Experiences of Hertfordshire Residents

Engagement: March – May 2023

Published: XXX

Authors: Miriam Blom-Smith and Chloe Carson

healthwatch Hertfordshire

Contents

Glossary

Angina: *chest pain caused by reduced blood flow to the heart muscles*

Atrial fibrillation: *a heart condition that causes an irregular and often abnormally fast heart rate*

Cardiovascular disease: *a general term for conditions affecting the heart or blood vessels.*

Congenital heart disease: *a general term for a range of birth defects that affect the normal way the heart works*

Coronary heart disease: *the term that describes what happens when your heart's blood supply is blocked or interrupted by a build-up of fatty substances in the coronary arteries.*

Heart attack: *a lack of blood supply to the heart that is usually caused by a blood clot in the coronary artery*

Hypertension: *the medical term for high blood pressure, which means your heart is working harder when pumping blood around your body.*

High cholesterol: *when you have too much of a fatty substance called cholesterol in your blood*

Stroke: *a sudden loss of brain function due to decreased blood flow to an area of the brain*

Vascular dementia: *a common type of dementia caused by reduced blood flow to the brain that results in changes to memory, thinking, and behaviour*

Glossary definitions are from the NHS and The British Heart Foundation.

About Healthwatch Hertfordshire

Healthwatch Hertfordshire represents the views of people in Hertfordshire on health and social care services. We provide an independent consumer voice evidencing patient and public experiences and gathering local intelligence to influence service improvement across the county. We work with those who commission, deliver and regulate health and social care services to ensure the people's voice is heard and to address gaps in service quality and/or provision.

About the Hertfordshire and West Essex Integrated Care System

The Hertfordshire and West Essex Integrated Care System (ICS) was established as a statutory body on 1st July 2022. Integrated Care Systems are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, coordinate and commission health and care services[1]. The Hertfordshire and West Essex ICS is made up of two key bodies – an Integrated Care Board (ICB) and Integrated Care Partnership (ICP).

Integrated Care Board (ICB)

The Integrated Care Board (ICB) is an NHS organisation responsible for planning and overseeing how NHS money is spent across Hertfordshire and West Essex, with the aim of joining up health and care services, improving health and wellbeing, and reducing health inequalities. The board of the ICB includes representation from NHS trusts, primary care and from Hertfordshire County Council and Essex County Council[2].

This report will be sent to the Hertfordshire and West Essex ICB Primary Care Board to inform how it can further support people to look after their heart health.

Integrated Care Partnership (ICP)

The Integrated Care Partnership (ICP) is made up of representatives from different organisations involved in health and care. This includes NHS organisations, local authorities and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. The partnership is responsible for developing an Integrated Care Strategy which will set out the priorities for Hertfordshire and West Essex for the next 10-20 years[3].

[1] Integrated care systems: how will they work under the Health and Care Act? | The King's Fund (kingsfund.org.uk)
[2] Health and wellbeing decisions – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)
[3] Health and wellbeing decisions – Hertfordshire and West Essex Integrated Care System (hertsandwestessexics.org.uk)

Hearing Patient Views about Primary Care in Hertfordshire and West Essex

Healthwatch Hertfordshire and Healthwatch Essex have been commissioned by the Hertfordshire and West Essex Integrated Care Board (ICB) Primary Care Workstream to undertake a series of engagement projects. The aims of the engagement projects include:

- Gathering lived experiences to feed directly into the Hertfordshire and West Essex ICS Primary Care Workstream
- Supporting and enabling the Hertfordshire and West Essex ICS to achieve wider participant engagement
- Engaging patients and the public on programmes covering key priorities and areas of importance at a regional and local level
- Making recommendations to the Hertfordshire and West Essex ICS Primary Care Workstream so improvements can be implemented

Using patient and public feedback, this engagement project will focus on improving the relevant services within different areas of primary care by making recommendations to the Hertfordshire and West Essex ICB Primary Care Board.

From February to May 2023, the Director of Primary Care Transformation at the ICB has requested that Healthwatch Hertfordshire explore public understanding and experiences of cardiovascular disease diagnoses, with a specific focus on:

- What do respondents know about the risks and symptoms of heart disease?
- For those who already have a heart disease-related condition, what was their experience of diagnosis like, and how do they manage their condition?
- How can local healthcare providers and services best support people with managing their risks and symptoms of cardiovascular disease?

Background

Overview

Cardiovascular disease, other known as heart disease, is an umbrella term for conditions affecting the heart or blood vessels, including coronary heart disease, angina, heart attack, hypertension, stroke, vascular dementia and congenital heart disease. Heart disease affects around seven million people in the UK and is one of the leading causes of death and disability[4]. However, it is often preventable. Around eight in every ten cases of heart disease are related to risk factors that can be controlled[5]. This research focuses on the types of heart disease which

[4] NHS England » Cardiovascular disease (CVD)

[5] Government to consider radical new approach to prevent life-threatening cardiovascular disease - GOV.UK (www.gov.uk)

primarily develop as a result of risk factors, rather than genetics alone. Someone with more risk factors is more likely to develop heart disease. These include[6]:

- Older age
- Male sex
- Black and South Asian ethnic backgrounds
- Family history
- Unhealthy diet
- Excessive alcohol consumption
- Inactivity
- Smoking
- Being overweight
- Type 2 Diabetes
- Level of deprivation
- Severe mental illness

There are three high-risk conditions that indicate poor cardiovascular health – having high blood pressure, high cholesterol levels in the blood, and atrial fibrillation (an abnormal heart rhythm). Many of the risk factors and high-risk conditions also relate to conditions such as cancer, Type 2 Diabetes, and dementia, suggesting that taking actions to prevent heart disease will also provide benefits for sustaining a heathier population overall. People with cardiovascular disease are also at a higher risk of severe disease and death from COVID-19 which further increases the importance of preventing and reducing heart disease[7].

Promotion and Prevention

Health promotion and disease prevention are essential to reducing the number of deaths from cardiovascular disease.

Primary Prevention

Primary prevention refers to reducing the risk of developing cardiovascular disease before it occurs through promoting healthy lifestyle measures. The NHS Long Term Plan[8] sets out preventative initiatives as part of its wider priorities that are designed to help people tackle obesity, and tobacco and alcohol dependency. Reducing tobacco use and levels of inactivity has been suggested to prevent around 81% of cardiovascular disease[9]. Eating healthy food and exercising regularly are also key ways in which the population can play an active role in their own health and healthcare.

Secondary Prevention

Secondary prevention is the early identification of risk factors and high-risk conditions. It is proven to help patients to live longer, healthier lives, and is therefore a key priority for primary care services in the NHS[10]. Currently, around 80% of heart failure is diagnosed in hospital, even though 40% of those patients had symptoms that could have prompted an earlier assessment[11].

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[6] Cardiovascular Disease (CVD) - types, causes & symptoms - BHF
[7] Cardiovascular disease in England | The King's Fund (kingsfund.org.uk)
[8] NHS Long Term Plan » Cardiovascular disease
[9] Self-care interventions for health (who.int)
[10] Cardiovascular disease in England | The King's Fund (kingsfund.org.uk)
[11] NHS Long Term Plan » Cardiovascular disease

The NHS Long Term Plan[12] aims to improve and increase early detection and treatment of cardiovascular disease, and rapidly treat and manage those with the high-risk conditions. To support this, those aged 40-74 are invited for an NHS Health Check[13] every five years, which is designed to identify early signs of conditions such as heart disease. The NHS is also running a national audit called CVDPrevent which will make it easier for GP practices to identify those who are at high-risk, or how an individual's treatment could be improved.

Self-management

When a person has been identified as having high blood pressure, high cholesterol, or atrial fibrillation, they can manage their condition(s) at home in order to reduce their risk of developing heart disease. Patients are often advised to modify aspects of their lifestyle such as eating heathier, increasing daily activity and cutting down on smoking and drinking alcohol. There are also initiatives such as home blood pressure monitoring which support the patient to take control of their health[14]. The NHS Long Term Plan also aims to normalise people routinely knowing their "ABC" numbers (atrial fibrillation, blood pressure and cholesterol)[15].

Health Inequalities

Since 1961 the death rate from cardiovascular diseases in England has fallen by over three quarters[16]. Although it continues to decline, progress has stalled since around 2010[17]. Due to the nature of its risk factors, it also remains a leading cause of health inequalities in the UK. The most deprived 10% of the population are almost twice as likely to die from cardiovascular disease than the least deprived 10%[18]. The development of cardiovascular disease is primarily dictated by lifestyle factors such as obesity and smoking, which are also known to be linked to socio-economic status[19]. As such, promotion and prevention methods must be accessible and achievable for the whole population, no matter their socio-economic position.

Local Picture

According to the British Heart Foundation (2022) around 24,000 people in Hertfordshire are living with coronary heart disease, and someone dies from a heart or circulatory disease every three hours, killing one in four residents overall[20]. These figures are reflective of the national statistics, but are still very concerning given the disease is largely preventable.

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[12] NHS Long Term Plan » Cardiovascular disease
[13] NHS Health Check - NHS (www.nhs.uk)
[14] NHS England » Home blood pressure monitoring
[15] NHS England » Cardiovascular disease (CVD)
[16] BHF England CVD Factsheet
[17] Cardiovascular disease in England | The King's Fund (kingsfund.org.uk)
[18] NHS England » Cardiovascular disease (CVD)
[19] Overview | Cardiovascular disease: identifying and supporting people most at risk of dying early | Guidance | NICE
[20] Data Set 376 (bhf.org.uk)

In Hertfordshire, 50% of patients eligible for the NHS Health Check take up the offer. This is better than the average 40% across England, but increasing this percentage would improve early identification and treatment of cardiovascular disease-related high-risk conditions[21].

Reducing the premature death rate of cardiovascular disease has been made a clinical priority of the Hertfordshire and West Essex ICB. A series of initiatives have also been implemented, including targeted work on raising awareness of the signs and symptoms of atrial fibrillation amongst ethnically diverse communities.

This engagement will therefore support this ongoing work by exploring public understanding of the risk factors and symptoms of heart disease, as well as the experiences of those with a heart disease related diagnosis in self-managing their condition(s).

Aims

The aim of this engagement was to hear from Hertfordshire residents about their understandings and experiences of heart disease and related high-risk conditions.

This included:

- To explore public understanding of the risks and symptoms of heart disease
- To understand how, and to what extent, those with a heart disease related diagnosis self-manage their condition(s)
- To consider patients' experiences of being diagnosed with a heart disease related condition
- To explore how the general public can be better supported to self-manage their cardiovascular health risk and existing conditions and/or symptoms.

Methodology

The aims of this research were explored by creating an online survey open to all Hertfordshire residents, whether or not they have an existing cardiovascular disease-related diagnosis.

Using a survey to collect data was considered the most effective method in order to reach and engage the population within the timescales of this research. However, participants were offered the opportunity to share their views using an alternative method to accommodate their needs and/or preferences.

The engagement period for the online survey ran from March – May 2023. The survey was promoted via social media and shared with the NHS, other statutory services, and the Voluntary, Community, Faith and Social Enterprise sector across Hertfordshire to distribute via their networks, contacts and social media channels. These stakeholders also received a digital flyer to support with promotion.

[21] NHS Health Check - OHID (phe.org.uk)

Key Findings

Demographics

229 Hertfordshire residents completed the online survey[22].

7% were aged 18-34 years old
30% were aged 35-54 years old
53% were aged 55-74 years old
10% were aged over 75 years old

81% were female
1% were transgender female
18% were male

80% were of a White British background
20% were from an ethnically diverse background[23]

17% identified as a carer
12% had a disability
29% had a long-term condition

56% stated that they had a little or a lot of disposable income
19% had either just enough, or not enough money for basic necessities

[22] Please note that percentages do not always add up to 100% due to some respondents choosing not to answer, or preferring not to say.
[23] Ethnicities engaged with included: Chinese, Indian, other Asian/Asian British backgrounds, Black Caribbean, Black African, other Black/Black British backgrounds, Asian and White, Black Caribbean and White, White Irish, White Italian, White Polish, other White backgrounds and other ethnic backgrounds not listed as options.

107 (47%) respondents had a medical diagnosis of high blood pressure, atrial fibrillation and/or high cholesterol.

- **62%** were aged between 55-74 years old. A further **22%** were aged between 35-54 and **15%** were over 75.
- **68%** were female, in comparison to **30%** male and **1%** transgender.
- **84%** were of a White British background, and **15%** were from an ethnically diverse background.
- **15%** identified as a carer, **13%** had a disability and **37%** had a long-term condition.

The remaining 122 (53%) respondents did not have any of the above diagnoses.

- **12%** were aged between 18-34 years old, **37%** were aged between 35-54 years old, **45%** were aged between 55-74 years old and **6%** were aged over 75 years old.
- **92%** were female, and **8%** were male.
- **76%** were of a White British background, and **24%** were from an ethnically diverse background.
- **19%** identified as a carer, **11%** had a disability and **22%** had a long-term condition.

Identification and Diagnosis

(when respondents had a medical diagnosis of high blood pressure, atrial fibrillation and/or high cholesterol)

62% had high blood pressure

***30%** also had high cholesterol, and **12%** also had atrial fibrillation*

- 45% were aged between 35-64
- 53% were aged over 65
- 64% were male
- 82% were White British, 6% were of an Asian background
- 16% had less disposable income

27% had high cholesterol

***41%** also had high blood pressure and **6%** also had atrial fibrillation*

- 54% were aged over 65
- 43% were aged between 35-64
- 75% were female
- 86% were White British
- 16% had less disposable income

20% had atrial fibrillation

38% also had high blood pressure, and **14%** also had high cholesterol

- 50% were aged over 65
- 44% were aged between 35-64
- 56% were female
- 87% were White British, 13% were White Other
- No respondents were from an Asian or Black background
- 13% had less disposable income – fewer than other conditions

Identification

25% of all respondents who had a diagnosis recognised their own symptoms, after which **60%** visited their GP, and **20%** contacted emergency services due to the severity of their symptoms.

"I measured my BP at home and then at the GP surgery who sent me to A&E."

"Asked for an NHS Health Check at my GP."

"Rang 999 with chest pain."

People aged 18-44 were the most likely to recognise their own symptoms at **80%**, followed by people from an Asian background at **40%**. Women were also slightly more likely than men to identify their symptoms, as were those under 65 years old compared to people over 65.

72% of respondents said their symptoms were recognised by a healthcare professional – most often by their GP or GP practice nurse. This figure fell to **60%** for people from an Asian background, and just **20%** for people aged 18-44. It is perhaps the case that those who feel they are at less risk of developing heart disease might be less likely to visit primary care with concerns, and consequently experience more severe symptoms before ending up in emergency care.

Seven participants specifically mentioned that their symptoms were recognised at a routine health check.

"My over-40s health check identified very high blood pressure and I was given an ECG and put immediately onto medication."

"I was impressed with the early diagnosis as I had no health issues or early signs of any problems to do with [my] heart."

"Condition discovered following blood tests for my annual review."

Atrial fibrillation was the condition where respondents were most likely to have recognised the symptoms themselves, with **30%** having done so.

Diagnosis

57% of respondents overall were diagnosed by their GP, **7%** by a nurse and **28%** by a hospital doctor. Other routes to diagnoses included seeing a private healthcare professional or health checks provided through work.

"My blood pressure measurements were requested by text from the GP. They were recognized as high and I was contacted and given a face to face appointment within a few days."

"I went to my GP surgery regarding ringing in my ears. They did routine blood tests and checked my blood pressure which was high."

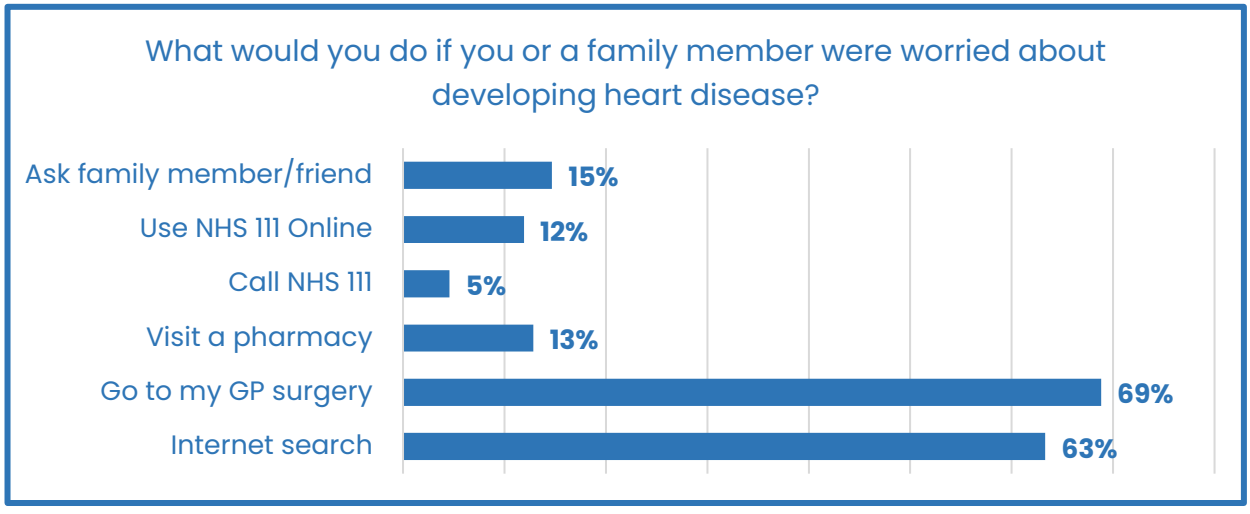
0% of respondents aged 18-44 were diagnosed by their GP, with **60%** being diagnosed by a hospital doctor. Men were also **more likely** than women (**35%** in comparison to **20%**) to be diagnosed by a hospital doctor. Those under 65 years old were also more likely to be diagnosed by a hospital doctor, at **28%**. This could indicate a reluctance or barriers for these groups in visiting their GP, or a misconception that they are not at risk due to their age, resulting in an emergency hospital admission.

Positively, at **80%,** those from an Asian background were more likely to be diagnosed by the GP, and the remaining **20%** by a nurse, rather than in hospital.

Atrial fibrillation was more than twice as likely to be diagnosed in hospital than high blood pressure or high cholesterol (**53%** in comparison to **22%** and **21%** respectively).

Pre-/no Diagnosis

The chart below shows the responses to what people without any diagnosis would do if they, or a family member, were worried about developing heart disease. Other answers included visiting a healthy hub or attending A&E.



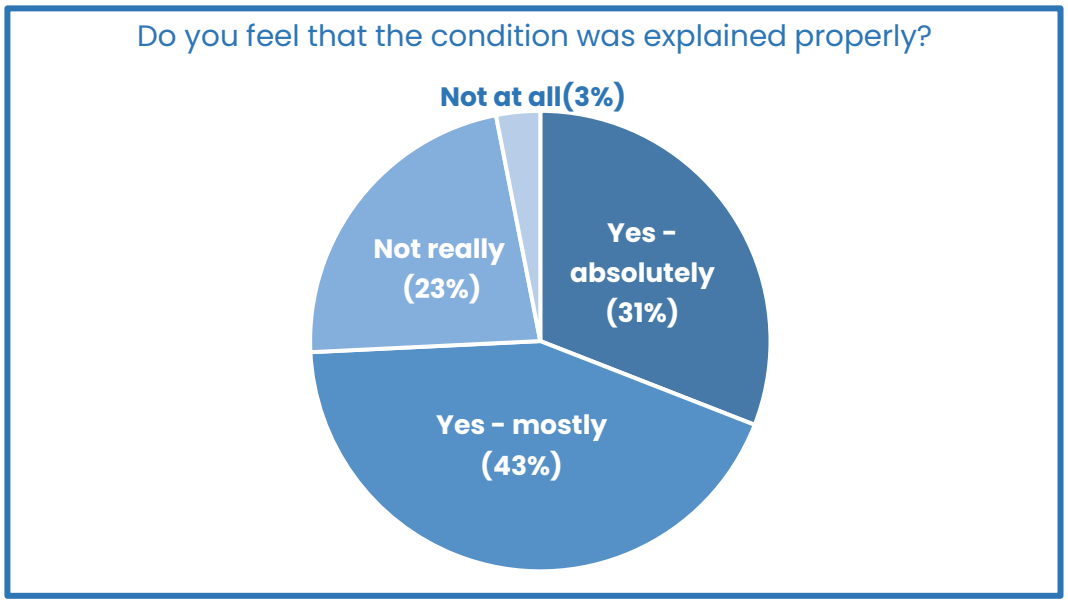
Interestingly, men were far **less likely** to look online at just **22%**, but were more likely to ask friends or family at **33%**. Those from a White Other background were even more likely to ask family or friends at **38%**. People with less disposable income, Asian and Black respondents, and those aged 65-74 were all **more likely** to look online.

People from a Black or Asian background were more likely to visit their GP at **80%** and **86%** respectively. Those from a White Other background were less likely to visit their GP if they had concerns at **54%**. Concerningly, only **50%** of 65-74 year olds stated that they would visit their GP, despite falling in an at-risk category.

At **13%**, not many respondents would visit a pharmacy, and no male respondents, or respondents from a Black background said they would visit a pharmacy if they had concerns about developing heart disease. However, respondents from a Black background were more likely to use NHS 111 at **40%**, in addition to those with less disposable income at **29%**.

Understanding of their Condition

For respondents who had a diagnosis, **74%** felt that their condition was explained to them properly, the extent to which is shown in the diagram below.



Many respondents had a positive experience, emphasising that they felt the healthcare professional was supportive and provided enough information.

"Positive experience despite being diagnosed, plenty of time to ask questions and explore medications."

"Great GP, always explains things in simple terms."

"In-depth and comprehensive. Continuing monitoring."

However, **28%** felt that their condition was either was not well explained, or not explained at all. These respondents said that they were not given enough information or support by their healthcare professional, and some did not feel adequately listened to. Of the diagnoses, high blood pressure was the condition that respondents were most likely to report was not explained properly.

"Just told I had raised cholesterol and recommended to go on statins."

"I was aware of the condition prior to meeting the GP. Initial doctor was reluctant to initiate treatment as I was deemed young even though there was a strong family history."

"Not much discussed apart from the need for medication although a brief mention to risk factors and management was given."

In addition, women were much more likely than men to indicate that their condition wasn't really explained properly – **32%** versus just **12%** of men. However, despite feeling like it wasn't explained well, **83%** of women still either absolutely or mostly understood the information given to them, which is not far from the **89%** of men who felt they understood the information.

"Unsure of severity – I would like advice on non-medical ways to lower blood pressure and would like an understanding of the various pills I have been prescribed."

"I was told it was on the high side and changed my diet but could have had more support/reassurance other than "we will repeat bloods in 12 months."

Overall, **84%** of respondents understood either absolutely (**41%**) or mostly (**43%**) the information that was given to them. However, **15%** indicated that they did not understand the information given and would have liked more support from their healthcare professional. Atrial fibrillation was the most common condition where the respondent stated that they either did not really, or did not at all, understand the information they were given.

"I felt it was explained well."

"Very clear and explicit."

"I did get to speak to a specialist over the phone but not sure that my level of risk requires the aspirin prescribed. Specialist did not require any follow-up so how bad is my heart?"

"Told that further checks regarding high cholesterol were not going to happen. Not at all reassuring. I continue with the medication prescribed several years ago."

Furthermore, **18%** of respondents they were not given a chance to ask their healthcare professional questions about their condition, although **74%** felt they were. Again, women were more likely to report that they were not given the opportunity to ask any questions, at **18%** in comparison to **12%** of men.

"Here are the facts; take the medicine!"

"Would like advice on non-medical ways to lower blood pressure and would like an understanding of the various pills I have been prescribed."

"The GP was clear in her explanation of the condition and treatment options."

Although only one Black/Black British person with a diagnosis responded, their experience was poor. The respondent felt that their condition was not explained properly, and they did not feel adequately supported by their healthcare professional.

"Doctors of recent operate on a fan belt and are often anxious about the number of patients to see, so, I did not feel properly supported."

Management of their Condition

Most respondents (**60%**) manage their condition by taking medication, with some noting that healthcare professionals have been supportive in helping them find the correct medication and dosage.

"I opted for medication because the GP did not feel there were many lifestyle improvements I could make. I was very nervous at the thought of managing without medication."

"My GP practice pharmacist worked with me until I had the correct doses and combination of medicines. I have been having annual reviews."

41% of respondents manage their condition through changing their diet and eating more healthily.

"Healthy diet and try to maintain healthy weight."

"Cut back on over processed/fatty/sugary foods."

27% manage their condition by exercising more regularly.

"Go to the gym regularly and exercise."

14% regularly monitor their blood pressure and have routine blood tests.

"I have regular blood tests every 6 months followed by GP discussion."

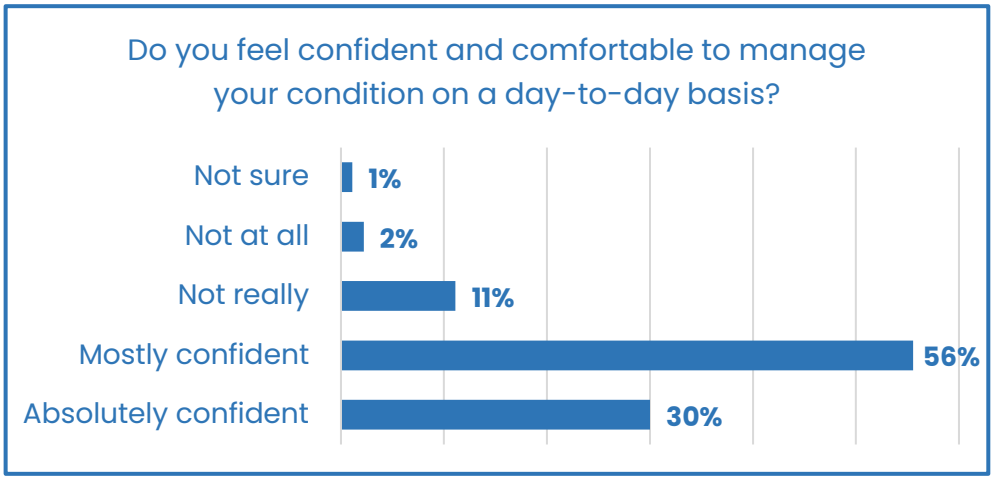
"Monitor blood pressure at home and give readings to GP."

11% have been making lifestyle changes to help manage their condition, including reducing stress and sleeping well.

"Manage sleep and stress levels to best of my ability."

"Relaxing but also keeping as fit as I can."

Overall, **86%** of respondents with a diagnosis felt either absolutely (**30%**) or mostly (**56%**) confident in self-managing their condition on a day-to-day basis, with just **13%** feeling not really (**11%**) or not at all (**2%**) confident, as demonstrated in the chart below.



The percentage of people where were “not really” or “not at all” confidence was significantly higher amongst those who identified as White Other, with **49%** of them feeling unconfident about managing their condition. People aged over 65, people of an Asian background, and those with less disposable income were also slightly less confident in managing their condition when compared to the average. Respondents who felt less confident managing their condition typically stated that they had difficulty keeping healthy or that there was a lack of information and support available.

“I am not disciplined with exercising and eating more vegetables.”

“Don’t know what my blood pressure should be. Don’t understand the multiple medications prescribed.”

“I get pains in my chest and get out of breath and don’t know if I should worry.”

“I am unable to exercise to the level I was before COVID shut us down. This has resulted in increased weight, which I have always struggled with.”

In addition, some respondents lacked confidence due to problems using technology, while others felt that their condition needed to be monitored more by healthcare professionals.

“I think I should be monitored more often.”

“I’m using at home blood pressure monitoring but I find it so stressful to do.”

“Take medication but no follow-up blood tests to see how I am doing.”

Awareness

Risk factors

When asking respondents without any existing diagnosis what the risk factors for heart disease were, we found that:

- **96%** recognised that *high cholesterol*, being *overweight* and having a *family history* of heart disease were risk factors.
- **90-95%** recognised that *high blood pressure*, *smoking* and *inactivity* were risk factors.

- **80-90%** recognised that *diet*, *Type 2 Diabetes* and *alcohol consumption* were also risk factors.
    - Male respondents had poorer awareness of these three risk factors, at **78%**, **67%** and **67%** respectively. Those aged 65-74 had a low awareness of Type 2 Diabetes at **67%** in comparison to the **85%** average.

ETHNIC BACKGROUND

Overall, only **54%** of respondents were aware that ethnic background was a risk factor. Positively, as highlighted above, people from Black and Asian ethnic backgrounds were far more likely to be aware of their own risk.

People from other White ethnic backgrounds and those with less disposable income were less likely to recognise ethnic background as a risk factor, at **46%** and **43%** respectively.

65-74 year olds and those aged over 75 were the least aware, at **33%** and **14%** respectively.

GENDER

Gender as a risk factor had the lowest awareness at **42%.** Despite their gender being more likely to be at risk, only **44%** of men knew this was a risk factor.

Furthermore, only **29%** of over 75-year olds, **17%** of 65-74 year olds and **29%** of those with less disposable income were aware of gender as a risk factor.

AGE

The average awareness of age as a risk factor was **69%**. Concerningly though, only **62%** of over 65-year olds were aware of age as a risk factor, despite being in an at-risk category.

Furthermore. onlv **67%** of over 75-vear olds were aware.

There were differences between different ethnic backgrounds' awareness of the risk factors associated with heart disease and the related high-risk conditions:

Respondents from **Black and Asian** ethnic backgrounds had a much higher awareness of the risk factors associated with heart disease:

- **100%** recognised high blood pressure, high cholesterol, atrial fibrillation, smoking, Type 2 Diabetes, inactivity, being overweight, family history, diet and alcohol consumption.
- **80%** of Black respondents recognised age (average was **69%**).
- **60%** of Black respondents recognised gender (average was **49%**).
- **100%** of Black respondents, and **71%** of Asian respondents recognised ethnic background (average was **54%**).

Respondents who identified as **White Other** had poorer overall awareness of risk factors:

- **54%** recognised Atrial Fibrillation (average was **74%**)
- **69%** recognised Type 2 Diabetes (average was **85%**)
- **62%** recognised inactivity (average was **90%**)
- **67%** recognised alcohol consumption (average was **85%**)

Symptoms

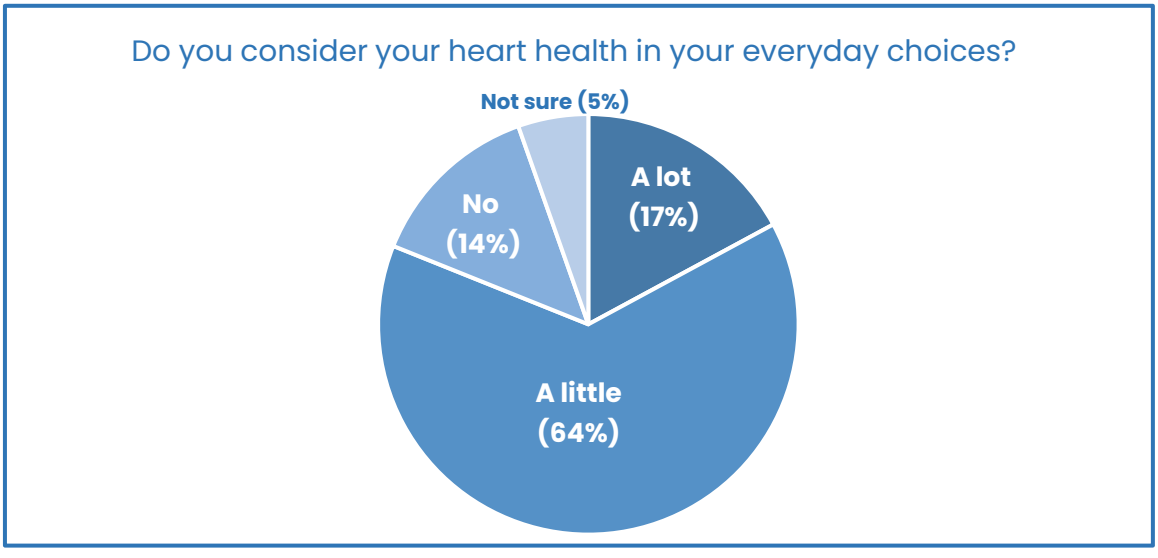
Respondents without any existing diagnosis most commonly identified breathlessness (**46%**) and chest pain (**27%**) as symptoms of heart disease. Other answers included fatigue, dizziness and swelling.

11% of respondents stated that they didn't know, and a further **35%** skipped question, which could indicate that they were either unsure or not aware of the symptoms.

Worryingly, **40%** of Black and Mixed Black/White respondents did not state any symptoms, nor did **40%** of men responding.

Prevention

Positively, most respondents without a diagnosis did still consider their heart health in their everyday choices, the extent to which is demonstrated in this chart:



The majority (**61%**) of respondents try to consider their heart health by living a healthy lifestyle, including eating healthily, regularly exercising, not smoking and limiting their alcohol intake.

"I watch my diet, take regular exercise, don't smoke, limit my alcohol intake, try to keep my stress levels down, am not overweight."

"I eat healthily, don't smoke, drink little and exercise everyday – even if just walking 10,000 steps."

"I am conscious of what I eat and drink and try to walk after often as possible for exercise."

"I try to maintain a good level of fitness or activity throughout the day as well as being considerate of the food I am eating."

Some respondents said that they consider their heart health in their everyday choices because they have a family history of heart disease.

"Family history of heart disease, so try to keep healthy in food and exercise."

"With a family history of heart disease I need to be careful."

While **10%** of respondents said that they take care of their health and wellbeing to support with their general health, rather than specifically their heart health.

"I try to eat healthy, trying to lose weight, and exercising regularly. Not just for my heart, but general health."

"I consider my health overall as a factor in my choices, so heart comes within that but not as a specific consideration."

"I think I make "healthy choices" in terms of lifestyle and diet not just in terms of heart health."

There was a significant gender divide, with **83%** of women considering their heart health in their everyday choices either "a lot" or "a little", compared to **56%** of men, despite their increased risk.

"I try to eat as healthily as possible, I walk for half an hour everyday to work and back. I am planning on getting more exercise by joining a gym and cut back on my alcohol consumption. As I am getting older and have gone through the menopause I am highly aware of the need to look after myself and my heart health."

Consideration of heart health also increases with age. **92%** of over 65s consider their heart health, and this decreased to **87%** for 45-64 year olds, and to a further **64%** for 35-44 year olds. Only **54%** for 18-34 year olds considered their heart health "a lot" or "a little" compared to the 81% average.

14% of all respondents did not consider their heart health at all. For some, reasons for this included constraints such as time, childcare, work, and physical and mental health issues.

Positively, **100%** of Black and Asian respondents said they considered their heart health in their everyday choices.

"I have an issue with binge eating and wish to overcome this to make healthier choices for my heart, body and overall wellbeing but struggle due to emotional factors."

"As a busy mum I think about my health but don't necessarily have the time to dedicate the ideals."

"I used to exercise and eat better but with other health issues I have stopped both in favour of just managing to get through the week at work."

"I was always fit as a youngster and could eat anything – it's hard to change."

For other respondents, they simply did not think about their health in their everyday choices, and/or do not always act on making healthier decisions, particularly if they do not see themselves at risk of developing heart disease.

"I consider it but don't really do as much as I should about it."

"I think about it but don't always do the wisest things to help it."

"I'm aware of risk factors for heart disease but it's not at the forefront of my mind when making choices as I don't have high blood pressure, high cholesterol, don't smoke and I'm not overweight."

Those aged 18-44 were the most likely to not consider their heart health at **30%**. People with less disposable were also more likely to not think about their heart health at **25%**, followed by respondents from a White Other ethnic background at **23%**.

Some respondents felt there could be more support and information around how to prevent heart disease.

"As heart disease is still a big killer in the UK, I would feel better knowing of ways to prevent it and remind me to prevent it."

Measurements

Respondents with or without a diagnosis of heart disease were all asked whether they know their blood pressure and cholesterol levels.

Respondents with a diagnosis

Blood pressure

Overall, **64%** of respondents knew their own blood pressure, and **22%** roughly knew, whilst **13%** did not know.

Positively, of those with a diagnosis of high blood pressure, only **9%** did not know their readings. In contrast, **16%** of respondents with a diagnosis of high cholesterol and **13%** with atrial fibrillation did not know their blood pressure levels.

Concerningly, some groups were significantly more likely to not know their blood pressure, in comparison to the **13%** average.

- **40%** of those from an Asian ethnic background
- **33%** of those with less disposable income
- **29%** of respondents from White Other ethnic background
- **27%** of men

Older people were more likely to know, with only **7%** of over 65s stating they do not know their blood pressure level.

Cholesterol

Overall, **38%** knew their cholesterol level, **31%** roughly knew, whilst **31%** did not know.

Of those with a diagnosis of high cholesterol, **23%** did not know what their cholesterol level was. **35%** of people with high blood pressure and **44%** of people with atrial fibrillation were not aware of their cholesterol level.

Again, some groups were far more likely to not know had their own cholesterol levels, in comparison to the **31%** average.

- **100%** of people from a Black ethnic background (n=1)
- **47%** of those with less disposable income (69% of those with more disposable income knew their cholesterol level)
- **47%** of those under 65 years old.
- **43%** of those from another White ethnic background.
- **40%** for people of an Asian ethnic background.

<u>Respondents without a diagnosis:</u>

Blood pressure

40% knew their own blood pressure, **32%** roughly knew it, and **29%** did not.

Some groups had a higher percentage of respondents stating that they did not know their blood pressure.

- **48%** of 18-44 year olds.
- **38%** of people from White Other ethnic background.
- **39%** of those with less disposable income.

Particularly concerning is that **71%** of people from an Asian ethnic background did not know their blood pressure level.

Positively, awareness increased with age. **100%** of over 75 year olds did know their blood pressure, as did **84%** of 65-74 year olds.

Respondents were asked what they would do if they wanted to check their blood pressure. **58%** said they would check on their home blood pressure monitor, and **14%** said they would buy a home blood pressure monitor. Some respondents had other means of access to a monitor, such as in the workplace or family. Men (**67%**) and those aged 65-74 (**100%**) were more likely to check using a blood pressure monitor, whilst people aged between 18-44 were less likely at **37%**.

37% of respondents said they would go to their GP surgery to check their blood pressure. People from a Black ethnic background and those from a White Other ethnic background were more likely to visit their GP, at **60%** and **54%** respectively. People with less disposable income and those aged 18-44 were also more likely to see a GP, at **50%** and **48%** respectively.

Men (**11%**) and respondents from an Asian ethnic background (**14%**) were far less likely to visit the GP to check their blood pressure.

18% of all respondents said they would visit a pharmacy to check their blood pressure, a figure which rose to **29%** for respondents from an Asian ethnic background.

Cholesterol

19% knew their own cholesterol level, **26%** roughly knew it, and **55%** did not know.

Respondents from a White Other ethnic background, and people from an Asian ethnic background were more likely to not know their cholesterol level, at **77%** and **71%** respectively.

In comparison, awareness of their cholesterol level was slightly higher amongst people from a Black ethnic background, with **40%** stating they did not know their cholesterol level compared to the **55%** average.

45-54 year olds were more likely to know their cholesterol, followed by 55-64 year olds.

Respondents were asked what they would do if they wanted to check their cholesterol levels, of which **79%** said would go to their GP. This figure was higher for respondents from an Asian ethnic background at **100%** and men at **89%**. However, concerningly, only **33%** of those aged 65-74 years old would visit their GP to check their cholesterol.

21% of respondents said they would visit a pharmacy to check their cholesterol level. This number was slightly higher amongst those aged between 65-74 years at **33%**. Those aged between 18-44 were most likely to check their cholesterol at a pharmacy, at **70%**.

A few respondents were not sure or did not know where to go if they wanted to have their cholesterol level checked, and a couple mentioned visiting a healthy hub.

"Visit a healthy hub session and speak to a nurse."

Barriers

*Of those **with** a diagnosis*

68% of respondents said they did not face any barriers in the process of identifying and diagnosing their condition, with **16%** saying they unsure. However, **14%** did face barriers. For some respondents, these included not feeling listened to, and a reluctancy from healthcare professionals to refer them and/or carry out further examinations.

> ***"Delay in getting first indication that something was wrong and finally getting medication to help. I had to visit the GP a number of times before being sent for a simple blood test to identify heart failure."***

> ***"Had to explain to GP reception what an NHS Health Check was."***

> ***"Reluctance of GP to refer to cardiologist."***

A few respondents faced barriers in accessing the NHS more generally, and said that issues in accessing an appointment with a GP led them to seeking private care and treatment.

> ***"Initially I could not get a GP appointment at our surgery, I could not even get them to answer the phone so I went privately."***

> ***"Difficulty in getting an appointment with the GP, then needed to get a private consultation as the NHS appointment was such a long wait."***

The likelihood of facing barriers was higher than the average **14%** for some categories:

- **19%** for people with a diagnosis of atrial fibrillation
- **20%** for people from an Asian ethnic background
- **20%** for those on with less disposable income
- **29%** for people from White Other ethnic backgrounds
- **33%** for those aged 18-44

Those aged 18-44 in particular felt that they experienced problems in receiving a diagnosis because of their age, and healthcare professionals not listening to and/or acting on the symptoms were they experiencing.

"I was diagnosed in my 30s – there was reluctance to commence medication initially which led to my blood pressure being uncontrolled and me being unwell."

*Of those **without** a diagnosis*

35% of respondents had interacted with a healthcare professional about their heart health, and **61%** had not. Respondents from an Asian ethnic background were slightly more likely to have spoken to a healthcare professional at **43%**.

However, people from a Black ethnic background and those aged 18-44 were far more likely to have not interacted with a healthcare professional about their heart health, at **80%** and **78%** respectively. Men were also slightly less likely, with only **22%** having spoken to a healthcare professional, compared to the **35%** average.

Positively, **91%** of all respondents would not have any concerns around doing so.

"I feel I am fairly well informed and have a good service from my GP."

"Always happy to speak to healthcare professionals."

For the **6%** who did have concerns, many of these related to health anxieties and/or difficulties in accessing an appointment with their GP.

"I am nervous of medical tests/procedures."

"There is no one to talk to. Unable to get a GP appointment "just for a chat!"

"Had several tests regarding heart problems – never received any results despite several calls."

"I have anxiety so my blood pressure tends to spike when I get it measured at the doctors. My concern is that this isn't take into account as they are only focusing on the reading not my overall health."

Respondents from a White Other ethnic background and those aged 18-44 showed greater concern around interacting with a healthcare professional about their heart health, at **23%** and

15% respectively. Concerns commonly centred around difficulties getting an appointment, or their symptoms not being taken seriously by clinicians.

> ***"I have now reached an age where two immediate family members have needed heart surgery, so feel it is very important to talk to healthcare professionals about myself. But I am finding this difficult due to not being able to get a non-urgent GP appointment."***

> ***"It's difficult to get an appointment about something you have, getting an appointment to discuss something as a preventative method would feel impossible because GP receptionists gatekeep. I am not aware of what is appropriate to talk to your local pharmacist about."***

> ***"As a young person I don't feel I'd be taken seriously by a doctor if I wanted to get my heart health checked. They'd make me feel that I was wasting their time because I don't have symptoms."***

NHS Health Check

Despite anyone over 40 being eligible for the NHS Health Check, still only **41%** of those aged over 45 had ever seen a healthcare professional about their heart health, with some emphasising concerns around getting an appointment. Even amongst people aged over 75, only **57%** recall speaking about their heart health with a healthcare professional, even though they are at greater risk of developing heart disease. This respondent shared their experience of a late NHS Health Check.

> ***"I had my health check some years after I became eligible as I had been too busy to book one beforehand. I was not encouraged by my practice to book one during that period and could have had a diagnosis some time earlier."***

Summary

Overall, these findings show some fairly positive results around awareness, prevention and management of heart disease and the three related high risk conditions.

However, careful consideration needs to be given to trends across particular demographic groups. For example, people from an Asian ethnic background had much better awareness of the risk factors associated with heart disease and were more likely to know that ethnicity was a risk factor. 100% of respondents from an Asian ethnic background without a diagnosis also said that they consider their heart health in their everyday choices.

Despite this, people from an Asian ethnic background were significantly less likely to know their blood pressure and cholesterol readings, and those with diagnoses showed lower levels of confidence in managing and measuring their condition, and were more likely to face barriers in receiving their diagnosis.

People from White Other ethnic backgrounds were also in a worse position. They were less likely to know their blood pressure and cholesterol levels and felt less confident in self-managing their condition. They also faced more barriers to diagnosis and were less likely to think about their heart health in everyday life. Lastly, they were more likely to ask their friends and family than visit their GP or a pharmacist if they had concerns.

Those aged between 18-44 were also a concern, as they were more likely to experience symptoms and be diagnosed in hospital rather than by a GP or practice nurse. They were also more likely to face barriers to diagnosis and have concerns about speaking to a healthcare professional about their heart health, and less likely to prioritise their heart health in their everyday activities.

Finally, men were another group in which greater consideration is needed. Men with a diagnosis were more likely to be diagnosed by a hospital doctor, and were less likely to know their blood pressure levels. Men without a diagnosis were significantly less likely to consider their heart health in their everyday choices, and were less likely to have interacted with a healthcare professional, despite being at a greater risk of developing heart disease.

Whilst these findings indicate good knowledge and understanding around heart health across Hertfordshire, they also highlight key areas for continued improvements. There are particular demographic groups which need targeted attention to ensure that they are receiving the appropriate information, support and care from primary care services.

Recommendations

Based on the findings outlined in this report, it is recommended at the Hertfordshire and West Essex Primary Care Board takes forward the following recommendations.

Signs and Symptoms

1. Increase awareness of the signs and symptoms of heart disease and its high-risk conditions.

2. Encourage residents to consider their heart health in their everyday choices, with a particular focus on supporting men, those aged 18-44, people with less disposable income, and people from White Other ethnic backgrounds.

Risk Factors

3. Highlight the importance of age, gender and ethnic background as key risk factors, particularly to those they impact.

4. Increase understanding of the risk factors associated with heart disease, particularly amongst men and people from White Other ethnic backgrounds.

Monitoring and Management

5. Promote opportunities for people to monitor their heart health outside of their GP practice, particularly emphasising the role of pharmacists.

6. Ensure residents feel confident in using at-home monitoring equipment.

7. Ensure residents are aware of their "ABC" numbers (atrial fibrillation, blood pressure and cholesterol).

Support

8. Ensure people with a diagnosis feel confident in self-managing their condition, with a particular focus on improving confidence amongst those aged over 65, people who identify as White Other, people from an Asian ethnic background, and those with less disposable income.

9. Ensure people with a diagnosis are routinely monitored and given sufficient information and support to self-manage their condition.

10. Consider increasing emphasis on, and support with lifestyle changes in addition to medication, for example exercise and dietary advice or referrals.

11. Strongly encourage residents to take up their NHS Health Checks as soon as they are eligible, and ensure practice staff are aware of this entitlement.

Health Inequalities

12. Further investigate the inequalities in diagnosis and management amongst different demographic groups.

13. Consider targeted interventions and engagement with particular demographic groups, including men, people of an Asian ethnic background, people of White Other ethnic backgrounds, those with less disposable income and those aged 18-44.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*		☐		
	NHS HWE ICB Primary Care Board meeting held in Public			**Meeting Date:**	**27/7/2023**		
Report Title:	**Access to health and care, including self-care, for adults with a learning disability**			**Agenda Item:**	**10.2**		
Report Author(s):	Sara Poole-Information and Guidance Officer-Healthwatch Essex						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	N/A						
Executive Summary:	Healthwatch Essex has been commissioned by the Hertfordshire and West Essex Integrated Care System (ICS) Primary Care Workstream to undertake a series of engagement projects. This report is focusing on-Access to health and care, including self-care, for adults with a learning disability-gathering feedback and lived experience. Key Findings: **Support** Adults with LD who still live with family can rely heavily on family members to manage their health appointments and medication. **Communication** Difficult to make a GP appointment via the phone. The 8am phoning process is not easy for many people with LD. This can increase feelings of anxiety. Medical professionals not talking directly to the patient with LD but to their carer or family member in face-to face appointments. Very disempowering. **Complex needs** Many adults with LD also have other health issues and numerous diagnoses. This can lead to families struggling to find the right services that meet the need of the person. **Consistency**							

	Having one point of contact for the adult and their support network can help to build relationships and confidence with a medical professional. This will also reduce the number of times that the persons situation/needs have be repeated.			
Recommendations:	To note the contents of the report			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	
	Quality Impact Assessment:	
	Data Protection Impact Assessment:	
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒

An Insight Into Health and Care Access, Including Self-Care, for Adults with a Learning Disability.

By Sara Poole
Healthwatch Essex Information & Guidance Officer
For Hertfordshire and West Essex Integrated Care Board
March-June 2023

Contents

1.0 Introduction

1.1 Healthwatch Essex

Healthwatch Essex is an independent charity which gathers and represents views about health and social care services in Essex. Our aim is to influence decision makers so that services are fit for purpose, effective and accessible, ultimately improving service user experience. We also provide an information service to help people access, understand, and navigate the health and social care system. One of the functions of a local Healthwatch under the Health and Social Care Act 2012, is the provision of an advice and information service to the public about accessing health and social care services and choice in relation to aspects of those services. This document was revised in July 2022 and the role of Healthwatch was further strengthen as a voice of the public with a role in ensuring lived experience was heard at the highest level.

The Healthwatch Essex Information and Guidance team are dedicated to capturing the health and social care experiences people in Essex are meeting daily. The team respond to enquiries relating to health and social care and are equipped through training, to offer specific information to the public or other professionals. The team are well placed to listen, reflect on and support people to share complex experiences such as the one's shared in this report.

1.2 Background

Healthwatch Essex were approached by Hertfordshire and West Essex ICB to undertake a series of projects focussing on the lived experiences of people in the area in relation to their health, care and wellbeing. Two projects are selected per calendar quarter for in depth engagement, with the production of a report based on this engagement. For this project, we set out to gather lived experiences of neurodiverse individuals in accessing primary care services.

1.3 Acknowledgements

Healthwatch Essex would like to thank all the members of the public and professionals who took part in this project through the survey and interviews. Our thanks are also made to those individuals who took the time to meet with us and share their personal, heartfelt and emotive stories.

1.4 Terminology

ASD - autism spectrum disorder.
Developmental Jargon Aphasia - specific language impairment.
DLD - Developmental Language Disorder.
HFT- a national charity providing services for people with learning disabilities.
ICB – Integrated Care Board.
Irlen syndrome – a perceptual processing disorder.

LD - Learning Disability.
PAH - Princess Alexandra Hospital.
PEDs - Personalised Eating Disorder Support.
SLT - Speech and Language Therapy.
Wolfson Centre - research centre focusing on reducing anxiety and depression in young people.
DWP-Department of Work and Pensions.

1.5 Disclaimer

Please note that this report relates to findings and observations carried out on specific dates and times, representing the views of those who contributed anonymously during the projects time frame. This report summarises themes from the responses collected and puts forward recommendations based on the experiences shared with Healthwatch Essex during this time.

2.0 Purpose

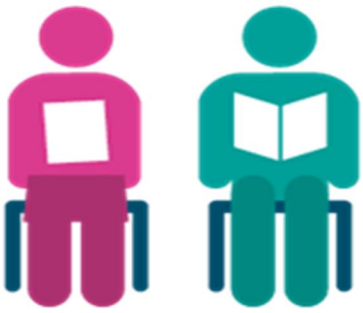
The aim of this project is to gather people's experiences of accessing and using primary care across west Essex. The focus was to gather feedback and lived experience from adults with Learning Disabilities and their carers/families and support workers.

2.1 Engagement methods

We connected with various organisations, including PACT for Autism, Families in Focus, Summit Services, Carers First, and ECL Day Centres to share details of our project and to share our Facebook page and website link requesting adults with LD, their carers, families and support workers for their feedback and lived experience regarding primary healthcare services. We also shared this request to numerous local Facebook groups in the west Essex footprint. The Facebook posts reached over 25,000 residents across this area.

Focus Groups

Group meetings were arranged in different settings to garner discussion and feedback.



Healthwatch Essex attended a local LD support group and talked to them about the project. There were sixteen adults ranging from aged 18-55 years old with LD and their support workers in attendance. The group were doing some arts and crafts when I arrived, they were colouring and drawing pictures for the upcoming coronation celebrations. The group also sat and ate a lunch together which had been prepared for them. One of the support workers introduced me and I explained who I was and why I wanted to talk to them. The feedback was varied:

'It's difficult to make a GP appoint at 8am. I suffer from anxiety, and I find this process very overwhelming and difficult to deal with.'

'I make my own appointments, but I tell my mum, so she is aware.'

'I attend my GP appointments with my mum as she is my carer but I get really upset when the doctor talks to her and not to me. It makes me feel like I don't exist.'

'I attend my annual health check and the doctor checks my blood pressure, sugar levels, heart rate, height and weight.'

'The light at the dentist can be too bright, and this is uncomfortable for me.'

'My mum orders my medication from the NHS app.'

'My parents help me with all my medical appointments.'

'I live in a house where I have a support worker from 8am-8pm every day. I make all my own doctors' appointments.'

'I am dyslexic and would find it easier to read forms/information/letters that are printed on yellow paper or have a yellow film available for me to use.'

'I don't go to my annual health check.'

This was the first time that I had met this group so some of them were shy and did not want to talk to me. Others were very comfortable and were happy to share their experiences. My main observation was how many of them relied on family members to assist them with their primary care needs. Many talked about how their parents are the

people who make their appointments and manage any medication they need but that they also need to be recognised as individuals themselves and not just someone who is cared for.

Interviews

Individual interviews were conducted to collect personal stories. All participants gave their consent to have their interviews recorded. Participants were willing for their experiences to be shared within this report, however, to ensure their anonymity and confidentiality of information they provided, all names used are pseudonyms to protect identities.

Mary-Ann*

Mary-Ann has two adult children. She has a son who is twenty-two years and was diagnosed at thirteen years old with ASD and LD. He also has a rare Lymphatic condition which affects one of his legs.

She also has a daughter who is nineteen years old and was diagnosed with ASD at eighteen years old (there was a three year wait for an NHS assessment, so the family chose to have a private assessment). She also suffers from Diabetes and Anorexia. She is currently an in-patient at an eating disorder unit in East Anglia.

'My daughter actually agreed to go to hospital because she had lost so much weight since December, but that was before her nineteenth birthday, so she was still eighteen. So, we had a really rocky road with her for the last year and a half, two years since she went into sixth form. Our journey with GPs, and in actual fact, not necessarily just with the GPs, but actually with the mental health service, has been absolutely appalling. First of all, two years ago the diabetic team said they wanted her to go to the eating disorder clinic. She agreed to go and see them down in Chelmsford for the PEDs. They said she didn't have an eating disorder and said that it was all in her head and discharged her, which I actually think is totally appalling.

So that was one thing, not recognising her illness and then telling us it was all in her head and then we were bashing backwards and forwards. And of course, because of that being said, she felt that she had to prove a point. Children with ASD who are very high functioning will want to prove a point sometimes. So, she proved even more, and her anxiety got really, really high to the extent that she needed to be admitted. So, we were

really let down by that service 100%. We then had to change GPs; we're on the border of West Essex and Redbridge. We live right on the border so our GP who is amazing is just on the border as well. The GP takes both West Essex and Redbridge patients. We've always had her care in West Essex; for her diabetes and everything, she was under PAH. She's now transferred over to Guys and Tommy's. That's only been a recent thing since Christmas around the same time as she was admitted. Saying that, they were really good but as soon as we said that we needed some support and her mental health was going down and they referred her into a crisis team because she was just crying and feeling overwhelmed with everything, we had someone come into the house from Redbridge, they came to the house and they said, this is what we can offer. The next day they came in and said, "I'm really sorry we can't offer you anything because you live in West Essex.'

Then of course our daughter, not knowing then that she was ASD even though we had known she had traits, of course she felt rejected. So, she'd been rejected twice, so that helped sent her mental health down more. Even coming into the house saying we can offer you this, then the next day coming back and saying, well really sorry, we can't offer you any services at all, so you just have to get on with it, is totally inappropriate. Out of all of this, it needs to be recognised that if you've got anyone who has a mental health problem, who is asking for help, it doesn't matter where you are based, you do not go into a house and say anything like that, especially to the person with a mental health problem. So, after that we had to then change GPs, as you can imagine that's been quite a difficult task. I'm quite lucky, I'm very knowledgeable of things. My background is such that I work with GPs sometimes. So, I work with multi agencies in the NHS, so I'm very lucky I can access things quite quickly and I know my pathways. 99% of people don't, and they've been struggling even more than I did. I did get a GP in West Essex after fighting and putting my foot down, but though then you only get support once a week. That is not going to be conducive to someone who's in crisis.

They focused on her anxiety and that was it, they didn't look at the eating part initially. We had a six-week programme of them coming in once a day initially because she was that unwell. They'd only come in for an hour, but she just closed down, she wouldn't talk to them. So, it was a bit of a losing battle to be honest. We then got discharged from them because they said there was nothing else they could do and of course, six weeks later she crashed and burned and was referred back to them. They decided then that it was an eating disorder. Oh, after a year, after we'd already said this is an eating disorder, they finally agree. So, then the eating disorder team came in lovely, they sent a lovely person, but they don't have the resources. In the meantime, we had got her diagnosed with her ASD, although it was privately done. She's in this unit now and we have been told that the piece of paper we have had done for the ASD assessment is not worth it because it's private. So now, a child who's still a very young person even though she's meant to be in adult services, has been told she can't have any of the services she needs locally because her ASD assessment that we were told by the NHS to get because there's a three year waiting list, we found the raised the money to get it done and they're not cheap, we've been told it's not worth the piece of paper it's on and that she ha' to have an NHS 'ne.

We will get through this, and I will find ways to help her so she can come out of where she is and get the right care she needs. But to go through what we've been through, it's broken the whole of our family, but it's not just once we've had it twice.'

Mary-Ann then talked about their experience with their son.

‘The first time was with our son when he was thirteen, he tried to take his life and then they took it seriously after me going backwards and forwards, backwards and forwards to the GP. He got a scholarship to the school he went to. He’s a bright kid, he dropped out of school at fourteen. He’s a really caring, loving person and he is really hardworking. He did decide he wanted to go into catering, and he got himself a place at college. He’s done the course; he got a distinction so he can do it. Although now his leg is causing problems, which is another setback because even though we haven’t declared it, it is a disability. When he bleeds, oh my God, he saturated the whole kitchen. It pulsates out when his leg starts to bleed so it’s hindering him from his work. So, they were quite good, and they did put things in place but of course if you’re catering, you do have to stand up the whole time. His experience with mental health services has been very poor. He can see when his anxiety’s high, but he doesn’t know how to deal with it because he’s got no one to support him to deal with it. And he’s been left to flounder. I do think it’s pretty disgusting.

I have to manage all his medical matters. Hopefully when he is 25, he’ll probably be a lot more able to do a lot of these things. But as we all know with ASD, that it’s a lot slower and especially if you’ve had some anxiety and problems, he still needs guiding a lot. A lot of reminding and I still need to do all the appointments for him; he’ll take the phone calls and then he’ll miss the crucial part, so I have to double check. He’ll sort out things like his medication but I’m normally the one who’ll make sure that the repeat prescription is done, I’m just about to change it over so that he can do it, but I think it will still be very hit and miss. It’s like my daughter, I still manage all her diabetic medication and everything. Get it delivered here and then I take to her.’

It’s just looking at ways differently; how can other people be helped so they don’t go through what our family have been through. They fall through the cracks; they fall through the network and then they have to be picked up. I know this sounds awful, but then it’s more of a financial burden on the NHS and for the services and for the general public. If we can get them early enough and sort this out and make sure there a clear pathway, it would be absolutely amazing. It does need to be a clear pathway but also there needs to be the resources initially, and I know people don’t always want to be the carers or the support workers because they say that it’s financially not worthwhile. But actually, that’s what we need, we need more mental health nurses and doctors, and we need definitely more on the eating disorder side, as they really lack resources.

I found out from a meeting that a third of Anorexia sufferers actually have ASD traits and are diagnosed eventually with ASD. So, if you are looking at that as even a starter, why isn’t there a specific pathway for that population? That’s still a massive population in that cohort. So, if people know this, why hasn’t this been looked at further and why isn’t there a certain care pathway to get them on the right path earlier? I know we had the added complication of a type one diabetic as well which was even more scary as you can imagine, but even then, people didn’t still jump until it was nearly too late. And that was with me jumping up and down every day.’

I asked Mary-Ann how well the different health teams worked together for her daughter due to her complex needs, including ASD, Diabetes etc.

‘So, that’s very interesting actually. The place where she’s gone is an eating disorder place, it is voluntary, but it’s got a really, really good name for itself. And actually, for the normal Anorexic pathway, it’s amazing. They are learning very quickly that my

daughter is materialising to be a full-blown ASD person. Whereas initially they weren't listening to me saying, "This is what works best with your daughter." They're now coming back and saying, "Actually we should have done what you advised." But at least they are now looking for help for the ASD pathway.

I really think that the eating disorder team in Chelmsford for children needs to be called to account and re-evaluated as their service is absolutely appalling. Maybe it might not be had they got enough resources, but actually, I don't think my daughter would be nearly as bad if she hadn't plucked up the courage to go and see someone to get help and then to be told in a meeting that it's not an eating disorder, this is all in your head. It's not acceptable at all and it really needs to be highlighted that that service has failed. It failed a seventeen-year-old.

The other thing I'll say 's that you need continuity. So, they need to have at least three regular people, not a different person every single time. I know the resources are really minimal. I know people don't want to do the job and I can understand why they don't want to do the job. But if we're going to have it so it helps, that's what you need.'

I then asked Mary-Ann what support she has.

'Why would I get support? Come off it! I talk to my family; I've got my sister. I have my husband around, but he has mental health problems as well. So, I'm supporting him at the moment as well.'

Shirley*

'If anything happens to me, she has nothing.'

Shirley has a 31-year-old daughter, Amy, who has a Severe Developmental Language Disorder and numerous other health issues.

The local LD service has told Shirley that Amy does not meet their remit. Amy is also Autistic and has developmental jargon aphasia and dyslexia.

'Amy tries to live independently but currently has no carers; this service fell apart during the covid pandemic. She does have a LD social worker, but I have found that many professionals lack understanding or knowledge about her condition and how it affects her being able to do daily tasks. Amy has complex needs; she lacks insight, lacks stamina, she doesn't really understand what's going on in the world. What you see isn't what you get with her, she is a crowd pleaser and will say yes to everything even though she doesn't understand what she is saying yes to.

I must make and attend all her GP appointments, I then have to debrief her afterwards, so she understands what happened during the appointment. All her medication is in Dossett boxes. I try to remind her what she needs to do but she sees it as nagging. Reminders are sent to her for eye tests, but these can get missed if I am not aware of them. Amy does not have an annual health check.

She also has lots of anxiety issues; she was seeing the mental health team where she used to live but not where she currently lives. She was told to phone the Samaritans if she needed help, but this is not an option due to her language disorder. I have not been able

to access any speech or language services for her, the GP has also tried but with no success.

This is some information from her Neuropsychological report. Her ability to hold onto heard information is low, her vocabulary is extremely limited, and she has difficulty generating the abstract relationship between words. The most striking aspect of Amy's performance was her difficulty with language tasks. Her ability to name objects is very poor though she does much better with familiar than unfamiliar objects. She has difficulty with the production of complex phonology which affects the level of complexity of her utterances. Her speech tends to be more comprehensible the shorter it is. This profile is characteristic of a specific language impairment (SLI), a developmental disability that selectively affects language especially. This is not usually classified as a learning disability because of the fact that performance on non-language tasks is often within normal limits. However, it is a learning disability in fact because overall education and the ability to function normally in many aspects of function in daily life are adversely affected by the poor language competence of these patients.

Unfortunately, I have had to deal with a couple of outbursts from Amy about situations that have caused her distress (anxiety and anger causes her language skills to drop) and it has taken all my energy to pull her out of a spiral of decline in order for her to function. Plus, chasing and asking HFT to contact the social worker for questions to give Amy time to think about what will be asked and formulate her answers for her up and coming meeting with social care, has taken up a lot of time. Of course, this has had a huge impact on my current health, which isn't good at the moment, and I have to schedule time to rest to recuperate.

I have two reports from the SLT and the neurologist regarding Amy's condition. When I asked the GP about a referral, they completed one for SLT; he stated it was sitting on a manager's desk but so far, we have not heard from anyone. This referral was primarily to ensure the social worker understood what and how Amy's language impacted function, as all the social workers so far, do not understand developmental language disorder nor female autism. HFT chased this up but was told that all SLT's are being used for swallowing difficulties.

Just to help you a little about the extent of Amy's language problems; she has damage with receptive, expressive speech, auditory processing disorder, word finding difficulties and working memory problems as well. We were also told by Professor Vargha-Khadem that she has lesions all over the brain and it has had an impact on neurological plasticity. Lucy's language disorder is unique, which is why we were catapulted to the Wolfson Centre when we eventually found a paediatrician who was interested and mainly had professors involved with her healthcare. Local services were not really involved, as it was beyond their knowledge, but DLD is not unusual, it is just ignored.

I have her last school report and her initial social care report when she left school that are particularly insightful and a vast range of other reports detailing anxiety disorder, dyslexia, Irlen syndrome, dyspraxia, Autism (late diagnosis) and development jargon aphasia to name but a few, if needed. Sadly, we are still uncovering healthcare problems and arguing for her to be diagnosed, with the latest being a problem with the HPA axis.

I hope this helps you to understand a little about my daughter, she is certainly not for the faint hearted, which is why we struggle with services.'

Darren*

Darren has three adult children who have a combination of LD, ASD and other medical conditions.

'My son needs 24-hour care and support; he hasn't been in any sort of education or training for over three years now. A place was found for him to attend college, but I would have had to pay for a private taxi to get him there and back which was unaffordable. I am unable to work myself at the moment due to my own health issues. He is unable to attend benefit interviews on his own, he doesn't understand what is happening and I have to speak for him. This makes the process really difficult and stressful for both of us. He will never be able to hold down a 'normal' job so why do we have to attend face to face interviews with DWP. The staff do not know how to communicate with him, so it's all left up to me.

He can't cope with going to the dentist, having any sort of equipment coming towards him really freaks him out. Going to the GP is also difficult, the environment is too busy and noisy, it overwhelms him, and he becomes difficult to manage. Why can't GP's have 'quiet' times like cinemas and supermarkets? He has never been offered an annual health check.

My other two children are able to work but still need a certain amount of support. They have had no input from any sort of adult services regarding their LD.'

Chris*

Chris has LD and is Autistic.

'I can't access care from my GP because you can only use the phone and I have anxiety, non-speaking episodes and audio processing difficulties. When I have attended the practice there are no accommodations for my sensory difficulties on offer and I am close to meltdown by being kept waiting in a busy, bright, noisy waiting room for long periods of time. A GP at my practice glanced at my diagnoses and said, "oh to look at you, you wouldn't think you had all these problems, you just look normal." I could go on but basically GP services are inaccessible.'

3.0 Key Findings and Recommendations

The main observation from our period of engagement was how many adults with LD rely on family members/carers to manage their health appointments and medication. Many need that level of support to monitor, make and attend appointments when required. This puts pressure on family members/carers to remember when health checks etc are due and to make sure that their loved one is prepared, understands why these checks need to be done and what the process is. This alone can take a great deal of time to explain and prepare for. GP's surgeries can be noisy and too busy for some adults with LD to cope with. This can be a barrier for them attending annual health checks. The process of phoning a GP surgery at 8am to try and make an appointment can also be a barrier for accessing primary care. Many people stated that this process was overwhelming and caused anxiety. Some people had carers who came in at certain times during the morning so were not always able to be there to make a phone call at 8am. Again, this could take days before an appointment was finally made. Talking to the person who the face-to-face appointment is for is vital for them not to feel excluded, one participant said that when the GP talks to his mum and not him during his appointment it made him feel like he didn't exist.

Routine dental and optician appointments were sometimes missed due to inappropriate communication. Some services dealt with the adult with LD directly and this led to appointments being missed and checks becoming overdue.

Some adults are able and confident enough to manage their own medical appointments with little or no support from family/support workers.

Adults with LD and other health conditions, such as ASD, speech and language conditions etc have struggled to access appropriate services, and often the combined issues have not been dealt with in an holistic manner and this had led to family/carers not being able to access what is required for their loved one. This has meant that other family members, usually parents are left to deal with the situation on their own with limited support/advice. The fight to find the right services puts immense pressure on an already stressful situation. Mental health services were highlighted as being inadequate to meet the needs of people with LD, it was difficult to access these services and then people were often discharged without any treatment and being told that there was nothing they could do for them. As one individual told us, 'Trying to get mental health support for someone with a learning disability is quite disgraceful, I am a carer and cannot get the help needed.'

Recommendations:

- An inclusive communications drive to promote annual health checks, dental and eye check-ups. Using social media, easy read documents, short videos and letters to adults with LD and their families/carers. Links to some useful examples: https://www.england.nhs.uk/learning-disabilities/improving-health/annual-health-checks/

  AHC Easy Read Guide Final.pdf (mencap.org.uk)

- Ensuring that correct contact information is on the GP learning disability register; is the adult with LD able to be communicated with directly or does it need to go via a family member or caregiver? Is it the correct form of communication that they can access and understand, phone calls, letters, text messages, is it up to date etc.

- Explore the possibility of LD friendly/appropriate GP session times with reduced noise levels, less people in the waiting room etc. Does the person need a double appointment to make sure there is time available in case they struggle with the situation and need extra time to adjust so the appointment is productive?

- Having one point of contact for the adult and their support network will help to build a relationship and confidence with a medical professional. This will also reduce the number of times that the persons situation/needs have be repeated.

- Focused training for frontline staff-receptionists as well as medical staff to raise awareness and understanding of people with LD and their needs. Taking the time to listen and understand that what could look/feel like poor behaviour could be frustration at not being understood.

- Examples of good practise as highlighted in the Healthwatch Essex Part of Understanding Inequalities: Co-Designing accessibility to health services in Mid and South Essex.

Our engagement and initial scoping activities highlighted existing projects, in other localities, that have improved support for patients with learning disabilities. Examples of these initiatives include:

Queensway Surgery, Southend: A practitioner there has led the way in promoting best practice when caring for patients with learning disabilities. She has a strong understanding

of how to communicate with patients, improving the uptake of annual health checks and earning the practice more income as a result.

Thurrock Health Centre has developed a 'Learning Disability Mission Statement' that showcases their 'philosophy of care' for patients living with learning disabilities. The statement, which can be found here, expresses the Health Centre's commitment to enhancing staff awareness about learning disabilities. Staff aim to work as a team with patients, families and carers to provide patients 'the best individualised care, whilst maintaining their dignity, privacy and freedom of choice'. The Learning Disability Co-ordinator at Thurrock Health Centre is Michelle Webb.

Purple All Star Strategy was established by Hertfordshire County Council and the University of Hertfordshire's Business School in 2014. The Purple All Star is a trademark given to GP Practices in Hertfordshire that demonstrate a commitment to bridging the health inequalities gap faced by people with learning disabilities and taking steps to ensure equitable health outcomes. GPs are supported by the scheme to achieve and maintain the standard. There are currently thirty accredited surgeries in Hertfordshire that have fulfilled 15 criteria areas, including having a learning disability champion, using the learning disability register, and displaying evidence of good practice, including strong annual health check performance.

Martin Hill, Louise McKay, Charles Theisinger, Yasmin Ellis, Alex Fletcher, and Joanne Tyler, 'Improving the quality of Learning Disability Annual Health Checks' (Mid and South Essex Health and Care Partnership, 2020): This quality improvement project aimed to understand the quality of Annual Health Checks being conducted in West Central PCN in Southend; responding to a lack of available data on the quality of checks being completed in mid and south Essex. The project provided recommendations for how Annual Health Checks should be promoted to the public. The authors called for GP surgeries to adopt communication that was specific and sensitive to individual patients. Seeking to promote and complete the health checks en masse served to depersonalise the process and alienate prospective patients.

The project aimed to increase the number of Annual Health Checks completed in the West Central PCN. They also recorded how the checks were conducted with individual patients; measuring whether GPs were completing all key elements of the check. One of the authors later noted that GPs completing checks would sometimes overlook questions about sexual health, therefore reinforcing the stigmatising assumption that people with learning disabilities do not engage in sexual activities. The authors also designed an audit tool that identified good practice, enabled monitoring of progress, and established whether support for patients with learning disabilities was consistent across a geographical area. There was little information, however, on how to successfully engage with and support patients with learning disabilities during the health check itself.'

4.0 Conclusion

Even though the engagement for this project was somewhat lower than anticipated, it is important to value and recognise the lived experience and feedback that was gathered.

Due to the complex needs of many of the people I spoke to, remembering to attend routine health checks was one of many 'jobs' that needed doing and were often put on the back burner while day-to-day life needed to be dealt with.

The people who did attend their annual health check generally said it was a positive experience and understood why they went.

Ensuring that adults with LD are treated with respect and understanding is the key to building a positive relationship so they are more willing to attend routine health checks and have a positive experience. All staff involved in the process of encouraging adults with LD to attend regular health checks need some knowledge and understanding of that individual's situation and support network makeup so effective communication is implemented.

This project highlighted how complex the needs of some adults with LD can be, this means a number of health professional can be involved in their care which can lead to confusion and uncertainty regarding who is leading which aspects of their care. There can be a high turnover of consultants/social workers/care staff etc which can also lead to confusion when people are trying to contact the people who are meant to be supporting them. Multi agency and team working is vitally important in this situation to ensure continuity of care is delivered and that person receives all the services that they require to live a full and healthy life.

Access to appropriate mental health services was also highlighted as many family members stated that their loved one was often discharged by mental health teams as they didn't meet their remit. This leaves already venerable people in limbo with no access to support. Carers support is also a vital part of making sure the network around the adult with LD is as stable as it can be. Identifying carers and asking them what help/support they may need is extremely important.

Taking ideas and learning from good practise in neighbouring ICB's/ICS's will help towards developing a plan which is effective and delivers consistent long-term results.

Healthwatch Hertfordshire and Essex: Access to Health and Care for Adults with a Learning Disability

Explored experiences of accessing primary healthcare for adults with LD:

- **Residents living in west Essex**

Key Findings:

Support

- Adults with LD who still live with family can rely heavily on family members to manage their health appointments and medication.
- Some adults are able and confident enough to manage their own medical appointments with little or no support from family/support workers.

Communication

- Difficult to make a GP appointment via the phone. The 8am phoning process is not easy for many people with LD. This can increase feelings of anxiety.
- Medical professionals not talking directly to the patient with LD but to their carer or family member in face-to-face appointments. Very disempowering.

Complex needs

- Many adults with LD also have other health issues and numerous diagnoses etc. This can lead to families struggling to find the right services that meet the need of the person.

Consistency

- Having one point of contact for the adult and their support network can help to build relationships and confidence with a medical professional. This will also reduce the number of times that the persons situation/needs have be repeated.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*		☐		
	NHS HWE ICB Primary Care Board Meeting held in Public			**Meeting Date:**	**27/7/2023**		
Report Title:	**COPD and other Respiratory Conditions in West Essex**			**Agenda Item:**	**10.2**		
Report Author(s):	Fergus Bird-Information and Guidance Officer-Healthwatch Essex						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☐
Report History:	N/A						

Executive Summary:

Healthwatch Essex has been commissioned by the Hertfordshire and West Essex Integrated Care System (ICS) Primary Care Workstream to undertake a series of engagement projects.

This report is focusing on-lived experiences of COPD and other respiratory condition in west Essex.

Key Findings:

Support

- Adults with LD who still live with family can rely heavily on family members to manage their health appointments and medication.
- Some adults are able and confident enough to manage their own medical appointments with little or no support from family/support workers.

Communication

- Difficult to make a GP appointment via the phone. The 8am phoning process is not easy for many people with LD. This can increase feelings of anxiety.
- Medical professionals not talking directly to the patient with LD but to their carer or family member in face-to-face appointments. Very disempowering.

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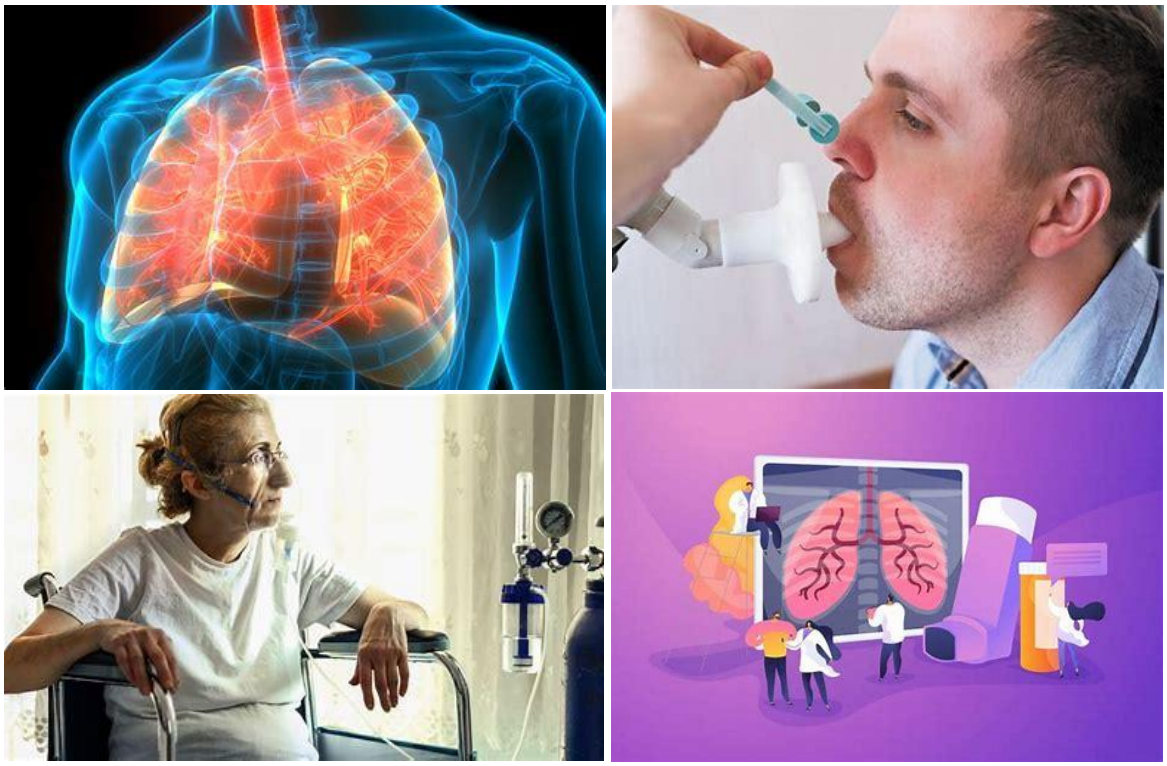
- Many adults with LD also have other health issues and numerous diagnoses etc. This can lead to families struggling to find the right services that meet the need of the person

Consistency

	• Having one point of contact for the adult and their support network can help to build relationships and confidence with a medical professional. This will also reduce the number of times that the persons situation/needs have be repeated.			
Recommendations:	To note the contents of the report			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☐

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	
	Quality Impact Assessment:	
	Data Protection Impact Assessment:	
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	☒
	Tackling inequalities in outcomes, experience and access	☒

Experiences of accessing treatment and support for COPD and other respiratory & lung conditions amongst people in West Essex



Produced by Healthwatch Essex
Fergus Bird
Information & Guidance Officer

April - June 2023

Contents

1.0 Introduction

1.1 Healthwatch Essex

Healthwatch Essex is an independent charity which gathers and represents views about health and social care services in Essex. Our aim is to influence decision makers so that services are fit for purpose, effective and accessible, ultimately improving service user experience.

One of the functions of a local Healthwatch under the Health and Social Care Act 2012, is the provision of an advice and information service to the public about accessing, understanding, and navigating health and social care services and their choices in relation to aspects of those services. This document was revised in July 2022 and the role of Healthwatch was further strengthen as a voice of the public with a role in ensuring lived experience was heard at the highest level.

The Healthwatch Essex Information and Guidance team are dedicated to capturing the health and social care experiences people in Essex are encountering daily. The team respond to enquiries relating to health and social care and are equipped through training, to offer specific information to the public or other professionals. The team are well placed to listen, reflect on and support people to share difficult experiences such as the one's shared in this report.

1.2 Topic Background

The NHS Long Term Plan identifies Chronic Obstructive Pulmonary Disease (COPD) and other respiratory conditions as a priority area.

Between them, respiratory conditions put a significant strain across primary and secondary care in the NHS. Unchecked, these long-term conditions take a stronger hold, and we see significant morbidity and mortality.

In 2019, the BMJ reported there were 1.3 million people with a diagnosis of COPD, an increase from under 1 million in 2000.

In terms of diagnosed cases, COPD is the second most common lung disease in the UK, after asthma. Around 2% of the whole population and 4.5% of all people aged over 40 live with diagnosed COPD. 115,000 people are diagnosed with COPD each year, equivalent to a new diagnosis every 5 minutes.

However, with a purposeful, integrated approach there are a number of high value interventions that can increase the wellbeing and prognosis of patients, while decreasing the burden on longer-term NHS care including GP visits and hospital appointments and admissions.

1.3 Acknowledgements

Healthwatch Essex would like to thank the hundreds of people who engaged with us, participated in this project, and completed the survey.

Our thanks are also made to those individuals who took the time to speak with us and share their personal stories. By gathering lived experience of their journey through symptoms, accessing healthcare professionals, referrals, diagnosis and ongoing care, this report can help shape a co-produced system that offers the best available pathway.

We would also like to thank our many partners, contacts, and networks who worked with us to share the project and survey throughout West Essex and help generate such a strong level of interest and feedback.

1.4 Disclaimer

Please note that this report relates to findings and observations carried out on specific dates and times, representing the views of those who contributed anonymously during the engagement period. This report summarises themes from the responses collected and puts forward recommendations based on the experiences shared with Healthwatch Essex during this time.

2.0 Purpose

According to Asthma & Lung UK statistics, the UK is among the top 20 countries for COPD mortality worldwide, so there is a clear disparity between where we are, and where we want to be.

This report has been designed to draw out the lived experience of our local population to identify real world issues, successes, and challenges. It is designed to provide a platform to help identify what's working well, what lessons can be learnt, and where improvements can be made.

For the NHS Long Term Plan to be successfully delivered, the areas for investment and the services commissioned need to be identified and developed around these shared lived experiences. The HWE ICB has committed to engaging and consulting with its people and communities through this process.

2.1 Engagement methods

Participants were contacted through the Healthwatch Essex website, through local West Essex based Facebook groups, the Healthwatch Essex newsletters, our own Facebook page, Instagram account and Tik-Tok. In-person outreach events and word of mouth also played an important role along with promotion of the project via our extensive networks.

Our partners, other organisations and working groups in West Essex, together with our volunteers and many individuals inside and outside of the NHS and ECC helped and supported our efforts to engage with and reach as many people throughout the area as possible.

They were engaged with in two ways:

Survey
A survey was created to gain perspective and insight from residents who have had experience of living with COPD and other respiratory conditions.

Interviews
Individual interviews were conducted to collect personal stories from members of the public. Interviews took place by telephone during April and May 2023 and all participants gave their consent to have their interviews recorded. Participants were willing for their experiences to be shared within this report, however, to ensure their anonymity and confidentiality of information they provided, all names used are pseudonyms to protect identities.

2.2 The survey

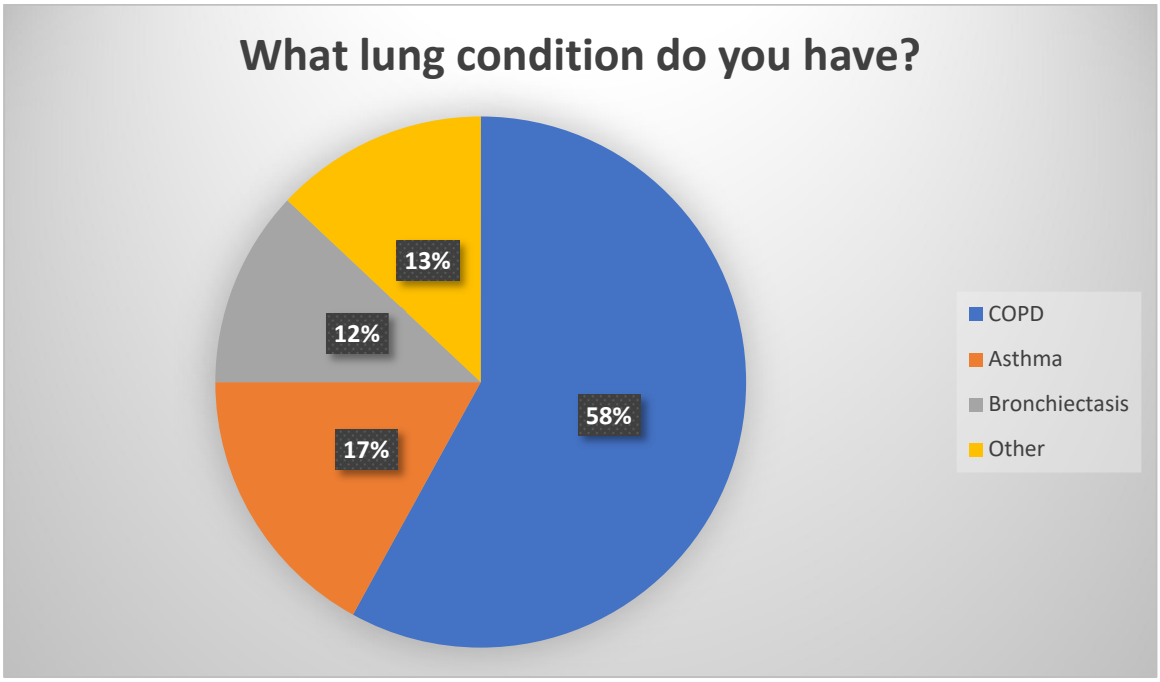
The survey consisted of ten core questions, mixing multiple choice questions and 'free text' information boxes enabling the participants to expand on their answers. There were an additional three demographic questions.

It was devised to encompass:

- The condition they have
- Their journey to diagnosis
- Ongoing reviews and treatments being offered
- Opportunities for self-management
- Impact on mental health

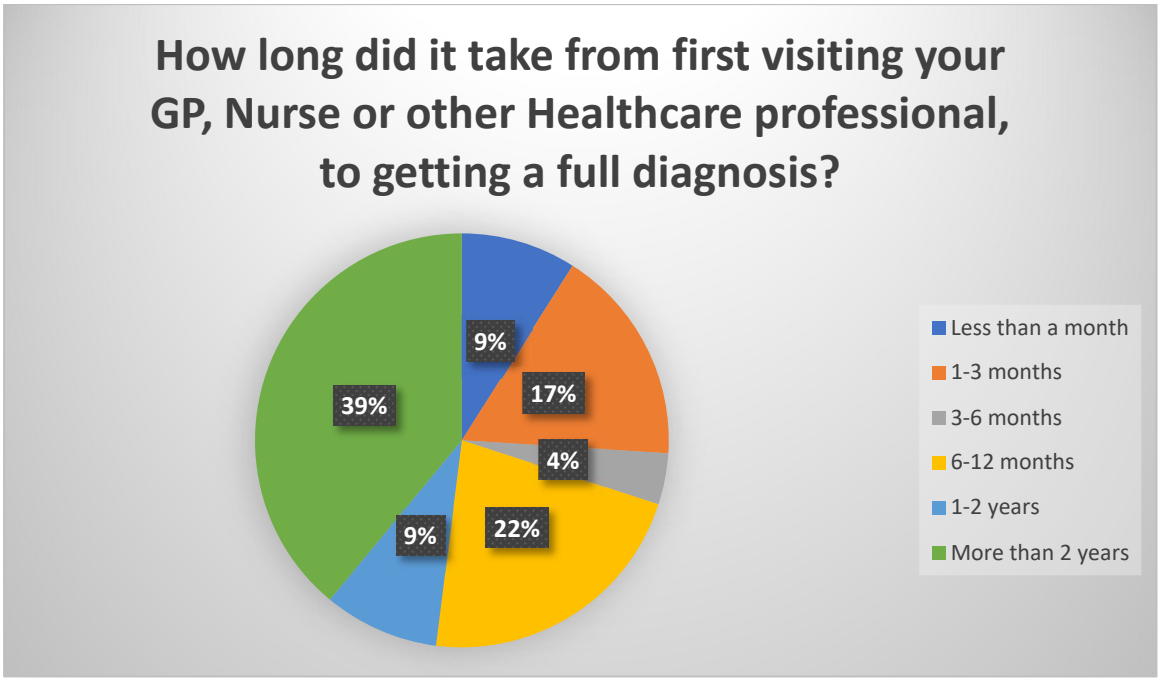
The survey was primarily in an online format but was also available to be printed off and filled out manually as required. The Information and Guidance (IAG) Team at Healthwatch Essex were also available if the survey needed to be completed in any other format, such as over the telephone. The questions, and responses received, are outline below.

The starting point was to establish what disease or condition they have been diagnosed with:



The emphasis of the survey was placed on COPD, with 58% of respondents diagnosed with the condition. However, it's important to take into account the lived experience of those with other respiratory, lung related illness.

In the next section, we delved further into their pathway to diagnosis. Firstly, we asked about the timescales, and then we asked people to tell us about their experience and what they went through:



The percentage of people who waited over two years is worrying, but timescales are purely statistical – it's the experience of the process that provides the insight and context.

A number of people referred to finding out they had previously been diagnosed with COPD but were not aware of their diagnosis at the time. If this were one incident, it could be easily dismissed and ignored, but there were numerous reports, for example:

'It came out of the blue one day when being examined by paramedics after being admitted to hospital. Upon arrival it was a shock when told "it's your COPD" it was in my records, but I had never been told about COPD, didn't know what it was or what it meant. Don't know how long it had been on the medical records or who diagnosed it and wrote it on there.'

'I was not told about the condition or prognosis in a timely manner. Subsequently found out the condition had been diagnosed some years before the referral to a specialist was made.'

'I am answering this on behalf of my late mother. She had COPD but was not informed until one occasion when she was admitted to hospital the doctor referred to it from her records and she had had it for several years! It was on her records, but she hadn't been informed before then. It was a shock. We had never heard of it so had to research it to understand what it was.'

Many feel that their symptoms were recognised, and their pathway was well managed, such as:

‘I first noticed a slight shortage of breath about ten years ago. The doctor sent me for a chest x-ray, and I was seen by a specialist at hospital who diagnosed COPD. It has got gradually worse over the years.’

‘I felt breathless when I walked and felt sick quickly, so I complained to my GP. We have damp in the home, and it effects my daily life condition and I have breathing problems. Thank God he listened and prescribed inhalers.’

‘It was over 15 years ago, so my memory is hazy. I thought I might have lung cancer because of a persistent dry cough. An X-ray immediately diagnosed COPD and care by a practice nurse began soon after.’

There were a wide variety of other experiences of the diagnosis road, a sample of which are below:

‘It was discovered during abdominal surgery.’

‘I had a cough that did not go away. I was eventually referred to a specialist who conducted a bronchoscopy.’

‘I gave up on the NHS. I paid for a private consultation who then did a referral. Once diagnosed, I was transferred into the NHS to manage.’

‘I had pneumonia and pleurisy at 40 years of age...I am now 58 and have suffered with chest infections ever since.... it’s a struggle every day.’

‘I visited my doctor after being taken to hospital unable to breathe. Visited my GP shortly after feeling breathless and very unwell. I was dismissed on two appointments. Fortunately, a nurse practitioner listened to me, looked at an X-ray I’d had two years previously and asked why this hadn’t been addressed. I had no knowledge of this until that moment. She took this further by arranging a blood test

and speaking to my doctor. From this CT scans were arranged and a large nodule along with scarring on the other lung were discovered.'

'I had several years of being told I had asthma and then brittle asthma before I was referred to a consultant who scanned and diagnosed bronchiectasis. Also, there was a lack of access to medication when I needed it as I was not prescribed antibiotics or steroids until an infection really took hold.'

'I was experiencing breathlessness and was red faced. I visited my GP and was eventually diagnosed.'

'I was diagnosed nearly 20 years ago following a number of visits to the GP. However, in the last ten years my asthma medication was changed when I changed surgeries because I moved, and in the last five years it's got progressively worse. I've had seven medications reviews and changes in as many months and I'm now waiting for a GP referral to the hospital respiratory team. I have had a year's wait for a heart referral and been told that I have chronic heart failure due to severe asthma. Other factors are also at play; I'm overweight and I have mild heart disease, but the asthma is difficult to control now and I'm borderline COPD.'

'I went to hospital, and I had a lot of tests and they told me I have heart failure following a diagnosis of pulmonary hypertension.'

'Last December/January, I had a COPD flare up at my daughter's house. She consulted her own doctor, who asked to see me. He prescribed antibiotics and steroids. I stayed immobile on my daughter's couch for nearly two weeks. The steroids were wonderful. I was not charged for my prescription, since I'm 78 years old. I had a totally positive experience with the NHS. Thank you.'

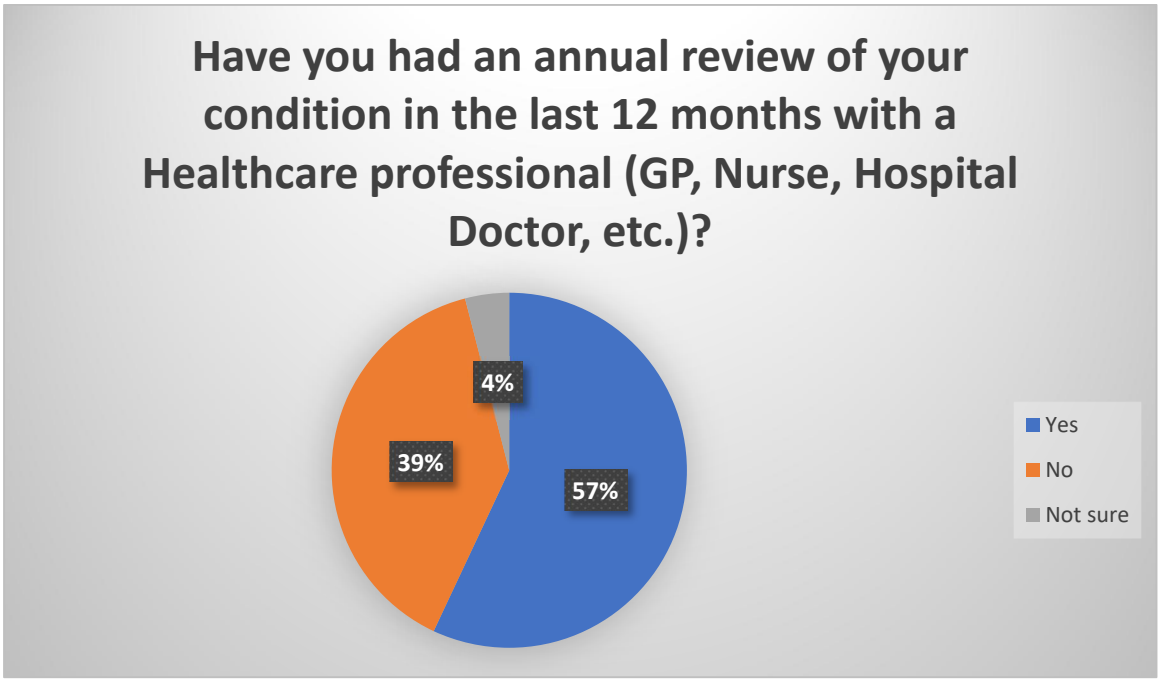
'I noticed I was getting short of breath when doing things.'

'I kept going to the GP with mucus plugs, but no infection showed.'

'I had chest infections and finally they decided further investigation was necessary. This happened very slowly, but I was eventually referred to hospital where I had a CT scan and a battery of tests from which the consultant diagnosed bronchiectasis.

She referred my care to the Respiratory team, who gave me a Pulmonary Rehabilitation course to teach me self-management.'

The next section of the report looks into people's current and ongoing care:



Nearly four out of ten people have not had a review of their condition in the last twelve months. This is clearly well below where it needs to be.

An overwhelming majority of people do not have a written self-management plan. The benefits of patients having a clear understanding of how to manage their condition are well established, so there is a clear and significant gap in service provision here.

We asked participants to tell us more about how they manager their condition, and what ongoing support they receive. A mix of their experiences are below:

'No ongoing support, I managed with Seretide and Salamol.'

'My condition is not well managed. My meds work first thing in morning once I take them, but I am constantly extremely breathless wheezing and coughing on any exertion during the day, every day. My chest becomes tight and sometimes painful, and I cannot get breath into me. It can last up to an hour; I take my salbutamol blue inhaler but it's taking longer each time to work.'

'I take a Trimbow inhaler, two puffs twice a day, this has enabled me to do without my Ventolin inhaler. I don't appear to get any ongoing support.'

'No support was provided.'

‘I always keep my inhalers with me and am taking my medicine, Montelukast and inhalers, on time.’

‘I received an inhaler.’

‘I take nebuliser fluids twice a day, Acapella twice a day, Carbocisteine three times a day plus Ventolin and Trimbow inhalers. I also have an annual asthma check and consultant appointment, and a rescue pack of antibiotics and steroids.’

‘I have a CPAP machine. I get one phone call a year to check is still working ok.’

‘I have an annual review with a hospital consultant, I regularly have to request additional asthma medication which is an issue. I have had to pay privately for an operation to improve breathing due to NHS delays etc, etc.’

‘I was told to stop smoking.’

‘I manage my condition with knowing what my body can handle physically. I attend yearly CT scans.’

‘I monitor my peak flows, avoid spaces where there are lots of germs (I wear a mask if needed). I have a rescue pack which I take if I get an infection...it took a long time to get this, and the consultant had to write to the GP twice as they wanted to give different medicines than he suggested.’

‘My mother suffered many flare ups and was given emergency prescriptions for antibiotics as she was familiar with the early signs of an infection. We also bought her her own nebuliser which reduced her need to be admitted to hospital on occasions.’

‘Since the Covid pandemic my GP practice ceased annual reviews for COPD - I have not had a spirometry test since 2018. Two years ago, I began to struggle with breathing and was referred to the Community Respiratory Team (based 14 miles from my home). The nurse there attempted by phone to assess my lung condition by

asking me to stand & sit repeatedly. As I had a badly injured my back, that was not possible. She sent a package of about 20+ exercises which I found difficult to stick with. When I started (private) physio for my back the CRT discharged me to my GP practice once more - since when I've heard nothing. I shall be asking for a review from them very soon.'

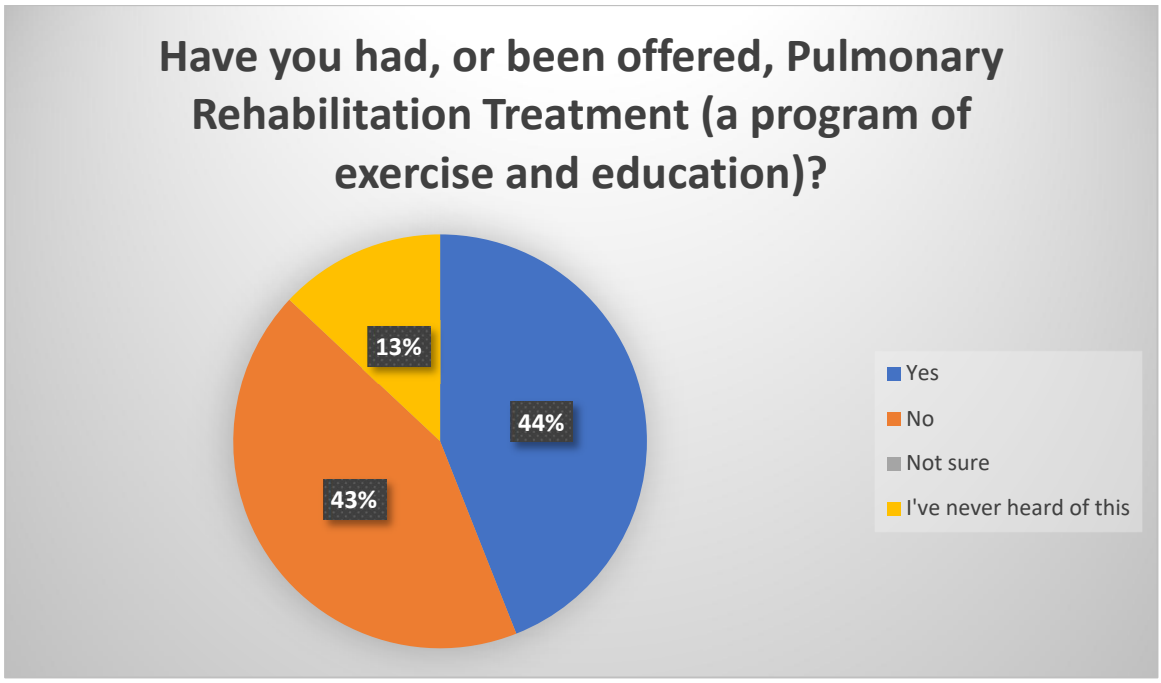
'I have 2 inhalers taken twice a day, Seretide and Eklira, plus Ventolin if I get very puffed out.'

'I see a consultant yearly. I have also seen a respiratory physio recently for the first time. I had to pay privately to see a consultant when first diagnosed as it was in the pandemic. A GP is mostly unavailable or involves a long-standing queue which I can't manage when I'm ill.'

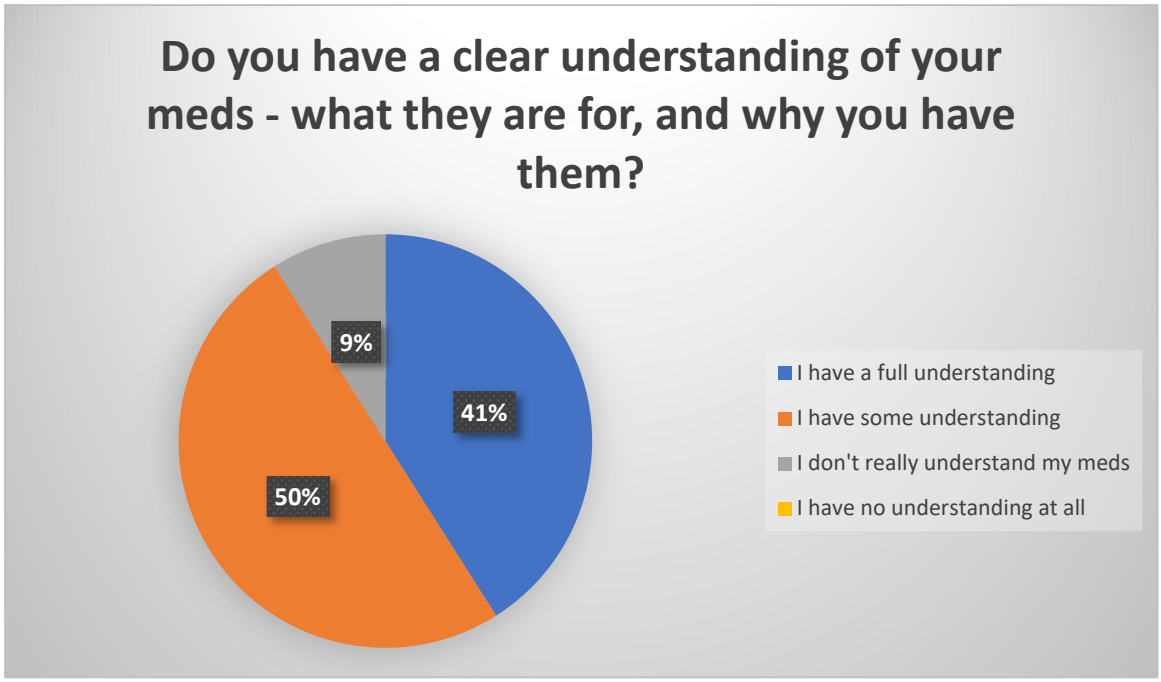
'I see my respiratory nurse annually and also can contact her if I have any problems.'

'I did have an asthma review recently at my GP surgery. I have been informed by one of the Respiratory team that my adult diagnosed asthma has in fact burnt out, but this news has evidently not reached the surgery. The reviewing nurse would not talk about bronchiectasis, but she did at least take my peak flow reading. I know the Respiratory Nurses are very busy, so I feel I should only contact them if I feel I have a real need. Bronchiectasis care involves a lot of self-management. At the moment I am coping and only deteriorating very slowly. I do daily breathing exercises, try to keep fit with Pilates and walking if the weather is suitable, and eat sensibly.'

The survey continued with:



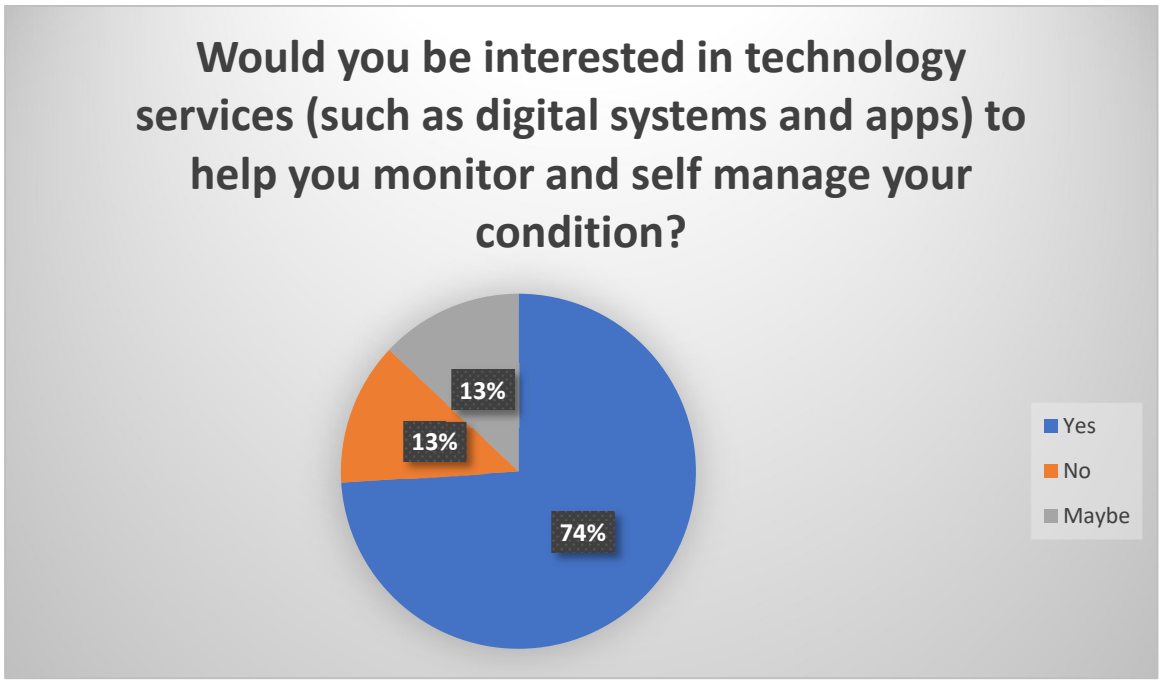
PR Treatment has been clearly identified and widely accepted as a program with significant ongoing benefits, but 56% of our participants haven't been offered it or aren't even aware of it.



To maintain and improve compliance, it's important that people are aware of the medications they are on, what they're for, and why they should take them. Over 90% of people have a full, or some understanding of what they're on. There's always

room for improvement to ensure as many people as possible are fully aware of what they're taking, but the statistics here are very positive.

We also asked about the possible use of technology.



Another very encouraging response that indicates significant opportunity as new technologies come on stream.

Finally, it was important to enquire about people's mental health, so we asked simply:

How would you say your mental health is impacted by your condition?

Here's some examples of what our respondents had to tell us:

'It has definitely impacted my mental health. I get anxious when I go out, not knowing whether I will be able to cope.'

'I have been slightly affected with unfounded fears. I also wake of a night and sometimes panic, and I have to sit up till I calm down and drift off to sleep again.'

‘I am mostly ok but constant infections are wearing and depressing.’

‘I am getting migraines too many times because of damp in my home. It triggers my asthma and I get lots of infection quickly. It’s very depressing.’

‘I spend too much time fretting.’

‘I still experience very poor sleep so am exhausted and stressed.’

‘I feel very low and depressed. There’s just no way out and it’s every day with no prospect of it ever getting better.’

‘I’m in good spirits and my mental health is unaffected.’

‘Mental health and physical health go hand in hand so not being able to do as much as I would like is depressing, so being aware at all times can be overwhelming.’

‘I get down at times as it limits me.’

‘Of course. Breathing difficulties and infections are very stressful/anxiety making.’

‘I feel afraid of my future.’

‘Okay, I’m tired mostly which can be quite upsetting.’

‘Currently mobility problems and general ageing changes affect me more. I do find a couple of breathing exercises quite useful when breathing 'tightens up'.’

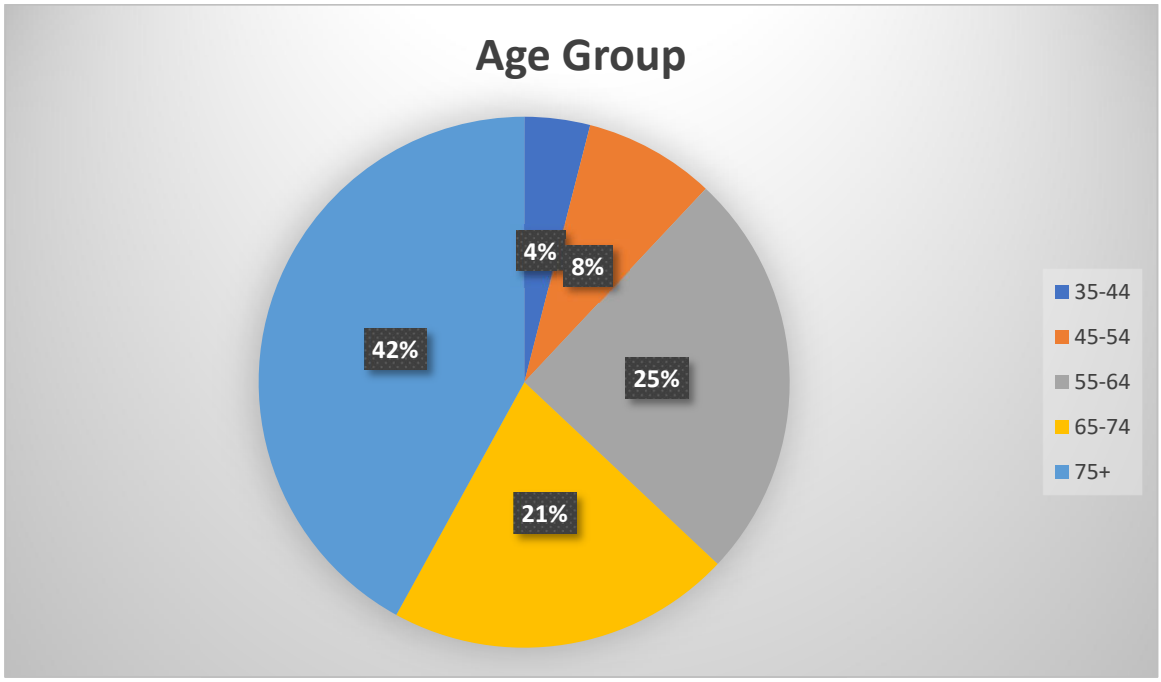
‘Not a lot, I just get a bit fed up when I have to stop and rest.’

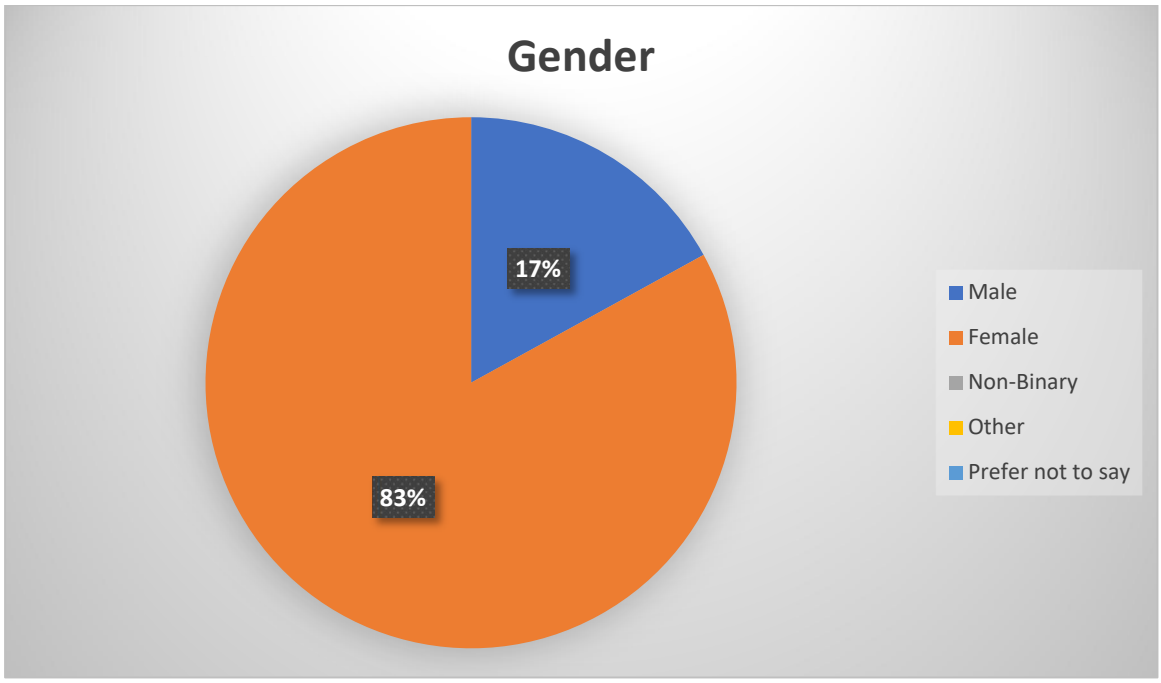
‘I feel like I have no quality of life anymore.’

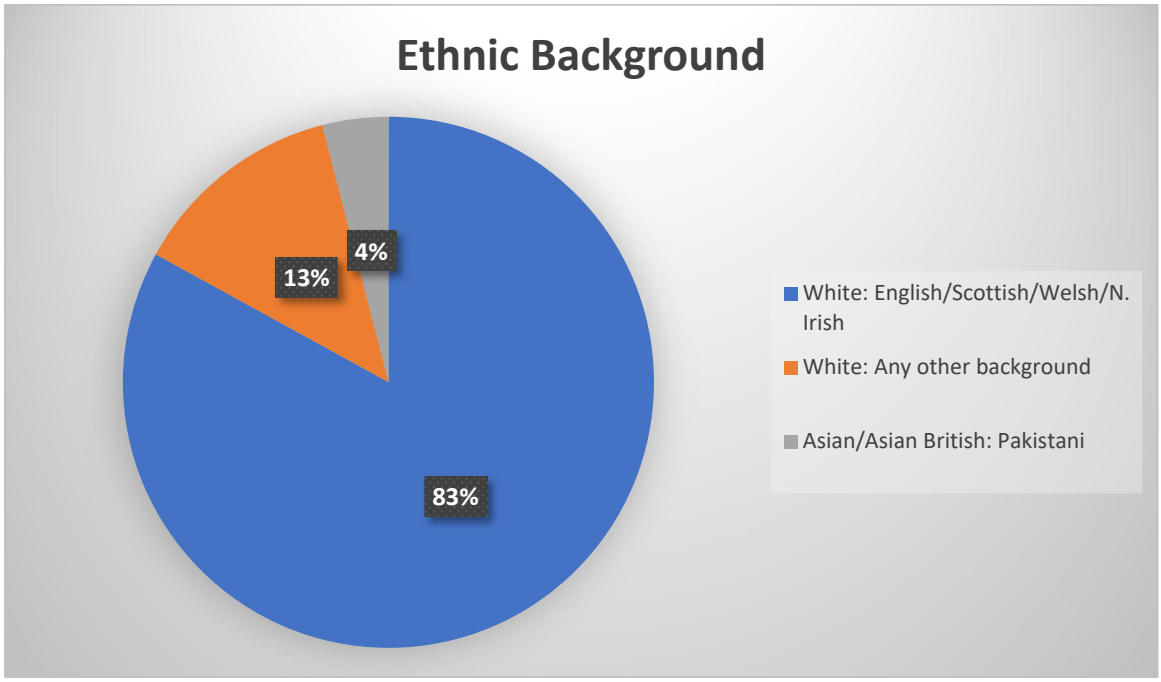
‘Yes inevitably, I feel very low, and I can’t get away from it.’

Demographics:

We asked respondents three demographic questions, focussing upon age, gender and ethnicity.







2.3 Interviews

Many people offered to talk to us directly and tell us about their stories in depth. We would like to thank everyone who took the time to talk to us and share their experiences, helping us to produce this report. From those that we have spoken to,

we would like to highlight three case studies reflecting the lived experience of people locally.

Case Study 1

Shirly* was diagnosed with COPD about 10 years ago.
'But it's only fairly recently that it's become a challenge. It's something that I sort of lived with fairly easily before.'

She's found the service from her GP has been significantly reduced since Covid.
'That's really been my main problems. With COVID, like everybody, they went over to telephone interviews. And the annual routine with the nurse, for people with COPD, asthma and possibly other conditions, that sort of broke down. And even when COVID was over, the GPs in West Essex stopped using spirometers, which means that there's no... you haven't got any exact sense of what's going on. Which has been one of my gripes really. And the other thing is that the arrangements for an annual review seem to have broken down.'

Without her knowledge, Shirly was referred to the Community Pulmonary team in Harlow.
'I had a phone call from them, a couple of phone calls. They tried to assess my lung capacity by asking me to stand and sit multiple times in a chair. Unfortunately, a couple of weeks before I'd had a bad fall, and I was physically in pain and not able to stand and sit with any sort of speed or repetition. So anyhow, they sent me sheets of papers with exercises. There are about 23 exercises, which just coming out of the blue and not very useful, quite frankly' ….. 'this document, obviously somebody had worked very hard to compile it, but it wasn't patient friendly at all.'
Shirly wasn't sure if she was doing the exercises correctly, but despite this, on the follow-up call, the nurse from the Pulmonary team said, *"I'll discharge you back to your GP"* and that was that.

The lack of face-to-face contact with anyone is also a significant worry for Shirly.
'I can see the benefit of telephone and video consultations for quite a lot of younger and middle-aged people who perhaps have flu or something that they need some help with, but not when it's complicated by other conditions.'
'...people in my age group, most of my friends are still alive. They're not even into mobile phones. I don't like my smartphone. I quite like my laptop, but quite a lot of my friends and age group don't even use computers. And yet the shift is so much over to digital.'

Following our conversation, Shirly was determined to contact her GP and insist on an appointment for an annual review, not only for her COPD, but for her general health. She monitors her blood pressure and oxygen levels at home but hasn't seen anyone in person since 2019.
'I shall get in touch with them and say, "Look, I'd like to come in person for a physical assessment."'

Case Study 2

Peter* has Bronchiectasis. He was diagnosed with asthma as a child, but then eight years ago he got a string of chest infections, and each time he was prescribed Amoxicillin, but it didn't work properly. Each infection just seemed to be worse.
'I had such a bad one, I think I could have died, quite honestly. I was absolutely full of phlegm and fever, not feeling very good at all. And my daughter insisted a doctor should come out, and the doctor who came out, he was one of the nice doctors at that surgery, and he told me I was very ill, gave me some antibiotics. I'm a bit surprised he didn't send me off to the hospital, but anyway, the antibiotics he gave me did the trick. It might well have been Doxycycline, which is sort of more or less the standard stronger one for people with that condition…'

At no point did any of the GPs talk to him about the possibility of any sort of other respiratory condition; it seems that they completely missed it. He was finally given a spirometry test, and subsequently referred to a respiratory consultant where he was finally diagnosed. This was 2019, four years after he started getting the chest infections.

It was still about five to six months before he was put on a pulmonary rehabilitation course though.
'It was extremely useful. There was a physiotherapist, and specialist respiratory nurses as well, and they were very good at informing you. It was to see how fit you were and to encourage you to believe that you could be more active if you weren't.'

Peter has had just one exacerbation since.
'One of the pulmonary nurses came out and she was really good and kind, this was during Covid, and she got the doctor to prescribe not only sort of an antibiotic to do with it then, but various things including an Aerobika, which worked absolutely wonderfully for me.'

However, at an asthma review, Peter had another bad experience and firmly believes there isn't enough knowledge about Bronchiectasis.
'In one of the asthma reviews, the man on the end of the telephone decided I'd be better off with a different inhaler. He changed me from the one I'd been taking for years to something new, which I believe is excellent for asthma, but it was

absolutely totally wrong for bronchiectasis, as I found out because it seemed to be worsened. The respiratory physiotherapist said, "No, that dries up the mucus, whereas in bronchiectasis, you need to cough it up." Totally the wrong thing. So, there is an awful lot of ignorance about bronchiectasis.'

He goes on to say:
'Well, I think really, more professionals need training in bronchiectasis. It is being, I think, more widely diagnosed because there are specialists who know it, but I feel that because I was palmed off by my surgery for several years, it has made my problems worse than they might have been.'

Although he's had a telephone review for his asthma, Peter hasn't had a review of his bronchiectasis since the end of Covid lockdowns.
'…not as regard to my bronchiectasis. And I'm beginning to wonder if I should phone the pulmonary rehab team and ask whether I should be getting a check. I think theoretically you get a check every year, but they're obviously very busy.'

Case Study 3

Like most people, Veronica's* journey to diagnosis started with her GP.
'I saw my GP loads, I kept going up there and saying, "Look, I'm coughing up these lumps of sticky sputum and, all the rest of it, sort of thing." And they said, "Oh yeah, it's nothing to worry about" or, "I can't hear anything with your breathing." But then of course, it obviously got progressively worse.'

Her first visit to hospital didn't go well.
'I had my day in hospital with all the tests, and then I was sent to respiratory where they did some more tests. I didn't see a consultant or anybody. There was just a letter to the GP saying, "You've got this and this, and this and this about breathing. I've told the GP to send you back if there's any more problems." So, I felt thoroughly dismissed. It was not okay.'

About six months later, following further flare-ups, Veronica finally saw a consultant and was diagnosed.
'The consultant was good, and answered all my questions'

She has an Oximeter at home, but has been offered little else, and was never told about a pulmonary rehabilitation course.
'Some days are horrible. Like yesterday was horrible. I coughed all day, couldn't stop. But today I'm quite good.'
'I do exercise. I go to yoga, et cetera, sort of thing, most weeks. So, if you like, I am exercising and I try and crawl. If it's a good day, I go, if it's a not very good day, I try and go, sort of thing, because there can be benefits.'

Veronica's life is complicated by the fact that she's a carer for her husband (although she doesn't see it that way), and her mental health and wellbeing is a struggle, something she's not getting any support for.

'My husband is ten years older than me. I'm not a carer for him, but put it like this, I do stuff. And you feel lousy, but you've always done it. Well not always done it but everything is the same. I worry. I do all that, particularly in the middle of the night when I'm sort of often awake and wondering about. Obviously, I'd say it's far worse in the middle of the night.'

'I don't like to think of myself as an ill person. It's limiting. And one of the worst things is planning, because you can't plan anything. Your plans maybe knocked out too. I was going to do Christmas, I hadn't done it for a while, but I was too ill, that sort of thing. But it can be much simpler than that, I will plan to go and do so and so, but then I'm not able to.'

However, when asked what one thing would help her with everything she's going through, the answer is incredibly simple.

'A good, reliable GP surgery where I can get an appointment when I need one and be seen.

**names have been changed to protect participant anonymity.*

3.0 Key Findings and Recommendations

Key Findings

Diagnosis

- Respondents often have to make multiple presentations to their GP surgery before getting a referral and subsequent diagnosis.
- Many people were diagnosed by chance when being assessed for separate issues by medical staff.
- Only 30% are diagnosed within six months of seeing their GP.

Management

- Written self-management plans are not being offered to the vast majority.

- Many respondents have not had an annual review since the end of Covid restrictions.

- A large proportion of sufferers are not being offered Pulmonary Rehabilitation treatment.

Technology

- Patients are very open to having technology help them self-manage their condition.

- Activity trackers and apps would be very popular.

Mental Health

- The long-term nature of the conditions and the slow 'inevitable' decline in health is leaving people anxious and depressed.

- Many respondents feel anxious about their future.

Recommendations:

Diagnosis

- GP surgeries must find a way to book in face-to-face appointments for people who present with chest and lung related issues, and then be prepared to conduct spirometry tests at the earliest opportunity.

- Very careful consideration of a diagnosis of COPD or other complex conditions should be taken, rather than deferring to an asthma diagnosis or dismissing potential symptoms as just a propensity to chest infections.

Management

- There is a huge gap between accepted best practice and what is actually happening on the ground. This has to be urgently addressed.

- Pulmonary Rehabilitation programmes, self-management plans and annual reviews are woefully behind acceptable levels. These are absolutely vital elements of an integrated and holistic care approach that can directly reduce the burden on hospital and GP visits, as well as having a significant

and positive impact and patient health and wellbeing. Due process and clear pathways need to be established and reiterated.

- Management of respiratory conditions must be fluid and treatment should be continually re-assessed. Annual reviews are key to ensuring this happens efficiently and effectively.

Technology

- Technology can provide quick wins in terms of management and self-management.

- Activity apps can be developed to dovetail with Pulmonary Rehabilitation programmes to help with continued exercise and motivation. The same can be done regarding education and dietary advice.

- These apps can also be linked in with home spirometer equipment, CPAP machines, Oximeters, etc., to provide patients with a very clear understanding of their current health.

Mental Health and Wellbeing

- Annual reviews with Pulmonary specialists or GPs make a significant contribution to patients' emotional welfare – feeling included, listened to, and supported.

- Sufferers can feel abandoned, with their health steadily declining and few options. Streamlined and effective signposting to support groups, financial advice, charities and complimentary NHS services will help create a nurturing wellbeing environment.

- The great thing here is that the best treatments and management tools for respiratory conditions are closely aligned with good, positive mental health. Being active, taking exercise and having a good diet are core to successfully managing lung disease, and for most people, they make a significant contribution to good mental health.
  Implementing Pulmonary Rehabilitation programmes and the other recommendations above will have a direct and positive impact on people's mental health.

4.0 Conclusion

Many respiratory conditions develop over time, making early diagnosis difficult, but a proactive response from primary care can make significant gains. A safety first, inquisitive approach with early referral will increase detection rates, and diagnosis statistics will be greatly improved.

There are well established low cost, high gain interventions that are perfect examples of how effective holistic care directly reduces the burden on GP and secondary care resources and hospitalisations.

The statistics from a wide variety of legitimate sources show that across the country we lag behind where we should be. The lived experiences we have garnered also reflect that for West Essex. There are pockets of successful intervention and treatment that indicate the pathways that are in place can and do work, but too often the opportunities are missed.

West Essex has a chance now to stand out and become a centre of excellence and establish itself as an example of best practise for providing access to the best and most appropriate healthcare for those in its population with COPD and other respiratory conditions.

Easy wins, quick gains, positive impact.

5.0 Terminology and Acronyms

HWE ICB – Herts & West Essex Integrated Care Board.

ECC – Essex County Council.

GP – General Practice or General Practitioner.

IAG Team – Healthwatch Essex's Information & Guidance Team.

COPD - Chronic obstructive pulmonary disease.

BMJ – British Medical Journal.

Broncoscopy – a procedure that lets doctors look at your lungs and air passages.

CPAP Machine – Continuous Positive Airway Pressure machine is a device for treating sleep apnea disorders.

Nebuliser – a machine that turns liquid medicine into a fine mist, breathed in through a mask or mouthpiece.

Spirometer – measures the amount of air you can breathe out in one second and the total volume of air you can exhale in one forced breath.

Aerobika – a handheld device you breathe into to help clear secretions (mucus) from your airways, making it easier to breathe.

Oximeter – a device to help you to check your blood oxygen saturation and your pulse rate at home.

Healthwatch Essex: COPD and Respiratory Conditions Report

Explored experiences of accessing treatment and support for COPD and other respiratory & lung conditions amongst:

- **People in West Essex**

Key Findings:

Diagnosis

- Respondents often had to make multiple presentations to their GP surgery before getting a referral and subsequent diagnosis.
- Many people were diagnosed by chance when being assessed for separate ailments by medical staff.
- 30% are diagnosed within 6 months of visiting their GP

Management

- Written self-management plans are not being offered to the vast majority
- Many respondents have not had an annual review since covid.
- A large proportion of respondents have not been offered Pulmonary Rehabilitation treatment

Technology

- Patients are very open to having technology help them self-manage their condition.
- Activity trackers and apps popular
- Opportunity to roll out an online Pulmonary Rehabilitation tutorial

Mental Health

- Long term nature of the condition and the slow 'inevitable' decline in health is leaving respondents anxious and depressed
- Many respondents feel worried about the future

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	X	*Meeting in private (confidential)*	☐			
	HWE ICB PRIMARY CARE BOARD				**Meeting Date:**	**27 July 2023**	
Report Title:	**PRIMARY CARE COMMUNICATIONS AND ENGAGEMENT**				**Agenda Item:**	**11**	
Report Author(s):	Heather Aylward: ICB Engagement Manager						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation Hertfordshire and West Essex ICB						
Purpose:	**Approval**	**X**	**Decision**	☐	**Discussion**	☐	**Information** X
Report History:	N/A						
Executive Summary:	This report provides an update of the work with the Patients Association in developing GP practice patient groups						
Recommendations:	▪ To note the update						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			X			

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	EQIA to be undertaken for Communications and Engagement strategy
	Quality Impact Assessment:	N/A
	Data Protection Impact Assessment:	N/A
Strategic Objective(s) / ICS Primary Purposes supported by this report:	***Improving outcomes in population health and healthcare***	*X*
	Tackling inequalities in outcomes, experience and access	*X*
	Enhancing productivity and value for money	☐
	Helping the NHS support broader social and economic development	☐
	Successfully complete and embed the transition of staff and functions from the three clinical commissioning groups into the Integrated Care Board	☐
	Develop the ways of working and profile of the Integrated Care System to ensure that its operating model is capturing the opportunities presented by closer system working	☐

1. Executive summary

Herts and West Essex Integrated Care Board (ICB) commissioned the Patients Association) to work with ICB engagement leads to provide development support for GP practice patient groups (PPGs). The work also supports the take up of the participation Enhanced Commissioning Framework (ECF).

This report provides an update on this work as phase two of the project comes to a close towards the end of the year.

The main activity in phase two has been:

- The establishment of a practice patient group resource page on the Patients Association website, including links to workshops and toolkits. This is accessible to the public and shares the good practice achieved through this work.
- We have continued to build resources including additional workshops on having a social media presence and how patient groups can help to reduce health inequalities. Two other workshops, supporting patient group members as volunteers and engaging with children and young people are being developed. Another one on health inequalities is also being planned.
- Targeted support offered to 85 practices, with the introduction of a patient led buddy scheme.
- Starting to build links with primary care networks.

2. Background

The aim of the ICBs partnership with Patients Association has been to work with local practice staff and patient volunteers to ensure that GP patient groups have the tools and support structures to increase patient involvement and diversity in a sustainable, practical and realistic way.

This project has been co-produced and initially focused on meeting the needs identified from a baseline survey and highlighting the benefits of a patient group with four workshops, followed in the next phase by another two. Currently being developed are a video on supporting patient group members as volunteers and engaging with children and young people.

Workshop title	Attended	Viewed Recording	Total views
1. Step by Step Guide to establishing a GP Practice Patient Group	36	127	163
2. Getting started, why have a patient group and what's in it for practices and patients	64	264	328
3. Effectively working together in partnership	48	165	213

4. Recruitment increasing diversity and communicating with the wider patient population	43	172	120
5. Making use of social media and setting up a Facebook page	66	80	146
6. Promoting healthy lifestyles and patient groups	30	To be uploaded and link shared	
Total people engaged	287	808	1095

Evaluation of phase two

Phase two has concentrated on providing targeted one to one support to 85 practices that had not taken part in the workshops or been in contact with the project team. Patients Association's project manager has made telephone contact with all 85 and has spoken with 64 practice managers or other practice staff.

A patient led buddy scheme has also been formally introduced, with nine practices currently being supported by four buddies. This pilot has shown that one or two meetings are required to support a practice with their patient group development, with some telephone support if required. A small number of buddies, who have significant experience in this area, is easy to manage, co-ordinate and sustain and can be supported currently from the ICB's communications and engagement team.

During the one to one support the importance of linking patient groups with wider patient engagement initiatives across the Primary Care Network and ICB have been highlighted. As well as connecting with the voluntary and community sector to widen recruitment and activity potential. Patients Association have also supported a number of practices with their community mapping.

Outcomes of phase 2

- Contact has been made with 135 practices: phone calls to 85 and targeted support to 64.
- Mapping: a comprehensive data spreadsheet, outlining current position and progress. This information will help track and analyse the project's impact.
- Growing patient group resources on Patients Association's webpages which will continue to be grown and shared more widely
- Presentation to NHS England's patient participation group where good practice from this work was shared.
- Buddy scheme developed as an ongoing resource to patient groups

3. Issues

It has been too soon to develop closer links with pharmacy and dentistry at this stage.

Patients Association has found that the contact with practice managers has shown their positivity, enthusiasm and commitment to patient engagement however the majority also expressed resource and time issues. They all welcomed the support offered.

Efforts are ongoing to reach the 21 practices who have not responded to calls or emails.

5. Resource implications

Continued support will be offered by the ICB communications and engagement team within current resources and once the work with PA comes to an end.

6. Risks/Mitigation Measures

That the resources in the communications and engagement team are reduced and the impetus may be lost if continued support isn't provided.

7. Recommendations

To note activity.

8. Next Steps

- There is still work to be carried out on following up with practices who require ongoing and more extensive support.
- All 135 practices and patient network will be followed up with a survey to measure outcomes in November/December 2023 when a full evaluation of the project will be produced
- Collaboration with primary care networks and the voluntary sector to foster partnership and using their expertise to enhance community involvement. 20 practices have identified they want to work with their PCN on joint patient group initiatives and these are being supported
- Additional workshops are being developed
- Ongoing follow-ups: re contacting practices to check on progress and collect video stories which can be used as testimonials and evidence of the project's effectiveness and impact.
- A full report will be provided with outcomes at the end of the project

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DRAFT MINUTES

Meeting:	**ICB Primary Care Digital**			
	Meeting in public	☐	*Meeting in private (confidential)*	☒
Date:	**Thursday 15th June 2023**			
Time:	**10:00am**			
Venue:	**Via MS Teams**			

MINUTES

Name	Title	Organisation
In attendance:		
Avni Shah	Director of Primary Care Transformation	HWE ICB
Megan Knight	ENH PC: Project Support Officer	HWE ICB
Inderjit Sunner	GP / PCN Rep for ENH	HWE ICB
Anup Shah	GP / PCN Rep for SW	HWE ICB
Vicki Anderson	Head of Shared Record Communication	HWE ICB
Parul Karia	GP & Primary Care Digital Lead SW	HWE ICB
David Coupe	GP System architect	HBL ICT
Shane Scott	Associate Director of Informatics	HBL ICT
Trudi Mount	Programme Director ICB Digital Team	HWE ICB
Ewan Maddock	Senior Comms Officer	HWE ICB
David Ladenheim	Lead Pharmaceutical Advisor S&W	HWE ICB
James Gleed	Associate Director: PC Strategy & Transformation	HWE ICB
Deepa Dhawan	GP Waltham Abbey, CD Epping Forest PCN	HWE ICB
Kolade Daodu	Clinical Director, Stevenage South PCN	HWE ICB
Ian Perry	Partner member: Digital Estates Infrastructure Lead (Chair)	HWE ICB
Tito Clark	Project Manager: Primary Care Digital	HWE ICB
Phil Turnock	Managing Director: HBL ICT	HBL ICT
Sarah Ost	Programme Director: Digital Transformation Strategy	HWE ICB
Adam Lavington	Director of Digital Transformation	HWE ICB

PCD/01/23	**Welcome, apologies and housekeeping**
1.1	The Chair welcomes all to the meeting.
1.2	Apologies received from: Cathy Galione / Gopesh Farmah / Philip O'Meara / Sara Lingard The Chair noted that the meeting was quorate.
1.3	**Declarations of interest** The Chair invited members to declare any declarations relating to matters on the agenda: None declared. No new DOI to note. Chair reminded all to update DOI if appropriate/required
1.4	**Minutes from the previous meeting** The minutes of the meeting held 20/04/2023 were approved as an accurate record.
PCD/02/23	**Action tracker**
2.1	The action tracker was reviewed, updates discussed and noted: **See action tracker document for full details.**
2.2	**PCD/05/22 –**SMS usage and data. Closed. Update by SS. **PCD/04/23 -** Community Pharmacy IT Integration pilot scheme, NHSE. Closed. Awaiting update from SL. **PCD/05/23 -** Feedback from Clinical Leads & Other Key Meetings. - update on digital roadmap. **Closed** **PCD/05/23 -** Operational Update HWE Covid Laptop Support & Maintenance. To Close (pick up with budget planning) **PCD/05/23 (c) -** HWE Desktop Allocation - Questionnaire to practices. Ongoing (pick up in operational.) Still outstanding **PCD/05/23 (b) -** GP IT SLA Report. Closed. Update by SS. **PCD/05/23 (i) –** Utilisation of Accurx/ Batch messaging/ Floreys/ SMS. Closed. Update by DC. **PCD/05/23 (j) -** Patient Access to Hospital records/ Interface between the patient and hospital Digi T Team update. Closed. Update SO. **PCD/08/23** - Interoperability between systems. Closed. Update by DC. **PCD/08/23** – Panic buttons IP update. Closed **PCD/05/23 –** Update on process, Governance reordering and sharing results between different providers. To be closed following CG Update
PCD/03/23	**Community Pharmacy IT Integration Pilot Update – Progress update**
3.1	**Awaiting update from SL. See action log for details.**
PCD/04/23	**Feedback from Clinical leads and others key meetings**
4.1	A. ICB wide Digital Clinical lead forum (PK)
4.2	B. National/Regional (PK) • **The clinical reference group meeting:** discussed digital technologies being used in HPFT. They introduced "a digital skills wheel", to map skills of new recruits and identify areas where educational support is needed. • HPFT is also using conversational AI/Chatbots to support patients in talking therapies. • Focus on accessible technology and working with adult social care and learning disability patients to improve digital inclusion. • Interoperability between HPFT, primary care, and pharmacy was highlighted as a key area, with the use of technology. • **ACTION:** Further discussions with HPFT to explore shared learnings and commonalities between their initiatives and primary care. • **Community pharmacy and ICS interfaces meeting**: re interoperability and systmOne. • Importance of data privacy and security when implementing digital technologies: Emphasis made for the need of robust measures to protect patient info and comply with relevant regs.

	• **ACTION:** Explore opportunities for collaboration with SystmOne, for best practice and smoother integration between different healthcare providers.
4.3	C. **NHSE GP IT review (SO)** • **ACTION:** Seek update on GPIT review progress - **COMPLETE** • Patient portal project and update on the progress made integrating digital tech across primary care. • To support forums like this to escalate into the system Wide Digital Board.Currently working on a process for forums to feed into the Digital Transformation Board – presented in July. • GPIT review is a 12-week cycle led by Channel 3 on behalf of NHS England - Received contributions from two suppliers for the review and are currently reviewing the information. • **ACTION:** Need to liaise with practice leads and highlights the importance of feedback. List of the practices that are still outstanding that haven't had contact or interviews.For follow up phone calls. The identified practices will be interviewed regarding their GPIT support, and constructive criticism will be gathered to improve services going forward
4.4	D. **Assistive Technology meeting (PK)** • High-level overview of the assistive technology, which involves digitally enabled technology collecting data to understand vulnerable patients' behavior patterns The data is analyzed and sent to a dashboard, interpreted with the aim of preventing hospital admissions. • Two pilot schemes, the ENH/SWH Early Intervention Vehicle and the ENH Community Rapid Response Team, have been involved in program. Results show positive outcomes noted. • Schemes aim to provide rapid assessment and support within the first 48 hours to prevent hospital admissions. • From Sept 22 to Feb 23, 454 Herts residents have been successfully supported through the emergency alert pathway, resulting in an estimated cost savings of £113,000. • Interest and support expressed for further exploration of the pathway. • **ACTION:** Set up meeting /a small working group with the organisations involved to discuss the next steps regarding the use of assistive technology. • Importance of digital assets in community pharmacy and the need to optimize their tools and systems for efficiency. • Challenges noted of managing the increasing IT workload and the need to prioritize and influence changes locally. Interface between pharmacy and general practice: need for seamless integration of pharmacist-provided services, such as blood pressure readings, into the GP system. • **ACTION:** IP intention to meet with LS to explore the integration of the practice's NHS mailbox with their clinical systems. • **ACTION:** Explore the possibility of direct links between secondary care and the GP system to avoid missing important communications - looking at the issue from both a system point of view and an individual practice point of view, emphasizing the contractual obligation to provide secure email or digital access for patients. • AS proposes unpicking the operational issue with hands-on support from HBLICT. • Potential of automating human actions currently performed on thousands of documents per day, which could free up resources. • **ACTION:** Consider exploring automation options for tasks currently performed on documents. Need to define the scope and objectives of automation in primary care. AS suggests back office automation testing and collaboration with providers.Possible collaboration with clinical leads and incorporating sustainable solutions.
4.5	E. . **Update on PC Digital Roadmap** • A draft of the ICP (Integrated Care Provider) digital roadmap was presented at the Primary Care Board.

	• The roadmap is continuously updated and expanded with new additions and explorations. • Two areas that need focus are digital inclusion and community pharmacy. Identifying two or three key priority. • Priorities for primary care include advanced telephony, NHS app utilization, automation of repetitive tasks, workforce digital skills, and infrastructure improvement. • The priorities will be documented in a short problem plan, complementing the broader strategy document. • There are ongoing discussions and questions regarding the implementation of the digital roadmap. • Inclusion of automation in the digital roadmap • If patients understand and accept the benefits of digital tools, they will be more receptive to the revolution in healthcare. importance of balancing digital capabilities with in-person care and ensuring access for patients who need it. • SS mentions primary care robot in HBL that is ready to be used for automating processes. • **ACTION:** Consider using the existing primary care robot in HBL to automate processes. • Abundance of digital development and the need to explore existing capabilities fully before adopting new innovations • IP example of using optical character recognition (OCR) to automatically recognize and code diagnoses. • **ACTION:** Investigate the capabilities of system one, such as OCR for automatic coding, and utilize them fully.
4.6	F. GMS contractual changes for 23/24
PCD/05/23	**Primary Care Risk Register**
5.1	• Need to identify primary care risks and differentiate them from system-wide risks. • Reminder: escalating primary care risks to the DTB considering the roadmap and implementation plan. • Operational issues - funding for GP laptops, which may not necessarily be risks. • High-level risks: GPIT review, BBID providers, budget management, and digitalization's impact on inequality. • **ACTION:** Arden and Gem - risk weight needs to be increased (out of contract this month) GPIT review will play a role in decision-making process - to be escalated. • **ACTION:** Update the exec team on Monday.
PCD/06/23	**Datix update**
6.1	Nil noted
PCD/07/23	**Operations Update**
7.1	**SS** • Updates regarding the panic button implementation, additional costs for software installation, out-of-hours calls statistics, pending survey, frustration over delays, and the need to analyse the survey results and reach conclusions for practice requirements. • The panic button for EMIS has been ordered for all EMIS practices. • AGEM support in West Essex is causing additional costs for software installation - work on minimizing or avoiding the cost. • Out of hours calls are being analysed for inclusion in monthly stats. - Approximately 2.5 calls per night between 6:30 and 8 pm. 25 calls and 25 ticket updates per night. **ACTION:** Survey to be sent out. (Due to requests for additional equipment/ need to determine support costs for laptops and equitable distribution) Give month to complete the survey and establish practice requirements. Need to analyse survey results and reach a conclusion.

7.2	**DC – EMIS and EMIS X** • Discussed issues with EMIS Web crashing. EMIS is making changes to convert EMIS Web into a 64-bit system (currently a 32-bit system/only use 4GB of RAM) to improve performance. Changes expected next couple of months, no action needed. • An additional app called EMIS Health Checker will be available to identify and troubleshoot problems. • The transition to the new system, EMIS X, will take place gradually, with different modules being introduced. EMIS Web and EMIS X will run in parallel during the transition phase. • EMIS X is planned to be fully available as a GP solution by 2026.Test sites, including Highview, will be set up to evaluate EMIS X before its full release. • The messaging module, similar to WhatsApp, will be one of the first modules- roll out to test sites in August onwards. • EMIS X provides an additional view of patient data, like having a second screen. These changes aim to improve the overall EMIS web experience for users. There will be further updates and changes to come in the future. • PT: Additional PC laptop capacity and processing needed for the EMIS X roadmap. • DC: Need to ensure compatibility with new devices and EMIS will provide updates. • **ACTION:** Ensure EMIS provides updates and communications to all sites and users. • **ACTION:** Create a simple A4 document with instructions for signing up for EMIS updates and distribute it to primary care teams. Share information about EMIS changes and transformation through practice manager forums and groups. • **ACTION:** Collect feedback and correspondence on the email transition related to the EMIS acquisition. Understand the strategic implications of the EMIS acquisition and communicate them within the group. Assess the impact of new functionality in the EMIS tool on practice adaptation. • Consider having the clinical system supply go directly to practices for better visibility. • Engage with the ICB's comms team for communications support. • Work with HBL etc to disseminate content effectively. • Clarify ownership and responsibility for system optimization. Assess the recruitment status of digital transformation roles in PCNs and ensure sufficient skills and workforce. The digital positions are crucial for communication and operational changes. Identify capable individuals for digital roles and ensure they have the necessary expertise. Encourage PCNs to make informed decisions about IT leads based on expertise and experience.
	TM - Access to records • 19 practices live, with one more expected to go live in the next couple of weeks. Remaining practices will be enabled by TPP and EMIS before October 31st. Receive weekly updates. Patient app usage.
	•
PCD/08/23	• **Finance Report update**
8.1	• Brief update: GPIT budget overspent for 2223 from AS (as PT not available) Majority cost pressure with HBLICT, AccuRX and SMS. • Must be able to articulate the benefits as well that are happening and how they fit with our model of delivery as well going forward (maximizing optimization) • Importance of GPIT evaluation and where that responsibility sits. • **ACTION:** Meet with HBLICT colleagues as well in terms of spec more and what they deliver and what they what we get from it, but also how do we look at evaluations as well from all of this. • Reiterating, if we don't have to spend it on a provider, if the NHS app could do it, then that saved money not adding to the to not adding to the spend. • SMS high cost: send only important message via route.
PCD/09/23	**Risk Register for PC Digital**
9.1	Explored during initial risk register section as CG unavailable
PCD/10/23	**Access Hub Issues with EA**
10.1	SS- update on the EMIS enterprise for access hub issues related to extended access. (still needs to be addressed and it should stay on the agenda.)

PCD/11/23	**Any other business**
11.1	• **Automation** (Covered during meeting • **AI:** Companies developing skin analytics/AI programs for dermatology. Active in NHS Lester, NHS, Mid, South, Essex Aim to reduce costs to the system for dermatology. Patients send photos of affected area, and the AI tool is approx. 99% effective at recognising skin cancer. • Communications: Prices SMS vs email. How we communicate with patients. Effective use of NHS app. • Self-book: contracts been extended on self-book to a 31st of 2023 to all sites.
PCD/12/23	**Date and Time of next meeting**
12.1	Thursday 20th July 2023 – 10.00 am
PCD/13/23	**The meeting closed at 12.11**

HERTFORDSHIRE AND WEST ESSEX TRAINING HUB

HWE ICB PRIMARY CARE WORKFORCE IMPLEMENTATION GROUP

22nd June 2023

1:00pm – 2:30pm

Microsoft Teams Meeting

Attendees		
Dr Nicolas Small (NS)	Training Hub Clinical Lead **(Chair)**	Hertfordshire & West Essex ICB
Joyce Sweeney (JS)	Head of Primary Care Workforce	Hertfordshire & West Essex ICB
Lucy Eldon (LE)	ICS Primary Care Clinical Nurse Lead	Hertfordshire & West Essex ICB
Louise Casey (LC)	Training Hub Operations Manager	Hertfordshire & West Essex ICB
Jane Scotter (JnSc)	Training Hub Operations Manager	Hertfordshire & West Essex ICB
Dr Richard Stanley (RS)	GP Trainer and Placement Expansion Lead	Hertfordshire & West Essex ICB
Dr Sarah Dixon (SD)	Primary Care Workforce GP Clinical Lead	Hertfordshire & West Essex ICB
Dr Jayna Gadawala (JG)	Primary Care Workforce GP Clinical Lead	Hertfordshire & West Essex ICB
Rebecca Ward (RW)	Primary Care Project Support Officer	Hertfordshire & West Essex ICB
Gaynor Samuel (GS)	Primary Care Project Support Officer	Hertfordshire & West Essex ICB
Georgina Peacock (GP)	HR Transformation Officer - Graduate Management Trainee	Hertfordshire & West Essex ICB
Steve Gregoriou (SG)	Systems Workforce Planner	Hertfordshire & West Essex ICB
Emma Salik (ES)	Associate GP Dean for HWE, HEE	Hertfordshire & West Essex ICB & Health Education England
Cathy Gleeson (CG)	Lead Pharmacist – Strategy and Pharmacy and Allied Health Professions Workforce Development Pharmacy & Medicines Optimisation Team (PMOT)	Hertfordshire & West Essex ICB
James Gleed (JaGl)	AD Primary Care Strategy and Transformation	Hertfordshire & West Essex ICB
Alice Baldock (AB)		
Mark Edwards (ME)	Associate Director for Workforce Transformation	Hertfordshire & West Essex ICB
Apologises		
Avni Shah (AS)	Director of Primary Care Transformation	Hertfordshire & West Essex ICB
Hannah Cowling (HC)	Associate GP Dean for HWE, HEE	Hertfordshire & West Essex ICB & Health Education England
Raja Vaiyapuri (RV)	Deputy Chief Executive, North & South Essex Local Medical Committees	North & South Essex Local Medical Committees

1.	**Welcome & Introductions** Confirmation that meeting is quorate. Apologises and welcome.

2.	**Declaration of Interests** There were no declarations of interest.
3.	**Meeting Notes from the last meeting on 23rd May 2023** The minutes of the meeting confirmed as accurate. No amendments requested. **Action Log Review:** **121 Oliver McGowen Mandatory Training** - **GP** gave update during meeting. Action closed. **129 Tier 2 Visa Support** - Deferred JS awaiting response from Tania Marcus. **131 Community Pharmacy PCN Leads Project** - Revised date of 27.07.2023. **133 Primary Care Racism Discrimination Report** - Deferred to 27.07.2023.
4.	**Primary Care Awards - Jayna Gadawala** • Save the date has been circulated. • Request for applications sent to all Primary Care including Pharmacy, Optometry and Dentistry. • Closing date for applications to be received 5th August 2023. • Request for all to promote the Primary Care Awards during any relevant meetings. • It was discussed and agreed within the meeting for the team to actively promote and encourage those from all areas to register applications. **CG** – Suggestion of linking in with the LPC, Helen Musson and Karen Samuel -Smith to promote within Pharmacy. **JG** – **LC** discussed with Helen Musson. Also discussing with Andrew Tarry and Michelle Campbell to link with LDC and LOC. **JaGl** – Can assist with contacts at LDC, LOC and LPC. **JG** – To send application information to Emily Perry to distribute to the locality teams.
5.	**Primary Care Careers Fair – Jayna Gadawala** • A hold invite has been sent for 21st September 2023. • Currently at the planning stage. • Formal plan to be brought to the WIG. **Action: Formal plan to be presented by LC at the next WIG on 27th July 2023.**
6.	**Guest Speaker: Steve Gregoriou** • Within his team they are working on collecting and reporting on Workforce Data including Primary Care, Secondary Care and Social Care to gain a full understanding of the entire Workforce. • The Workforce report is aligned to reflect performance measures and to gain an understanding of Workforce issues across the sector. • To develop a long-term skill-based Workforce Plan we work with Primary Care, providers, and key Stakeholders to ensure the population needs, embedding training and education requirements, so we have a sustainable Workforce Plan for the next 5 years. • Data sources NWRS and HEE portal. • Building a new Workforce Planning platform called Click Sense to allow us to update data monthly.

	• Primary Care to have a dashboard for data collation. The data we look at is vast, this allows to obtain any trends and to forecast. • We are looking at age profiles, specifically around retirement. • Understanding the population, its condition and matching the job roles. To be able to support the wider team in Workforce Planning. • Task and Finish group to be set up for Click Sense Project. **JaGL** and or **JS** to be invited. **Action: Mapping data collation to ensure work is not duplicated. Discussion of how the new platform Click Sense will work. Update to be provided at the next WIG on 27th July 2023.**
7.	**GPN Update – GPN Compassionate Appraisals - Alice Baldock** • Implemented to highlight the value of nurses and importance of their role within General Practise as part of the Clinical Team. • It is not performance related or needed for revalidation. • To be held with another peer to reflect on the year, learning events and what went wrong. • Allow for signposting to various resources particularly within the Training Hub. Appraisals to take more of a mentoring format. • We know there is a gap in nurses requiring support but not accessing it, the Compassionate Appraisal was developed for the nurses to have confidential time to reflect and access support. • Held a full training day and reflective practise session. The pilot involved 16 nurses. • Feedback from the training day was positive, the nurses enjoyed linking with colleague's face to face. Learning a skill of open questioning and effective appraisals. • Toolkit used to document learning and reflections which can aid revalidation. • Paper on the pilot scheme has been drafted and will be available to share when this has been completed. • Funding allocated was specifically given for Nurse Compassionate Appraisals. Further discussion took place by members of the WIG regarding PCN Training Teams taking the Compassionate Appraisals forwards and the challenges they may face in terms of Practice Managers releasing nurses to be able to take part in training. It was agreed this was an important piece of work that needs to be explored more and continued not only for nurses but the wider Primary Care Workforce. It is crucial piece of work that will aid maintaining wellbeing within the Workforce. **Action: Discuss and plan continuing the Compassionate Appraisals across other PCNs, plan to then be brought to a future WIG meeting.** **NS** – Suggested some markers of Good Practice could be used to encourage practices to engage with the process. **SD** – Suggested the use of the Protected Time to Learn for a training session. **GPN Update - Lucy Eldon** • Commissioned 20 places for the GPN course. • PCN Education Teams Student Expansion meeting was yesterday, 21st June 2023. • Across the ICB there are 2.9% of students which we are looking to increase. • Nursing Associates there are 15 in progress with 4-5 starting in September 2023. • ACPs, 10 starting in September 2023 with some on the waiting list which we are hoping to have places for. • Unfortunately, we were unsuccessful in employing an ACP Ambassador Supervisor, we are discussing how we move forward with HEE.

	Action: Paper to be produced on lessons learnt specifically during the pilot of the Nurse Compassionate Appraisals.. To then be discussed at a future meeting. **<u>Pharmacy Development Update - Cathy Geeson</u>** • NHSE Community Pharmacy Independent Prescribing Pathfinder Bid – Awaiting a response still. Aim to provide an update at the next WIG. • The team have been working with colleagues to have a Pharmacy Workforce Strategy which will then be part of the Primary Care Strategic Delivery plan. • Some of the high-level objectives to be shared from that, to ensure we co-ordinate to avoid duplication of workstreams across the ICB. • Capacity of Clinical placements is one of our objectives with that comes the additional need for more training which will require us to look at the quality of the placements. **Action: CG and LE to work together to support the quality of placements.**
	<u>Any Other Business</u> **NS** - Within the WIG meetings currently we are sharing information and holding ourselves accountable, but we need to review how this then correlates to our strategies. JS and NS to review format of the WIG meetings to have a more strategic approach. An invitation of members of the WIG to share your thoughts on this with NS and JS via email. The aim is to not necessarily to have a major change but to tweak and refocus the future WIG meetings. **NS** - SD has made an application to the Patient Safety Awards, which the Training Hub have been shortlisted for. Thank you given to SD and the wider team for the work undertaken to achieve this. **JaGI** - In agreement with the reflection on the focus of this group and how that all ties in with the delivery of the Strategic Delivery Plan. Capturing the strategic direction within workforce, education and innovation and the work we do in terms of some of the National and Regional Programmes. That's where we adjust our focus.
	<u>Date of next meeting</u>: 27th July 2023 13:00 – 14:30

Future Meeting Dates

27th July 2023	13:00 – 14:30
7th September 2023	13:00 – 14:30
26th October 2023	13:00 – 14:30
27th July 2023	13:00 – 14:30