ICB Primary Care Board Meeting [Public Session]

Thursday 24 November 2022

Microsoft Teams

09:30 - 12:00

Meeting Book - ICB Primary Care Board Meeting [Public Session] Thursday 24 November 2022

HWE ICB Primary Care Board Meeting Held in Public Thursday 24 November 2022

09:30	1. Welcome, apologies and housekeeping		Chair
	2. Declarations of Interest		Chair
09:35	3. Minutes of last meeting held on Thursday 22 September 2022	Approval	Chair
	4. Action Tracker	Approval	Chair
09:40	5. Questions from the public	Information	Chair
09:45	6. Primary Care Board Governance - Sub-group Terms of Reference	Information	Avni Shah
09:50	7. Directorate Report [Verbal update]	Information	Avni Shah
10:05	8. Risk Register	Discuss / Information	James Gleed
10:20	9. Update from Healthwatch	Discuss / Information	Geoff Brown/Sam Glover
10:35	10. East of England (EoE) Partnership Strategy for Community Pharmacy	Approval	Renate Scheffer
10:45	11. ICS Digital Strategy	Discuss / Information	Adam Lavington
	11.1 Development of the Primary Care Roadmap		Rachel Hazeldene
	11.2 Digital Exclusion		Joanna Richardson
11:00 - 11:15	COMFORT BREAK		
11:15	12. Development of Primary Care Strategy - Plan on a page	Information	Avni Shah
11:30	13. Voluntary, Community, Faith and Social Enterprise (VCFSE) Health Creation Strategy	Discussion	Tim Anfiligoff
11:45	14. Reports/Minutes from subgroups		Avni Shah
	14.1 Primary Care Workforce Group		
	14.2 Primary Care Digital Group		
	14.3 Communication and Engagement		
11:50	15. New risks identified		Chair
11:55	16. Reflections and feedback from the meeting		Chair
12:00	17. Close of meeting		

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

The Nolan Principles

In May 1995, the Committee on Standards in Public Life, under the Chairmanship of Lord Nolan, established the Seven Principles of Public Life, also known as the "Nolan principles". These principles are the basis of the ethical standards expected of all public office holders.

The Hertfordshire and west Essex Integrated Care Board recognises that in all its work it must seek to meet the highest expectations for public accountability, standards of conduct and transparency. It will therefore ensure that the Nolan principles, set out below, are taken fully into account in its decision making and its policies in relation to standards of behaviour.

1. Selflessness. Holders of public office should act solely in terms of the public interest.

2. Integrity. Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity. Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability. Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness. Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty. Holders of public office should be truthful.

7. Leadership. Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

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 22 September 2022**			
Time:	**09:30 – 10:50**			
Venue:	**Conference Room 2, The Forum, Hemel Hempstead / Microsoft Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Nicolas Small (NS) **(Meeting Chair)**	Partner Member	Herts and West Essex ICB
Rachel Joyce (RJ)	Medical Director	Herts and West Essex ICB
Ian Perry (IP)	Partner Member	Herts and West Essex ICB
Gurch Randhawa (GR)	Non-executive Member	Herts and West Essex ICB
Avni Shah (AS)	Director of Primary Care Transformation	Herts and West Essex ICB
Marion Dunstone representing Elliot Howard Jones	Chief Operating Officer	Hertfordshire Community HNHS Trust
In attendance:		
Alice Baldock (AB)	Medical Director	Herts LMC
Michelle Campbell (MC)	Head of Primary Care Contracting	Herts and West Essex ICB
James Gleed (JG)	Associate Director Commissioning Primary Care	Herts and West Essex ICB
Rachel Halksworth (RH)	Assistant Director for Primary Care Contracting	Herts and West Essex ICB
Iram Khan (IK)	Corporate Governance Manager	Herts and West Essex ICB
Joanne Marovick (JM)	Voluntary Community Social Enterprise Alliance Representative	Herts and West Essex ICB
Helen Musson (HM)	Chief Officer	Community Pharmacy Hertfordshire to support pharmacies across Hertfordshire
Tracey Norris (TN)	Minute taker	Herts for Learning
Annette Pullen (AP)	EA to Director of Primary Care Transformation	Herts and West Essex ICB

Anurita Rohilla (AR)	Chief pharmacist and Associate Director for Allied Health Professions	Herts and West Essex ICB

PCB/01/22	**Welcome, apologies and housekeeping**
1.1	The Chair welcomed all to the first Hertfordshire and West Essex ICB Primary Care Board (PCB) meeting. This was a hybrid meeting held in public but was not a public meeting. It was hoped that by the next meeting, the three patient representative members would have been appointed.
1.2	Apologies were received from: • Prag Moodley, Partner Member, Elizabeth Disney, ICB HWE, Nicky Williams, LMC
PCB/02/22	**Declarations of interest**
2.1	The Chair invited members to declare any declarations relating to matters on the agenda: • None declared. • All members confirmed their declarations were accurate and up to date.
PCB/03/22	**Questions from the public**
3.1	None received for this meeting.
PCB/04/22	**Primary Care Board Governance: (Terms of Reference)**
4.1	Avni Shah introduced the report (see pages 4 – 10 of the document pack) highlighting the following points and noting the main changes to previous iterations of the terms of reference: • The PCB would set the direction of primary care as a whole (not just general practice). • Focus would be on outcomes not activity. • Members of the PCB were appointed in their professional capacity and not to represent the need of their own organisation. • Item 5.2 has been removed. • Membership and chairing arrangements have been confirmed. • Three patient representatives would be appointed (one from each locality). • Representatives from all areas of primary care were included (eg dentistry and optometry). • Discussions were underway with Public Health colleagues for their representation on the board. • The recruitment/appointment process of GP members would be completed by the end of October. • The terms of reference would be reviewed in 6 months' time.
4.2	The following points were raised in discussion: • Should the relationship with the Quality Committee be explicitly stated? • It was expected the PCB would have relationships/links with a number of the other committees of the HWE ICB, e.g. the Peoples Board, Digital, Quality and Performance. • The Chair of the PCB was also the deputy chair for the Quality Board which ensured a co-ordinated approach to the identification of emerging risks. • Anecdotal general practice feedback had been positive on the creation of the PCB and its terms of reference.
4.3	**The Primary Care Board approved the terms of reference**
PCB/05/22	**Risk Register**
5.1	James Gleed introduced the report (see pages 11-21 of the document pack) highlighting the following points: • A number of risks had been downgraded since the first iteration of the risk register which had been created in May (NB Risk 318 and Risk 324). All risks with a score higher than 12 had been reviewed. • By the end of the month, all lower rated risks would have also been reviewed
5.2	The following points were raised in discussion: • Further work was needed to ensure the stated risks related to the whole of primary care and not just general practice. • The interdependency and interrelationships of different risk were noted. Care would be taken to ensure that as one risk was addressed and reduced, it was not done at the expense of another risk area. • As more delegated contracts were taken on, more specific risk and system-wide risks would be identified. • Another column could be added to the risk register to highlight where these interdependencies lay. • A high-level summary of the PCB risk register would be shared with the ICB Board.

	• An ICB Board development session on risk and risk reporting had been arranged for October.
5.3	**The Primary Care Board approved the work to date on the risk register.**
5.4	***ACTION: JG to provide Risk update including delegated risks of dental/optometry/pharmacy - 24 November 2022 meeting.***
PCB/06/22	**GP Patient Survey Results**
6.1	Michelle Campbell introduced the report (see pages 22-28 of the document pack) highlighting the following points: • Mirroring the national picture, patient experience/access has declined, this was despite the ICS meeting or exceeding most of the patient indicators. • A work programme was in place to address this and included: • New avenues for access; telephone, online, text/email. • Digital transformation. • Advanced telephony roll-out. • The workforce was not growing at the same rate as demand; this did not just include GPs but the wider workforce, e.g. PCN DES, community pharmacists etc. • The PC team were reviewing practices for outliers – those with good access (reputations and data) would be invited to share best practice and support would be given to those practices in need of improvement. • Other factors impacted access, e.g. estates. • Practice quality visits would resume, and the data collected would help inform decisions/actions re the deployment of the winter access fund. • The government target of non-urgent patients to be seen within two weeks had just been announced. • The data highlighted that 50% of appointments were made for same day and over 60% of appointments were face to face. There was only a low number of patients who were not seen within two weeks.
6.2	The following points were made in discussion: • Estate restrictions was highlighted as a major barrier. Many practices did not have the space to appoint any more ARRs roles for example. A national toolkit was being developed to ensure the most efficient use of estates. • Had enough consideration been given to health inequality? It was noted that access in areas of deprivation had other barriers to just the front door. Each practice would be profiled to understand its population health needs and ensure equality of access and where necessary targeted outreach would be put in place. • The difference between access and uptake was noted and that within a PCN there could be variations of access. • It was suggested that the action plan could be expanded to include who was leading each task/timeframe and geographical pinch points. • All positive changes introduced during covid should remain and be built on. • Bottlenecks experienced by GPs were highlighted (e.g. chasing appointments or prescriptions on behalf of patients, dealing with social care issues). • Despite the higher number of appointments being offered, patient satisfaction was still low; possibly driven by the current media narrative. A consistent communication strategy to publicise the different point of access that were currently available was essential. • Better understanding of staffing ratios in those practices with “good” access would help inform future discussions. • Some service users did not want/were not able to use the new digital method of access. • The public perception of the need to see a GP would take time to change. • Opportunities for space sharing between primary care and the voluntary sector could be explored, voluntary organisations rent premises all over Herts and West Essex. A shared space between charitable groups and medical services might improve access for some vulnerable groups. • PCB priorities should be focused on outcomes not access. • A data dashboard was in the process of being created so that public health management data could be used to highlight and address issues. Drilling down into inequalities was crucial to ensure the PCB was focused on the right priorities.
6.3	**Primary Care Board noted the GP patient survey results**
6.4	***ACTION: MC to provide update to the Board on development of the framework/dashboard – 24 November 2022.***

PCB/07/22	**Primary Care Workforce Training Plan**
7.1	Sarah Dixon and Joyce Sweeney introduced the report (see pages 29-40 of the document pack) highlighting the following points: • The report outlined the work of the Training Hub to strengthen the primary care workforce and assist in attracting and retaining staff, recognising the challenges in recruitment and retention. • The PCN training team had been successfully piloted in each of the three places and this would now be rolled out to all 35 PCNs, with learnings from each of the pilots being shared. • MOUs would be issued within the coming month. Each team will have a GP, AHP and Nurse lead. The PCNs will lead the appointment of the team and the contract of employment for the team will be the responsibility of the PCNs. The PCN training team will support training and development of the Primary Care Workforce -clinical and non-clinical roles.
7.2	The following points were made in discussion: • The PCB were keen to explore how primary care professionals (GPs and practice nurses) could get exposure in acute and community trusts for the greater good of the system as well as for their own CPD. • Did capacity and staff training correspond to where the greatest patient need was? To address inequality, this needed to be mapped out. The GPs most able to fit in additional CPD might not be in the areas of greatest patient need for example. • The Training Hubs were in their infancy, it was hoped and expected that they would integrate and support the whole primary care workforce. Synergies would be possible between community providers and the Training Hubs as all organisations had learning and development teams; this was essential to avoid duplication. • Rotational roles would be developed to ensure an integrated approach. • This would be a good area for a deep dive at a future meeting.
7.3	**The Primary Care Board noted the primary care workforce training plan**
7.4	***ACTION: Add to work plan for a future meeting (January 23) deep dive on Primary Care Workforce and the work to date on the training hub***
PCB/11/22	**Any other business**
11.1	None raised.
PCB/09/22	**Reflections and Feedback from the meeting**
9.1	The Chair noted that it was good to be meeting face to face and that members had highlighted various governance points.
PCB12/22	**Date of next meeting**
12.1	Thursday 24 November 2022
PCB/12/22	**The meeting closed at 10:50**

Herts and West Essex Integrated Care Board PRIMARY CARE BOARD Action Tracker Last updated on 17 November 2022

Private / Public	Action Tracker Ref No	Date of Meeting	Subject	Action	Responsible Lead	Deadline Date	Comments and Updates	Status
Public	PCB/05.5/22	22.09.2022	Risk Register	**Provide risk update inc delegated risks of dental/optometry/pharmacy**	J Gleed	**24.11.2022**	**15.11.2022 - update:** subsequent to the last update all of the remaining risks have now been reviewed and risks associated with POD delegation discussed and confirmed – the updated log including the delegation risks will be presented to Nov PC Board meeting	**Closed**
Public	PCB/06.6/22	22.09.2022	GP Patient Survey Results	**Provide development of framework/dashboard**	M Campbell	**24.11.2022**	**15.11.2022 - update:** At the last MDT meeting the West Essex Dashboard was presented to the group. This Dashboard is built using several data sets from national and local sources – this is populated mostly by the BI Team and includes all indicators suggested as part of this MDT Access programme. The ICB BI Team are currently populating the dashboard to include SWH and ENH GP Practices. The Dashboard automatically RAG rates the practices and provides a Ranking Trend; this is then used to identify areas of focus. The WE team also use this dashboard to inform a "Super Action Log" which is a live document used to support the practice. The ICB wide populated dashboard is due to be completed by the end of November. The Dashboard includes information by practice on CQC rating, GPPS results, QOF achievement, Workforce data, 111 calls and A&E attendances per 1000 pt, capitation history, Resilience applications, GP Profile (E-DEC), Premises information, LES and DES Activity.	**Open**
Public	PCB/07.3/22	22.09.2022	Primary Care Workforce Training Plan	**Add to work plan for a future mtg - date TBC - deep dive in Training Hubs**	J Sweeney/ S Dixon	**26.01.2023**		**Open**

RAG Rating Key:	
Red	**Open (overdue)**
Amber	**Open (on-going)**
Green	**Completed / Action Closed**

Statement to Hertfordshire and West Essex IC Board meeting scheduled for 24th Nov. 2022

I'm Raymond Woodcock a resident of Stansted Mountfitchet. My issue, the need for a licensed Community pharmacy near Stansted Surgery and keep Boots on Cambridge Road.

During Jan. 2022 664 residents signed my petition supporting this need, I represent them and many more who have since spoken to me.

The 2022 ECC H&W PNA report states in the chapter Uttlesford, "No gaps in the provision of necessary pharmaceutical services have been identified in the Uttlesford locality. No gaps in pharmaceutical services have been identified that if provided either now or in the future would secure improvements or better access to relevant services across the Uttlesford locality." RW emphasis.

Well before this PNA was published Kemi Badenoch our MP wrote to ECC H&W detailing her considered support for our need. Stansted Mountfitchet Parish Council Chair, Mrs. Maureen Caton sent a detailed 11 page report supporting this need and Raymond Woodcock representing over 664 people in the community and surrounding communities sent a detailed 7 page report to ECC H&W/PNA team. The issues raised have not been mentioned in the Uttlesford chapter of the PNA. They have been ignored.

I hope you, the IC Board who also represent the community of Stansted Mountfitchet and surrounding settlements have also read this PNA report, the Uttlesford chapter is flawed? I cannot comment on other parts of the report as I do not have the detail required.

The Chapter Uttlesford District is it flawed?

No assessment of the only licensed community pharmacy in Stansted Mountfitchet was carried out. We have detailed evidence confirming that Boots on Cambridge Road is not accessible to those in our community who are wheelchair bound. A UDC Officer visited this pharmacy and was told by the pharmacist that people who are unable to climb the steps to enter this shop would be seen outside it "whatever the weather", even if they have very personal issues to raise with the pharmacist. This is surely discrimination and unacceptable.

Comment in the report of travel times by public transport does not mention the full journey to include the return journey time by those who have no transport of their own, our bus service is such that the return journey time takes generally 2 hours. The PNA makes no mention that Boots is overloaded by the ever-increasing demand on it, frequently patients are asked to return later to collect their prescriptions, others tell me they have received wrong medicines. People have complained and are told that staff are doing the best they can, bearing in mind the pressure of demand on them. This we would not refute.

Boots staff are not incompetent they are simply overloaded but this is not recognised or even considered by the PNA authorities.

We now face another major issue, Elsenham Surgery which also has a dispensing service is experiencing major problems, it is probable that it will be absorbed into Stansted Surgery with its dispensing service being stopped. If this happens the pressure on Boots will clearly increase.

Some basic numbers, Stansted Surgery has 12,000 patients and Elsenham Surgery 7,000 patients.

The NHS Constitution states:

1. “It has a wider social duty to promote equality through the services it provides”.

2. “The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.”

What can you do to help us?

Stansted Mountfitchet and surrounding communities need your help. Read our reports, I’ve attached mine. Meet us in Stansted Mountfitchet and talk to us. You can invite NHS England – East to join the visit. Consider the facts and not only the flawed ECC H&W PNA Report.

We need another NHS licensed community pharmacy and to keep Boots on Cambridge Road and we need it urgently, this will help all including the less fortunate in our community, the disabled.

Those who understand our situation by living in or frequently visiting Stansted Mountfitchet and who support our need include:

Mrs. Kemi Badenock, MP for our locality.

Cllr. Ray Gooding, Essex CC for our locality.

Uttlesford District Council Chief Officer Mr. Peter Holt

Stansted Mountfitchets Uttlesford District Councillors.

Cllr. Janice Loughlin representing Stort Valley on Uttlesford District Council.

Councillor Maureen Caton Chair of Stansted Mountfitchet Parish Council.

Mrs Janice McDonald Chair of Stansted Surgery PPG.

An above all, Stansted Mountfitchet and surrounding communities.

Raymond Woodcock

17/11/2022 updated 20/11/2022

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	ICB Primary Care Board				**Meeting Date:**	**24/11/2022**	
Report Title:	**Primary Care Board Governance: Sub-group Terms of Reference**				**Agenda Item:**	**06**	
Report Author(s):	Joyce Sweeny / Joanna Richardson						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	Primary care sub-groups						
Executive Summary:	Terms of Reference for Primary Care Digital Group and Primary Care Workforce Group						
Recommendations:	The Board are asked to note the Terms of Reference for the sub-groups						
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

Primary Care Digital Group
Terms of Reference

1. Introduction

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) Primary Care Digital Group.

2. Purpose and remit

The Hertfordshire and West Essex (HWE) Integrated Care System (ICS) Primary Care Digital Group will shape and inform the Digital Strategy for Primary Care that will enable delivery of the wider ICS Primary Care Transformation agenda. It will provide strategic leadership for the delivery of primary care digital transformation across the ICS aligned to the agreed priorities and key drivers of the system. The board will review the establishment and maintenance of an effective system of governance, risk management and internal control.

3. Role and responsibility

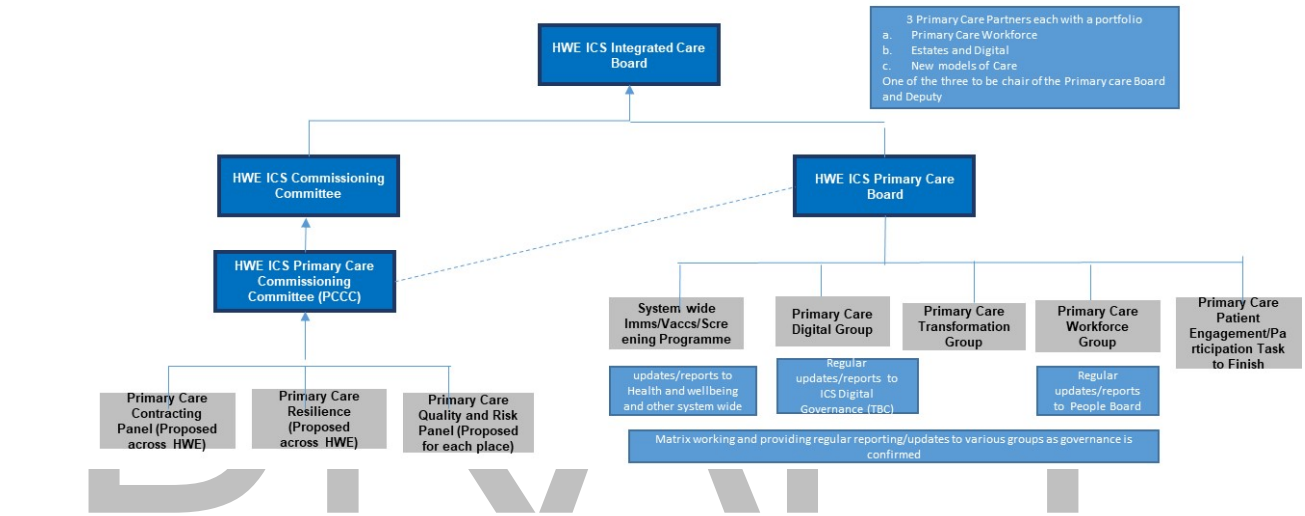
The Primary Care Digital Group adopts a collaborative approach and works with inconjunction with other transformation groups. The groups responsibilities include:

- Ownership of the creation and delivery of the ICS Primary Care Digital Strategy; comprising all services including general practice, pharmacy, dentist, optometry
- Ensure the ICS Primary Care Digital Strategy compliments and aligns to the wider ICS Digital Strategy and interdependency to other transformation and enabling workstreams including workforce/estates etc.
- To ensure the Digital Programme approach supports the delivery of the ICS Primary Care Digital Strategy
- To provide a platform for strategic decision making and escalation
- To promote and facilitate collaborative cross system working
- To oversee and agree implementation plans arising from national, regional and ICS priorities and milestones
- To oversee progress against agreed deliverables
- To assess key risks and unblock operational issues
- To establish sub-groups where required
- To approve key documentation and bid submissions
- To disseminate information to appropriate stakeholders internally and externally
- Provide oversight of the Digital First Primary Care Programme
- Provide strategic direction to HBL ICT as a provider for primary care digital

4. Accountability and Governance structure

The Digital Group will report to the Hertfordshire and West Essex ICS Primary Care Board and regular reports to Primary Care Commissioning Committee on progress and ICS wide Strategic Digital Group. It will also provide regular updates as requested to other groups such as the ICS Design and Delivery Board and others as the ICB governance develops.

Proposed Primary Care Governance



5. Lead executive/ chair

The ICS lead of Primary Care Digital will chair the HWE ICS Primary Care Digital Board and is responsible for supporting members of the board in:

- Providing strategic direction and decision making.
- Ensuring the group achieves its overall objectives and delivers the anticipated benefits.
- Actively promote work undertaken
- Monitoring the progress of the groups work programme.
- Escalating issues and removing barriers to progress as necessary and in a timely manner.
- Ensuring completion and submission of reports to meet timelines
- Financial oversight

6. Composition of membership

- Primary Medical Service Partner - chair
- ICS Primary Care Clinial Lead for Digital – deputy
- ICB Director of Primary Care Transformation
- ICB Director of Digital Transformation
- Place based Primary Care Clinical Leads for digital
- Programme manager of Digital First Primary Care
- Senior representation from HBLICT
- ICB AD for Primary Care Transformation/Head of Primary Care for Place

Attendees
LMC/LPC/LOC/LDC to be invited to attend
Other Clinical leads as appropriate including primary care clinical leads from place
Other ICB managerial leads such as finance/workforce/transformation/estates as appropriate

8. Attendance/ deputising arrangements

An attendance record will be held for each meeting.

Deputies will be allowed to attend meetings on behalf of members, if they are designated, and notified in advance.

9. Quorum

The quorum shall be the attendance of a minimum 4 members, one of which should be the Chair / Deputy Chair; and at least

1x Place based clinical lead
1x ICB Director
1x ICB Senior manager primary care/digital

10. Member roles and responsibilities

- All members are required to attend or send a deputy.
- Workstream and Portfolio leads must ensure that reports and papers are submitted to enable circulation 5 days before the meeting.
- All members are required to complete assigned actions and provide updates to the Board in line with the action log.
- All members are required to be full and active participants, to ensure that relevant expertise is available to the Board to facilitate effective management of the workstreams.

11. Meeting frequency

Meetings of the HWE ICS Primary Care Digital Board will be held

- Monthly

In the event of significant issues or situations arising the Chair will be made aware and decide upon the requirement to convene an interim meeting.

12. Serviced by

The servicing, administration and minute taking for the Chair is undertaken by

- The draft meeting minutes and action log will be circulated seven days after the meeting
- All highlight reports for the HWE ICS Primary Care Digital Board will be submitted five days before the meeting

- The agenda and supporting papers shall be forwarded to each member of the group and planned attendees five working days before the date of the meeting

13. Standing agenda items

- Welcome and Apologies
- Declaration of conflict of interest
- Previous meeting minutes and action log
- Relevant Programme / Workstream updates
- Finance and spending - Quarterly
- Risks
- Date of next meeting

Terms of Reference approved by xxxxxxx on xxxx

The terms of reference shall be reviewed annually and approved by the HWE ICS Primary Care Digital Board.

Review date: July 2023

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Primary Care Workforce Implementation Group

Terms of Reference

1. Introduction

1.1 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) Primary Care Workforce Implementation Group (WIG).

2. Purpose and Remit

2.1 The Primary Care WIG is a multi-professional body which operates at ICB level and brings together key stakeholders and organisations including Health Education England (HEE), NHS England (NHSE) and other agreed stakeholders to: -

- Support the delivery of Primary Care workforce planning, education and training, leadership and organisational development;
- Identify the key priority areas to support GP workforce recruitment and retention;
- Identify the key priority areas to support Primary Care Nursing workforce recruitment, development and succession planning;
- Identify the key priority areas to support the wider team development including Practice Management;
- Identify the key priority areas to develop, support and embed the new roles within Primary Care;
- Enable clinical/non-clinical perspectives to inform strategic decision-making;

2.2 The Primary Care WIG will play a key role in supporting the delivery of key national policy areas such as General Practice Forward View (GPFV), Long term Plan (LTP), Peoples plan, Five Year Framework for GP Contract Review; and will support the development and delivery of the HWE Primary Care Strategy (including any agreed recommendations of the recent Fuller Stocktake Report).

2.3 The Primary Care WIG will have a multi-professional focus, agreed ToRs and accountability needs to reflect the nature of the collaboration between HEE, NHSE/I and the ICB, and thus a mechanism developed to ensure robust reporting to the appropriate organisation responsible for the "commissioning" of any given workstream.

3. Role and Responsibility

3.1

- Lead on the strategic development and delivery of the Primary Care workforce component within the overarching HWE Primary Care strategy and People Plan;
- Oversee the implementation and delivery of the Primary Care strategy and work plans;
- Develop, monitor, review the annual Primary Care workforce plan including having robust prioritisation with regular reporting and assurance to the Primary Care Board, Primary Care Commissioning Committee, People's Board and other relevant committees in the ICB and in addition to other external partners as appropriately requested;
- Oversee the implementation of national requirements from NHSE/I and HEE in relation to Primary Care workforce;
- The group will receive regular reports from the subgroups/task to finish groups as appropriate;
- Lead of the workforce planning, education and training opportunities, testing new ways of working through development of innovative plans such as portfolio roles, enhance development of new roles, career pathways and leadership development;
- Oversee the development of Primary Care network workforces including new additional roles within PCNs;
- Being mindful that Primary Care workforce is dependent on development and future of estates and digital and can primary care looks at new hence working in a matrix way across other Primary care functions;
- To review Primary Care workforce risks;
- The group will adhere to the ICB procurement and financial limits;

3.2 Communications and Engagement

- Proactive engagement in responding to items and presenting data or information as part of the group;
- Two-way communication of information both at and between meetings;
- Acting as a representative of their organisation/department/expertise;
- To disseminate information from the group across their stakeholder area regarding organisational and directional change of innovation;
- To review and share operational experience across the group to promote best practice and spread solutions;
- To declare any conflict of interest as items arise;

4. Accountability and Governance Structure

4.1 The HWE Primary Care Workforce Implementation Group is accountable to NHS England and Health Education England but also within the ICB to primary care governance via the Primary Care Board. Decision making will be undertaken by the HWE WIG in accordance with processes outlined within these policies and strategic/operating plans:

- HWE ICBs Procurement Strategy and Standards of Business Conduct and conflicts of interest policy;
- Health Education England Quality Framework;
- Primary and Community Care Training Hub programme - Common Operating Guidance;
- HWE Operating Plan;

- HWE Primary Care strategy;
- HWE People Plan strategy.

5. Operating Principles

5.1 Recording of Interests: on appointment and at the start of every WIG meeting, members will be required to declare any interests of relevance, financial, professional, personal and indirect interests.

5.2 Confidentiality: All members of the group shall not reveal or disclose any information identified as confidential without the permission of the Chair. This applies to the content of any discussion as well as papers and records.

6. Reporting Responsibilities

6.1 The Hertfordshire and West Essex Primary Care Workforce Implementation group will provide regular reports and assurance to the Primary Care Board, Primary Care Commissioning Committee, People's Board and other relevant committees in the ICB and in addition to other external partners as appropriately requested;

- The Primary Care Workforce Implementation group will be supported by a number of workforce Clinical and Non clinical leads and chaired by the HWE ICB Training Hub Clinical Lead;
- Workforce leads will provide regular highlight reports and where necessary exception reports or in-depth reports as required by the WIG.
- The Group will provide the forum for discussing and agreeing ICB level Primary Care Workforce and Education initiatives and funding requests; although, it is accepted that due to time constraints associated with external funding opportunities, decisions may need to be made by email between meetings. It is expected that a final sign off decision will be made by Director level and finance lead and reported to Primary Care Commissioning Committee (PCCC) as appropriate.

7. Membership and Chairing Arrangements

7.1 Core Membership

ICB Primary Medical Partner with portfolio lead in Workforce – Chair

Director of Primary Care Transformation/Assistant Director of Primary Care Strategy

Head of Primary Care Workforce

Director of Nursing/Deputy

Primary Care Nurse Lead

Place Primary Care Workforce Clinical Leads x 3

Finance Lead

ICB Peoples Board Representative

7.2 In attendance

- NHSE/I Representative
- First 5 Leads x 2
- Wise 5 Lead
- Expansion and Capacity Lead
- Quality Lead
- Ambassador Leads for Additional Roles as appropriate
- Representatives from Local Professional Committees (LMC, LOC, LDC, LPC)
- Primary Care Workforce Operational Managers
- Practice Manager Representative
- Associate Dean, HEE
- Representatives from Education Centres ie Universities
- Other leads as appropriate

8. Quorum

8.1 The group will be quorate when at least four members are present. At least three Clinical Leads and ICB Director/Deputy must be present.

9. Member Roles and Responsibilities

9.1 All members are required to attend or send a deputy.

9.2 Workstream and Portfolio leads must ensure that reports and papers are submitted to enable circulation 5 days before the meeting.

9.3 All members are required to complete assigned actions and provide updates to the group in line with the action log.

9.4 All members are required to be full and active participants, to ensure that relevant expertise is available to the WIG to facilitate effective management of the workstreams.

10. Meeting Arrangements

10.1

- The Group will meet every six weeks.
- Members who cannot attend will be expected to send deputies.
- Papers will be circulated at least five working days before each meeting.
- Action logs will be circulated within 10 working days of each meeting.

Minutes of Meetings

- The secretariat will minute the outcome and the actions of the group including recording the names of those present and in attendance.

- Members and those present should state any conflicts of interest in relation to agenda items to the Chair prior to the meeting

- Any new relevant interests declared at a meeting will be confirmed in writing to the Head of Corporate Governance and added to the ICB's Register of Interests

11. Monitoring and Review

11.1 The Terms of Reference will be reviewed on an annual basis, or sooner if required. The next review will take place one year from the date of approval stated below.

Date of approval: 22 September 2022

Date of review: (Within first six months)

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Primary Care Board				**Meeting Date:**	**24/11/2022**	
Report Title:	**Primary Care Risk Register**				**Agenda Item:**	**08**	
Report Author(s):	Andrew Tarry, Head of Primary Care Commissioning James Gleed Associate Director Commissioning Primary Care.						
Report Signed off by:	Avni Shah Director Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☒
Report History:	A new Risk Register for the HWE ICB Primary Care Directorate has been created; this brings together and replaces risks previously recorded and tracked on individual CCG Risk Registers. Work commenced on this as part of the preparatory work for creation of the Hertfordshire and West Essex Integrated Care Board. The Risk Register was presented to the Primary Care Commissioning Committee in Common of the three Herts and West Essex CCGs in May 2022 and to the Herts and West Essex ICB Primary Care Board in August 2022. Following discussion at the last Primary Care Board in September where 2 key actions were agreed: • Including risks with delegated dental, optometry and pharmacy contracts. • Review of all the risks with lower risk ratings (lower than 12)						
Executive Summary:	A summary is provided of the latest ICB discussions regarding the developing approach to the identification of joined-up risks across the wider system. It is proposed that key risks from other relevant areas are shared with the Board in future updates to provide a broader view of risks impacting on Primary Care. Some updates to existing risk controls, gaps in controls and gaps in assurance recognising recent developments, especially reflecting the ICB transition. Also updates to ensure controls and measures remain valid for the current year. Deletions are marked by strikethrough; new text highlighted in red.						

	Risks 325 and 333: both risks have been closed, as noted in the September paper, so have duly be removed from the Risk Register. It was proposed in relation to risk 333 that a new broader risk regarding implementation of Enhanced Access (EA) across the ICB is added. On reflection, existing risk 331 has now been amended to capture the broader risk as noted above. **Risk 331**: reduce risk score from 12 to 6 (low) – rationale: Enhanced Access services commenced from 1st October, with all PCN plans agreed. All staff transferred to the PCNs where relevant and only some outstanding issues with a low number of staff. Some remaining operational & IT infrastructure issues are to be resolved. **New Risks are proposed as follows:** - Additional Role Reimbursement (ARR) scheme budget utilisation and recruitment to these roles. - Closure of COVID-19 Vaccination Centres, meaning greater reliance on current general practice and community pharmacy resourcing. Both risks require review and approval by the Board. Key high level risks associated with Dental Optometry & Community Pharmacy (DOP) delegation are appended to this update. The risk register is a dynamic document and is presented to the Primary Care Board for review, discussion and information.
Recommendations:	The Board is asked to agree the proposed changes to the risks that have been reviewed.

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	☐

1. Executive summary

The process of transferring risks contained in the HWE Primary Care Risk Register onto the *Datix* electronic system has been completed.

Since the register was last presented to the Primary Care Board in September all of the risks have been reviewed with resultant changes proposed (register is appended – Appendix 1).

A summary is provided of the latest ICB discussions regarding the developing approach to the identification of joined-up risks across the wider system.

It is proposed that key risks from other relevant areas are shared with the Board in future updates to provide a broader view of risks impacting on Primary Care.

Key high level risks associated with Dental Optometry & Community Pharmacy (DOP) delegation are appended to this update.

The risk register is a dynamic document and is presented to the Primary Care Board for review, discussion and information.

2. Background

Historically each of the three CCGs in HWE developed and maintained a primary care risk register; risks meeting predetermined thresholds were reported to Board.

Work commenced on a new consolidated risk register across HWE as part of preparations for the creation of the HWE ICB.

Each of the three individual risk registers have now been fully reviewed and archived as part of creating the new consolidated ICB risk register across the three 'places'.

3. Issues

It is recognised that there is a need to join-up identification and recording of risk across both the ICB Directorates and with wider system partners. The ICB Risk Review Group, led by the Associate Director of Integrated Governance and Organisational Alignment, is progressively seeking to use this forum to ensure a rounded discussion on risk between teams, with possible scope to include wider system representatives in the future.

A meeting was held with the Associate Director of Integrated Governance and Organisational Alignment, including specific discussion regarding the approach to the joined-up identification of risk. From this discussion it was noted that as part of the consideration of this it is important to draw the distinction between individual organisational risk and risk in the wider system and/or to patient care in HWE. It is also apparent that a decision made by one provider could create a risk for another; noting that the remedy to this is perhaps greater partnership working and decision-making, not joined up risk assessment per se. Joining up risk assessment is cross-directorate and cross-organisational and therefore needs to be led at organisation/multi-partner level, rather than this being a primary care specific initiative. Whilst noting the above the Board may wish to consider whether it may be prudent to consider recognising a new risk around the multi-agency service planning and system decision making in response to this and previous board discussion around joining up risk.

Notwithstanding the above, it was recognised that the key task for the next 6 months is to ensure that all directorate risk registers across the ICB are fully updated and reflective of the key risks.

In terms of Primary Care it is recognised that there are other key areas, such as Estates, IT and Digital which have very direct bearing, with key risks impacting on Primary Care. Work is ongoing to ensure that key risks from these and other relevant areas are shared with the Board in future updates to begin to provide a broader view of risks impacting on Primary Care; not just those within the remit of the Primary Care Directorate.

For this update we wanted to ensure the Board were sighted on the high-level risks associated with Dental Optometry & Community Pharmacy (DOP) delegation (Appendix 2). These are recorded on Datix but are not on the Primary Care specific Risk Register. Noting that further regular updates will be provided to both PCCC and PCB between now and March 2023.

As part of the place specific Primary Care Risk & Information Sharing Groups, debate was had regarding any potential requirement to capture individual general practice level risks on the wider Directorate Risk Register. It was reflected that previous discussion on this topic had concluded that individual practice risks should not be included, as there is already a mechanism to report these risks to the Primary Care Commissioning Committee by sharing the relevant Risk and Information logs per place.

4. Actions

The required review of all lower rated risks on the register as noted in the September Primary Care Board update has now been undertaken. From this review it is proposed that the following changes are made to the risk register:

Some updates to existing risk controls, gaps in controls and gaps in assurance recognising recent developments, especially reflecting the ICB transition. Also updates to ensure controls and measures remain valid for the current year. Deletions are marked by strikethrough; new text highlighted in red.

Risks 325 and 333: both risks have been closed, as noted in the September paper, so have duly be removed from the Risk Register. It was proposed in relation to risk 333 that a new broader risk regarding implementation of Enhanced Access (EA) across the ICB is added. On reflection, existing risk 331 has now been amended to capture the broader risk as noted above.

Risk 331: reduce risk score from 12 to 6 (low) – rationale: Enhanced Access services commenced from 1st October, with all PCN plans agreed. All staff transferred to the PCNs where relevant and only some outstanding issues with a low number of staff. Some remaining operational & IT infrastructure issues are to be resolved.

New Risks are proposed as follows:

- Additional Role Reimbursement (ARR) scheme budget utilisation and recruitment to these roles.
- Closure of COVID-19 Vaccination Centres, meaning greater reliance on current general practice and community pharmacy resourcing.

Both risks require review and approval by the Board.

5. Resource implications

Further senior management input is required to ensure that the Primary Care Risk Register is owned by all and to ensure that leads take specific responsibility for their respective risks within Primary Care. A regular monthly meeting has been arranged to support this review process.

6. Risks/Mitigation Measures

As noted above.

7. Recommendations

The Board is asked to:

Agree the proposed changes to the risks that have been reviewed and the new risks proposed.

Note the stated ambition in terms of the ICB approach to joined-up risk identification, the focus on ensuring that all ICB Directorate risk registers are fully updated and the intention to share key relevant risks from other Directorates impacting on general practice with the Board.

Consider the recognition of a new risk concerning the multi-agency service planning and system decision making in response to this and previous board discussion around joining up risk.

Review the Dental Optometry & Community Pharmacy (DOP) delegation risks.

Review the approach to the recording and reporting of individual general practice level risks.

Receive the risk register at future meetings (in accordance with the Primary Care Board's Annual Cycle of Business) for review and discussion in order to satisfy itself that risks are being appropriately captured and rated and that relevant/proportionate mitigation and controls are in place.

8. Next Steps

Ongoing review and update of the remaining risks on the register

Ensure that the recent proposed updates to the risk register are entered onto the Datix system.

Work with other Directorates to ensure that key risks from relevant areas are shared with the Board in future updates.

Transition Risks

11 November 2021

Risk Profile														Assurance Mapping								
ID	Datix ID	Date Opened	HWEICS Strategic	Committee	Executive Owner	Risk Lead	CCG Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Controls	Gaps in controls	1st Line Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assu	2nd Line Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective	2nd Line - Level of assu	3rd Line Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	Gaps in assurance	Approval status
PC1	318	10/11/2021	1 2 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Transformation at Place	**IF** points of participation and influence for primary care in the new ICB and HCP structures are not made clear during the transitional period… **THEN** meaningful engagement with primary care may not be sustained into the new ICB arrangements… **RESULTING IN** challenges enacting ICB plans for delivery at place.	20	12	8	No movement ↔	1. Agreement of ICB governance structure 2. Oversight of previous CCG leadership roles in the initial transitionary period 3. Use all avenues to engage Primary Care, such as existing CD/Primary Care meetings 4.Appointment of key Primary Care roles 5. Embedding of Primary Care leadership roles & agreement of appropriate engagement fora	~~Plans for the ICB and place based structures are not yet widely understood.~~ ~~ACTIONS:~~ ~~Draft internal communications strategy and stakeholder engagement plan has been developed: these need to be regularly reviewed and refreshed in light of new requirements.~~ 1. Further development of engagement fora & embedding of PC leadership roles. Clinical Leads induction event held. 2. Commencement of engagement in key ICP & ICB meetings requiring PC engagement	~~Iterative development of ICB and HCP structures is being aligned through Transformation Board sub groups. Regular~~ Primary Care SMT and wider team meetings. Primary Care attendance at place SMT meetings	Reasonable	Updates to the ICS Partnership Board, Healthcare Partnership Boards and Audit Committees.	Reasonable	Transformation assurance processes with NHSE/I	Reasonable	ICB and HCP structures ~~to be finalised and signed off by partners.~~ Fully implemented and embedded	The risk was approved for inclusion by Committees meeting in common, March 2022. Reviewed by PCB Sept 22 & agreed to risk score reduction from 20 to 12
PC2	320	10/11/2021	1 2 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care at Place	**IF** pressures in general practice, exacerbated by the Covid-19 pandemic and pent up non-Covid demand, remain at the current high level... **THEN** there may be insufficient capacity for GP practices, primary care networks and federations to deliver against transformation of care priorities in a way that demonstrates tangible improvements for patients... **RESULTING IN** sub-optimal patient experience due to continued pressures across the system and especially in acute services.	20	12	8	No movement ↔	1. ICB providing support to GP practices, PCNs and GP federations in planning for the transformation of delivery of care in Hertfordshire and West Essex. 2. Primary care teams have implemented the national GP Forward View transformational programme which includes extended access. 3. 'E-consultation' has been accelerated due to the pandemic and national and local initiatives are being implemented to develop practice telephony to deal with increased demand. 4. Organisational development programmes for PCN clinical directors and PCN managers are being supported. 5. PCN DES sign up: national requirement now met with all practices in a PCN, or non-participating practices covered by other PCNs as a local agreement. 6. Primary Care Input in ~~Member input for~~ ICS clinical strategy. ~~ICAG developing west Herts clinical and care strategy. Clinical leads for all locality delivery boards now appointed.~~ 7. Training for Primary Care Networks to equip them to develop at pace in line with national requirements and for GP Federations to help them to understand their role in the development of PCNs. 8.Further ICB investment for PCNs to support training and implementation of services at PCN level, including additional workforce, training provision and backfill to attend. 9. Further training being identified to support GPFV/NHSLTP priorities. ~~10. DES specifications have been signed up to by all PCNs.~~ ~~11. Direct booking solution in General Practice has been implemented.~~ ~~12. The CCGs agreed to continue to support practices in prioritising patients to aide recovery:~~ ~~o Protecting income under the GPECF for 21-22 and into Q1 22-23;~~ ~~o Further identifying financial support to general practice to support wider system pressures.~~ 10. Introduction of ICB wide ECF scheme, including Primary Care OPEL status reporting as part of the wider system reporting and improve understanding of pressure points for general practice. 14. ~~The CCGs have redeployed staff to vaccination sites to support administrative and operational tasks and~~ Continue to support practices with IT infrastructure to mitigate the impact of workforce challenges with increasing numbers of primary care staff needing to work remotely and isolate. 11. ~~Meetings between clinicians and officers to discuss issues and solutions (weekly in HVCCG, fortnightly in ENHCCG).~~ Fora for regular engagement between ICB and PCN CDs, primary care and clinical leads in all 3 places	~~Need for further alignment of processes and structures is being addressed but not yet complete.~~ ~~ACTIONS:~~ ~~1. ECF programme to be aligned across HWE in preparation for the ICB.~~ 1. Arrangements for appropriate primary care input at all key ICB and HCP meetings and sub groups have been agreed and being implemented ~~Further participation in the HCP by all partners is being developed, including discussions about key points of influence for PCN Clinical Directors and Locality representatives. HCP sub groups are taking forward development, co-ordinated by HCP Leads.~~ ~~3. Director of Strategy and Integration for WHHT has put together an analysis of all the HCPs in HWE and proposed how their governance might interact with the new ICB structures.~~ ~~4. Associate Director of Integrated Governance and Organisational Alignment is proposing structures for the ICB for discussion and feedback.~~ 2. Primary Care Strategy for the ICB being developed.	• Primary Care Working Groups support the preparation and monitoring of plans with any risks or issues escalated. Risk registers monitor resilience in all practices. • Resilience panels receive applications for support • ICS population health management group. • Practices are compliant with national and regional guidance during the Covid 19 pandemic.	Reasonable	•~~P~~Place based delivery boards have a strong primary care presence and monitor delivery against locality plans. • ~~A~~All overseen by the Primary Care Commissioning Committees and Primary Care Board and reported to ICB Boards as appropriate. •~~P~~Primary Care updates and assurance papers to other ICB Committees and groups as appropriate. •~~A~~Approval of expenditure above PCCC authorisation limit is escalated to another Committee or Board meeting. •~~A~~Assurance papers to Audit Committee in March 2020. Audit and Assurance Committee receives internal audit reports and updates on risk register •~~C~~Clinical Senate and Integrated Clinical and Care Advisory Groups to the Health and Care Partnerships support strategy development.	Reasonable	•~~N~~NHSE/I Regional Team receives PCCC in common papers. •~~P~~Practices are compliant with national and regional guidance relating to the Covid 19 pandemic. •~~P~~QC reporting shared with ICB. •~~N~~NHSE/I remedial actions discussed with ICB •~~I~~Internal audits of Primary Care Networks and Delegated Commissioning provide reasonable or substantial assurance.	Reasonable	ICB and HCP structures ~~to be finalised and signed off by partners.~~ Fully implemented and embedded	Approved by Committees meeting in common March 2022 Reviewed by PCB SeptZ2
PC3	321	04/03/2022	1 2	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Transformation at Place	**IF** Primary Care is not supported to optimise capacity and address variation, **THEN** patients may not experience improved access to urgent, same day primary care, **RESULTING IN** negative impact on patient experience, patient safety, system resilience and commissioner reputation.	16	12	8	No movement ↔	~~1) £6.16m allocation to HWEICS of Primary Care Winter Access Funding has enabled:~~ ~~- Increasing winter capacity via PCNs: 159k additional appointments from November 2021 to March 2022.~~ ~~- Additional capacity through extended hours/respiratory hubs/paediatric hub.~~ ~~- Acceleration of community pharmacy consultation service: more than 60 practices trained and live by January 2022. Remainder to be completed in Q4.~~ ~~- Reinvigoration of PPG network: listening events.~~ ~~- Communications materials for patients and public to support understanding of models of care.~~ ~~- External company to support clinical triage and overflow in general practice: expressions of interest received from 10 PCNs.~~ ~~- Tailored practice plans: access improvement visits underway~~ 1. All HWE practices have access to a time limited (to April-23) additional outbound functionality enabled through MS Teams and negotiated nationally. This solution will enable staff to use MS teams to make outbound only calls independently of the existing telephone solutions. This will free up the existing lines for incoming calls. 2. Improvements in practice telephony infrastructure: 55 practices across Hertfordshire and west Essex bids have been approved for implementation in line with the national advance telephony specification. The vast majority of the new system installations having been completed. 3.22/23 Winter Pressure funding of £1.43 per patient & a further £0.602 pp from IIF redeployment 4. Further work in train to reinvigorate patient groups and help promote new healthcare roles and access to services, aligning expectation with offer.	1. Additional demand and constraints of the pandemic. 2. Release of pent-up demand, accumulated during the pandemic when people were less likely to consult their practice or seek specialist care. 3. Need for general practice to take a pivotal role catching up on the backlog of care for patients on its registered list who have ongoing conditions. 4. Tailored practice plans and visits have revealed some themes re barriers to improvements: access to additional IT; premises constraints; workload prioritisation. 5. Actions may require longer term solutions relating to capital investment and workforce development. 6. Expansion of acute in-hours visiting to HV and WE is challenging in the short term due to increased system demand and pressure.	Reports to ICS Executive and Partnership Board Oversight Group discussed emerging issues.	Reasonable	Reports to PCCC	Reasonable	Reports to NHSE/I	Reasonable	Not all proposed measures can be introduced in the short term for all practices.	Approved by Committees meeting in common with the addition of reference to reputational risk. Reviewed by PCB Sept22
PC4	323	13/04/2022	1 2 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Transformation at Place	**IF** the pace of organisational development for primary care networks and their clinical directors does not increase... **THEN** there may be insufficient capacity for GP practices, primary care networks and federations to deliver against transformation of care priorities and a limited amount of collaboration between PCNs and other local delivery partners... **RESULTING IN** delays in delivery of transformation objectives to improve quality and accessibility of services.	16	12	8	No movement ↔	1. Provision of additional investment and support to primary care to develop PCNs in planning for the transformation of delivery of care in Hertfordshire and West Essex. 2. PCN DES sign up: national requirements now met for all PCNs and practices. 3. Directorate has a suite of projects designed to increase resilience and sustainability of primary care. 7. Individual work programme risks reviewed at team meetings. ~~8. Clinician /Officer meetings.~~ 8. HWE ICB Training hub offers/provides training and educational support to PCNs 9. PCN Workforce & PCN Development Plans 10. PCNs provided with Population Health Management support, to develop plan to support specific patient cohorts. 11. Recruitment to ARRS roles.	1. Further ARRS recruitment to be completed. 2. 2022/23 GP Transformational Support Plans to be agreed and remaining (H2) funding drawn down	Progress reports provided to ICS Primary Care Exec and Partnership Board	Reasonable	Reports to PCB and PCCC	Reasonable	NHSE/I receive PCCC papers	Reasonable		Approved at the PCCCs meeting in common in May 2022. Reviewed by PCB Sept22

Transition Risks

Risk Profile														Assurance Mapping							
ID	Datix ID	Date Opened	HWE/CS Strategic	Committee	Executive Owner	Risk Lead	CCG Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Controls	Gaps in controls	1st Line Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assu	2nd Line Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective	2nd Line - Level of assu	3rd Line Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	Gaps in assurance	Approval status
PC5	324	04/03/2022	1 2 3 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	AD Primary Care Commissioning and Contracting	**IF** there are not consistent and rigorous processes for monitoring quality and performance of contracts and investments... **THEN** there is potential for variable outcomes in improvements across the three geographical areas... **RESULTING IN** inequalities in the quality and performance of ICB primary care services and disparities in costs for the same services in different locations.	20	12	8	No movement ↕	1) Individual processes are in place for ICB, for example: - ~~Integrated Quality and Performance Reports to Boards meeting in common and in public.~~ Inclusion of PC data in Quality and Performance reporting to ICB Board - PCCC meeting has independent input from an out of area GP. - PCCC membership has a non-GP majority. - Risk and information sharing meetings with all relevant teams, LMC, Nursing & Quality and CQC. - Support packages in place for all practices with an existing ratings of 'Inadequate' or 'Requires Improvement' - Quality visits to practices and Extended Access sites - Practice Manager meetings 2. Healthwatch action plan 3. Reporting to single ICB Primary Care Board, with non-GP majority membership. Single Primary Care Contracting Panel now in place	1. Review of different approaches in the 3 ICB places **ACTIONS BEING TAKEN**: - Identify current arrangements; compare and identify differences; assess differences in outcomes - Agree which process (or combination of processes) produces the best results - Implement one process across the ICS footprint 2. In process of establishing contractual/performance delivery monitoring processes across the ICS 3. Reviewing approach to joint Quality/Contracts visits. Propose using current WE risk dashboard format as a consistent ICB wide format. 4. Assessment of PCNs needs further consideration - relationship between PCNs & member practices, supervision of PCN staff	Internal quality and performance monitoring processes in each place. Support to practices with 'inadequate' or 'requires improvement' rating. Support to practices with access challenges, e.g. staffing or premises.	Reasonable	Reports to PCB and Quality Group ~~and Performance Committees and CCG Boards~~ Assurance to PCCC Liaison with CQC and LMC	Reasonable	Liaison with CQC and LMC Internal audit opinions ~~External audit conclusions~~ Updates to patient groups e.g. Patient Network Quality (PNQ) Monthly meetings with Healthwatch Presentations at Local Authority Overview and Scrutiny Groups	Reasonable	Extent of reporting of primary care quality and performance to Public Board - for discussion: terms of reference and work plans for ICB committees are being developed by the ICS. There is also discussion of Quality Groups at place at request of the ICS. Some practices reluctant to engage or nor highlighted as potential risks may be inspected by CQC, with further unknown risks emerging.	Approved at the PCCCs meeting in common in May 2022. Reviewed by PCB Sept 22 & agreed to risk score reduction from 16 to 12
PC7	325	04/03/2022	1 2 3	Primary Care Commissioning Committee	Director of Primary Care Transformation	AD Primary Care Commissioning and Contracting	**IF** Primary Care sustainability is not robust enough... **THEN** we may not be able to ensure continued delivery of primary medical services... **RESULTING IN** a reduction in quality, patient safety and experience.	16	12	4	No movement ↕	1. Routine practice and extended access hub visits. Individual practice visits to support mergers, resource and capacity issues, estates and infrastructure issues 2. Business Continuity Plans - Support for PCNs to develop BCPs and facilitate mutual aid 3. Targeted support for practices who are rated 'inadequate' or 'requires improvement' by the CQC 4. Support offered to all practices for preparation for CQC inspection or other CQC Reviews including 'mock visit' 5. Targeted support where practices have access challenges such as workforce or premises 6. Regular monthly meetings with the CQC 7. Meetings with the LMC 8. Monitor workforce levels through audit 9. Support to practices in the further development of Primary Care Networks as part of the delivery of The Long Term Plan 10. Targeted workforce initiatives through the ICS funding available 11. Supporting practices to access GP Resilience Funding. 12. Primary Care OPEL Framework introduced as part of ECF 13. Potential Practice Closure plans 14. Action plan to identify and investigate opportunities to improve patient access, including promotion of self-care, self-referral and community pharmacy scheme. ~~Support and additional funding from NHSE provided to practices via additional COVID Expansion Funding to support restoration and improved access to services~~ 15. Additional Roles Reimbursement Scheme for PCNs ~~Guidelines to support practices with 'reset' based on national and local guidance~~ 16. Additional winter capacity funding for 2022/23 to support the demands faced across the system as a result of the pandemic 17. Support for PCNs to deliver services at scale e.g. Asthma diagnostic hubs	Solutions to substantive workforce and premises limitations take time to implement. Interim arrangements may need to be actioned.	Available and monitored data sources to gauge practice sustainability: QOF achievement and exception reporting CQC rating GP Patient Survey results Workforce audit information Premises concerns Acute utilisation Quality (complaints & PALS) ICB support requests Risk rating for practice GPAD data	Reasonable	The Primary Care Commissioning Committee reviews the forecast risk resilience tool routinely and also on an ad hoc basis if new information is received. Reports to PCB	Reasonable	CQC inspections and reports	Reasonable		Approved at the PCCCs meeting in common in May 2022. Reviewed by PCB Sept22
PC8	327	04/03/2022	1 2 3	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Transformation at Place	**IF** primary care recovery and prioritisation of workload is not adequately supported... **THEN** meeting of primary care contractual requirements may be affected, particularly relating to routine and preventative work... **RESULTING IN** negative impact on patient access, care and experience, QOF outcomes and wider system pressures.	15	12	6	No movement ↕	~~Engagement with other ICBs and learning~~ ~~Information about arrangements for shielding patients /hot sites~~ ~~Initial primary care recovery plans disseminated~~ ~~Phase 3 recovery plans: recovery metrics sent and received from practices~~ ~~Covid Capacity Expansion Fund - enabled practices to increase staffing and service provision~~ 1. Additional Winter Capacity Funding support ~~Winter Access Fund Programme~~ ~~2. Respiratory hubs or equivalent provision for patients with infectious respiratory illness established and funded since first wave of Covid-19 pandemic~~ 2. Introduction from Oct-22 of ICB wide ECF scheme to support general practice prioritisation, deliver LTC management etc	1.Unable to meet high BAU demand 2.Unable to clear back logs for: complex long term conditions; health checks; medication reviews; screening; and spirometry diagnostics. **Actions:** Establish key actions and timescales and monitor progress.	Place based recovery plans for primary care services	Reasonable	~~Progress updates on recovery to PCCCs meeting in common~~ Reports to PCB ~~CCG boards meeting in common~~	Reasonable	CQC inspections and reports Internal audit reports External audit conclusions	Reasonable	Ongoing exceptionally high demand in primary care.	Approved at the PCCCs meeting in common in May 2022. Reviewed by PCB Sept22
PC9	328	04/03/2022	2	Primary Care Commissioning Committees meeting in common	Director of Primary Care Transformation	AD for Primary Care Strategy and Digital lead	**IF** the quality of data available to practices and Primary Care Networks is not adequate ... **THEN** this will limit the ability for primary care to meet new responsibilities relating to population health management... **RESULTING IN** failure to achieve forecast outcomes in population health and healthcare and tackle inequalities in outcomes, experience and access.	16	12	4	No movement ↕	1. Procurement of one solution across ICS on data platform i.e. Ardens - Upgraded Ardens Manager 'National Contracts' package procured for practices and PCNs for 2022-23 2. Development of Primary Care Dashboard 3. PCN DES "Tackling Health Inequalities" service implementation 4. Primary Care teams aligned to PCNs/Localities to support development of PCN PHM Plans	1. Currently variance in IT solutions and processes across the CCGs - single BI platform to be implemented 2. Confidence of data recording/reporting 3.Regular /consistent health outcomes and activity data set shared with primary care needs to be established	Co-ordination of consistent BI data reporting across ICS; PHM training to PCNs, Primary Care Managers	Reasonable	Assurance to PCCC	Reasonable	Reporting into ICB	Reasonable	~~TBC~~ None identified	Approved at the PCCCs meeting in common in May 2022. Reviewed by PCB Sept22

Transition Risks

Risk Profile														Assurance Mapping							
ID	Datix ID	Date Opened	HWEICS Strategic	Committee	Executive Owner	Risk Lead	CCG Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Controls	Gaps in controls	1st Line Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assu	2nd Line Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective	2nd Line - Level of assu	3rd Line Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	Gaps in assurance	Approval status
PC10	329	04/03/2022	1 2	Primary Care Commissioning Committee	Director of Primary Care Transformation & Director of Workforce	Head of Primary Care Workforce	**IF** there were no forecasting or forward planning for changes and challenges in general practice workforce... **THEN** we would be unable to foresee changes in workforce and act proactively to address expected shortfalls in any profession... **RESULTING IN** threat to patient care as patients may not have access to a range of skilled professionals in primary care.	9	6	3	No movement ↕	1. Monitoring workforce trends 2. Taking novel approaches to recruitment and retention 3. Providing updates to PCNs including ARRS position 4. Primary Care Teams working with PCNs to submit forward ARRS workforce plans 5. PCN workforce teams connected to current /future issues in practices/PCNs 6. Plan with system partners to avoid destabilising the workforce	1. Increasing numbers of GPs and GPNs taking retirement mean further plans necessary to address retention or recruitment. 2. Difficulties recruiting to some AHP roles due to competition for their skills. 3. PCNs have autonomy for ARRS recruitment plans and have identified finances (shortfall in salary cap and management overheads) and risk (liability for staff given uncertainty about future of PCNs) and perceived value of some non-GP roles as barriers	Quarterly Workforce Data Collection Annual Skill Mix Collection	Substantial	Update reports to PCB and PCCC Progress monitored in ICS Workforce Group	Substantial	Reports to NHSEI	Substantial	None identified	Approved at the PCCCs meeting in common in May 2022. Reviewed by PCB Sept22
PC11	330	04/03/2022	1 2	Primary Care Commissioning Committee	Director of Primary Care Transformation & Director of Workforce	Head of Primary Care Workforce	**IF** there is a lack of career development opportunities in primary care ... **THEN** primary care may be less attractive as a career choice... **RESULTING IN** doctors, nurses and other allied health professionals leaving primary care and choosing alternative career paths, making primary care less resilient and creating instability in patient access.	12	9	3	No movement ↕	1.International GP Recruitment Programme 2. Qualified Nurses Return to Practice Campaign 3. Qualified Nurses to make PC career choice 4. GP Fellowship Scheme 5. New to Practice Fellowship programme for GPNs and GPs 6. First5 Networking/support forums 7. Wise5 Networking/support forums 8. GPN/HCA networking/support forums 9. Monthly lunch time educational webinars for all Primary Care staff clinical and non clinical 10. Monthly evening educational webinars for clinicians 11. GPN Appraisal support programme 12 .Leadership programmes for GPNs 13. Advanced Care Practitioner networking/support forum 14. GPN Leadership networking/support forum 15. Apprenticeship webinars for clinical and non clinical roles 16. Clinical supervision sessions for GPNs/HCAs 17. HWE ICB Training hub offer all primary care staff career clinic sessions 18. Creation of PCN Training Teams	1. Increasing numbers of GPs and GPNs stepping down due to system pressures/ taking early retirement are exacerbating the risk. 2. Difficulties recruiting to primary care roles due to competition for their skills. ~~Additional support for mentorship and training of~~ 3. Underutilisation of ARRS budget ~~roles required - proposal for PCN training teams being developed~~	121 line management meetings Workstreams reviewed at Workforce Team meetings Workstreams reviewed at WIG meetings	Reasonable	Reports to PCB and PCCC	Reasonable	Reports to NHSEI Review of workforce position and work programmes at LMC Operational and Liaison Meetings	Reasonable	None identified	Approved at the PCCCs meeting in common in May 2022. Reviewed by PCB Sept22
PC12	331	03/05/2022	1 2	Primary Care Commissioning Committee	Director of Primary Care Transformation	AD for Primary Care Contracting	**IF** the transfer/commencement of the GP Extended Access Service to PCNs is not proactively supported... **THEN** workforce challenges & sub-optimal service delivery is likely ... **RESULTING IN** a.Staff may leave the incumbent provider due to uncertainty caused by the GP Extended Access transfer, resulting in a risk for future provision b.Incumbent providers may lose experienced staff through TUPE which could destabilise their remaining services c. service delivery potentially not meeting patient need, poor utilisation of appointments	16	6	4	Risk rating improved	1. Proactive support to incumbent provider with TUPE. (West Essex specific issue) 2. Agreement of Exit Plan. (West Essex specific issue) 3. Monitor project plan and deliverables and escalate appropriately any deviations - Oct-22 - all staff have transferred to the PCNs now – there are some outstanding issues with a couple of members of staff but the risk is low. 4. Liaison with PCNs to review & agree plans that adequately meet patient need 5. Monthly monitoring of key data - hours provided vs patient utilisation	1. Two West Essex Extended Access Operational Service Leads have resigned- however HUC are recruiting permanently to these positions and provided reassurance that even if EA is no longer provided by HUC there will be positions for these staff within the IUC contract. 2. More detailed performance monitoring, including use of multi-disciplinary roles, to be agreed 3. Some IT infrastructure issues, especially re the deployment of EMIS hubs, means there will be a transition to full service delivery arrangements 4. Perceived lack of clarity in the PCN specification requirements, especially in terms of % of provision by GPs vs other staff	Exit plan agreed and TUPE support in place (West Essex specific) Monitoring and escalation processes in place.	Reasonable	Reports to PCB and PCCC ~~Exec and Finance committees.~~	Reasonable	LMC engagement	Reasonable	None identified	Approved at the PCCCs meeting in common in May 2022. **PCB Nov22 - for review and agreement of proposed risk score reduction from 16 to 6**
PC13	332	03/05/2022	1	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Workforce	**IF** there were a lack of further training and education opportunities in primary care... **THEN** there would be a failure to keep knowledge relevant and up to date. Capabilities will not be kept up to the same pace as others in the same profession. **RESULTING IN** a. Practice colleagues being unable to maintain and enhance their knowledge and skills needed to deliver primary care to patients. b. Practices would fail their CQC Inspection c. Mental Health issues would increase across the GP population. d. General Practice would have a lack of registered nurses.	6	3	3	No movement ↕	1. Trained Infection Prevention and Control Champions in each practice. 2. The mid-career GP initiative 3. Qualified Practice Nurse Revalidation support 4. Business Fundamentals for GPs 5. Student Placements - nurses and Graduate Managers 6. CPD funding offer for all GPNs/AHPs 7. HWE ICB Career clinics 8. Monthly educational webinars for all health care professionals clinical and non clinical 9. Supporting PCNs to run Protected time to Learn events monthly (reinstated from Nov 2022) 10. Creation of PCN Training Teams	1. Apprenticeships in Primary Care 2. School Engagement and Work Experience Placements 3. Student Placements - other professions	ICS Training Hub ICB Training lead appointed	Reasonable	Reports to PCB and PCCC	Reasonable	National funding in place for Training Hub	Reasonable	Further opportunities to be developed	Approved at the PCCCs meeting in common in May 2022. Reviewed by PCB Sept22
New Risk 1	TBC	09/11/2022	1 2 3 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	Head of Primary Care Transformation at Place	**IF** the Additional Role Reimbursement (ARR) scheme budget is not fully utilised by PCNs **THEN** this available funding for additional primary care roles is lost to individual PCNs & the ICB system **RESULTING IN** a. missed opportunities to provide further additional capacity in general practice b.further pressure on existing workforce c. PCNs may be less able to continue collaborative development d.PCNs less able to meet the requirements of the PCN DES, meaning key prioritise may not be met e. variance in service provision between PCNs	12	12	8	New risk	1. Primary Care Team engagement with PCNs to support with ARRS plans 2. sharing of PCN experiences with ARRS roles via CD/PCN forums 3. Recruitment support offered via Essex Primary Care Careers 4. Further national funding deployed, including PCN Leadership & Management support to improve PCN operational capacity 5. PCN Training Teams being launched to support ARR scheme & wider general practice workforce	1. Further work required on liaison with HPFT re Mental Health PCN roles 2. Reliance on PCN engagement & appetite on recruitment 3. Awaiting further national clarity on ARR scheme funding beyond 23/24	Review by Primary Care SMT	Reasonable	Reports to PCB and PCCC	Reasonable	Reporting to and liaison with NHSE/I Regional Team	Reasonable		For review and approval by PCB Nov-22

Transition Risks

Risk Profile														Assurance Mapping							
ID	Datix ID	Date Opened	HWEICS Strategic	Committee	Executive Owner	Risk Lead	CCG Risk Description	Rating (initial)	Rating (current)	Rating (Target)	Risk Movement	Controls	Gaps in controls	**1st Line** Operational functions enforcing required behaviours and working practices throughout the organisation's day-to-day activities	1st Line - Level of assu	**2nd Line** Oversight functions undertaking scrutiny and monitoring of the governance framework to ensure that it operate in an efficient and effective	2nd Line - Level of assu	**3rd Line** Functions providing independent and objective challenge and assurance with regards to the organisation's governance arrangements	3rd Line - Level of assurance	**Gaps in assurance**	**Approval status**
New Risk 2	TBC	09/11/2022	1 2 3 4	Primary Care Commissioning Committee	Director of Primary Care Transformation	Program Director C19 vaccinations	**IF** - the closure of Mass COVID-19 Vaccination Centres proceeds as planned, with insufficient contingency **THEN** – there will be increased pressure on PCNs and Community Pharmacy capacity **RESULTING IN** – limited ability to respond to a surge in the C19 vaccination programme, potentially leading to reduction in vaccination availability, lower vaccination rates & consequent wider impact on the healthcare system	9	9	6	New risk	1. Ability for Community Pharmacy & General Practice to scale up operation 2. Working with NHSE to understand likelihood of surge & potential required steps in this scenario	1. Working with HCT and region to understand the financial impact of maintaining a roving HCT team to support surge 2. PCNs giving notice not to be part of the programme post Autumn program	Contingency plan in the process of being agreed post Autumn program	Reasonable	Reports to PCB and PCCC	Reasonable	National and regional directives being followed	Reasonable	None identified	**For review and approval by PCB Nov-22**

ICB risks associated with DOP Delegation - at 19th October 2022

ID	Opened	Handler	Manager	Description	Directorate	Likelihood (initial)	Consequence (initial)	Rating (initial)	Risk level (initial)	Controls	Gaps in controls	Risk Type	Risk Subtype	Likelihood (current)	Consequence (current)	Rating (current)	Risk level (current)	Risk Directional Movement	Likelihood (Target)	Consequence (Target)	Rating (Target)	Risk level (Target)	Approval status
336	19/05/2022	Joyce, Rachel	Rohilla, Anurita	If ... NHS England commissioned services(including community pharmacy, dentistry, optometry and specialised commissioning (where NHS England are transferring services to the ICB)) are not clearly defined in terms of scope, funding and staffing. Then ... the ICB will not have the resources to deal with these areas Resulting in ... insufficient capacity and lack of robust processes for effectively managing community pharmacy contracts and specialised commissioning and/or a knock on effect on other services provided by PMOT and other departments.	Medical including PMOT	Highly likely	Major	16	Immediate action required	Awaiting further guidance from NHSE/I on the full delegation of primary care and other specialist commissioning functions, including timeframes, level of expectation and confirmation of transferring resource. Sharing of local projects, plans, best practice and avoiding duplication works well. Implementation and reporting is at a local ICP level. Ongoing disucssions between primary care and NHSE/I about the transfer of responsibilities and the establishment of a System Community Pharmacy Clinical Lead	Awaiting further guidance from NHSE/I on the full delegation of primary care and other specialist commissioning functions, including timeframes, level of expectation and confirmation of transferring resource. Staff capacity planning may be impacted by potential redeployment of staff to manage COVID-19 outbreaks across the health system.	Transition risks	Business continuity risk	Possible/likely	Major	12	Take and monitor action		Unlikely	Moderate	6	No action required	In holding area, awaiting review
369	20/05/2022	Kinniburgh , Jane	Emson, Mary	If the safeguarding team resource is not increased in a timely manner Then- the team will not have the capacity to meet all of their statutory obligations, in particular in relation to delegation from NHSE Resulting in- non-compliance with statutory regulation Reputational damage (Safeguarding Adults)	Nursing and Quality	Almost certain	Major	20	Immediate action required			Aligned Risks	Clinical Quality and Patient Safety (Including equipment)									In holding area, awaiting review
442	15/08/2022	Watson, Michael	Surgenor, Simone	IF the governance substructures required under the new delegation arrangements are not understood and put in place for April 2023, THEN requisite assurance and decision structure will not have been established, RESULTING in the ICB breaching its delegation responsibilities and legal duties. Linked to the previous transition risk R026 (394). Transition Workstream Risk Register ID: R041	Chief of Staff (including Communications and Governance)	Highly likely	Moderate	12	Action is discretionary	12.08.22 - an initial ICB internal meeting took place regarding delegation and what it would entail on 10.08.22. This is part of an ongoing programme. Entries are also due to be included in ICB sub-committee work plans. Links also to be made with mirroring areas adopting the same. NHS E support anticipated.		Transition risks	Project/Programme risks	Highly likely	Moderate	12	Action is discretionary	No change	Possible/likely	Negligible	3	No action required	Final approval
455	12/01/2021	Kinniburgh , Jane	Harvey, Mr Chris	IF there is a lack of information from NHSE&I regarding delegation of functions to the ICB including timescales and expectations, THEN there is a risk that relevant Teams will have inadequate time to prepare for the delegation of primary care quality oversight and improvement, primary care complaints, additional safeguarding and IPC requirements etc, RESULTING IN a lack of robust processes being in place to maintain oversight of quality and safety, and provide a responsive services. Transition Workstream Risk Register Ref: R029	Nursing and Quality	Highly likely	Major	16	Immediate action required	Awaiting further guidance from NHSE/I on the full delegation of primary care and other specialist commissioning functions, including timeframes, level of expectation and confirmation of transferring resource. Development of business case for identified additional resource once guidance and transferring resource confirmed and requirements fully scoped.	Guidance from NHSE/I delayed until 2022 impacting on any potential planning and recruitment Staff capacity planning may be impacted by potential redeployment of staff to manage COVID-19 outbreaks across the health system.	Transition risks	Project/Programme risks	Highly likely	Major	16	Immediate action required	No change	Possible/likely	Moderate	9	No action required	Final approval

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Primary Care Board				**Meeting Date:**	**24/11/2022**	
Report Title:	**Update from Healthwatch –** **a. Findings from Access to GP Services for Children and Young People** **b. Findings from Access GP services in Broxbourne, Harlow and Uttlesford**				**Agenda Item:**	**09**	
Report Author(s):	Geoff Brown, Chief Executive, Healthwatch Hertfordshire Chloe Carson, Senior Research Manager, Healthwatch Hertfordshire Fergus Bird, Information & Guidance Team-Healthwatch Essex Sara Poole, Information & Guidance Team-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 Hertfordshire (HwH) and Healthwatch Essex (HwE) have been commissioned by the Hertfordshire and West Essex Integrated Care System (ICS) Primary Care Workstream to undertake a series of engagement projects. From August to November 2022 the Director of Primary Care Transformation at the Integrated Care Board (ICB) requested HwH and HwE to explore access to GP services with a specific focus on engaging with: • Parents, carers and children and young people across Hertfordshire and West Essex • Residents living in the Borough of Broxbourne (and Harlow and Uttlesford for West Essex) Online surveys were launched to gather public views and experiences. The detailed reports provide the richness of the experience of our population. The aim of these reports is to have an objective view in engaging with our local population on key areas which will support the ICB in building on the good practice across HWE but also taking into account from the experience and feedback from patients to make a change where appropriate.						

<table>
<tr><td></td><td colspan="4">This is the first set of reports. Aim is to agree 2 topics every quarter which support transformational change. Note whilst the methodology delivered by both HwH and HwE is the same, the presentation of the reports is different and aim is to try and get an consistent way of presenting whilst drawing common threads across both and key differences which may be pertinent to one area.

Following discussion at the board, it is imperative to have a detailed discussion after on feedback and next steps on key actions to be taken forward and report back.</td></tr>
<tr><td>Recommendations:</td><td colspan="4">The Board is asked to note discuss the
Findings across the 2 areas of work across HWE
Agree for a small group to meet with Healthwatch colleagues, primary care leadership outside Primary Care Board to finalise the agreed recommendations for Board to discuss at subsequent meeting</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>
</table>

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	☐

Access to GP Services for Children and Young People in West Essex




Produced by Healthwatch Essex
Fergus Bird
Information & Guidance Officer

June - October 2022

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.

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

Accessing GP Services is a widely publicised and crucial issue throughout the country.
The IPSOS GP Patient Survey 2022 looked at the overall experience of making an appointment (for all age groups).
Nationally, 56% rated the experience as good vs 26% rating it bad.
For HWE ICS, the figures were 54% good vs 27% bad.

Looking specifically at ease of getting access to GPs via phone (85% of people trying to make an appointment try by phone), 53% of people nationally said it was easy (down from 68% in 2021).
For HWE ICS the figure is 48% for 2022 – 5% below the national average.

However, children and young people are a core demographic not specifically picked out and reported on in this data.
What data there is, is statistically sound, but doesn't include service users experience, their feelings or the impact.

Improving the health of Children and young people is one of the core principles of the HWE ICB's constitution.

1.3 Acknowledgements

Healthwatch Essex would like to thank the members of the public who participated in this project through completing the survey. Our thanks are also made to those individuals who took the time to speak with us and share their personal stories. We would also like to thank our partners, contacts, and networks who helped publicise the survey.

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

Part of the HWE ICB Constitution states that the members of the Board will work to ensure that the Board's resources and powers tackle complex challenges, including:

- improving the health of children and young people
- acting sooner to help those with preventable health conditions

'Children and young people' has been identified as an important demographic within our community – one that needs special consideration and policies.

As such, this report aims to capture the thoughts, emotions and lived experience of those people trying to access GP services within West Essex for themselves or on behalf of a friend or loved one. From this, we aim to provide key learnings and recommendations in order to help develop policies and processes to match the needs of the local population.

The health of children and young people can be an emotive topic for parents, their wider family, teachers, carers, friends, and many more. It is important that we assess the impact that any problems or delays have physically and emotionally, not just for the patient, but for family and friendship groups as well.

Listening to the lived experiences of those directly affected can help us shape how we manage the processes and platforms available to this specific group. Dovetailing this in with the practical and logistical steps being implemented to make full use of GP Services, including nursing, physiotherapy, practitioners and more, combined with phone and online systems, reception and admin staff and efficient triage, can all improve this vitally important dimension of NHS healthcare.

2.1 Engagement methods

Participants were contacted through the Healthwatch Essex website and newsletters, partners, other organisations in West Essex, relevant online communities and through word of mouth. They were engaged in two ways:

Survey
A survey was created to gain perspective and insight from residents who have had experience of accessing GP services for children and young people.

Interviews
Individual interviews were conducted to collect personal stories from members of the public. Interviews took place by telephone during September and October 2022 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

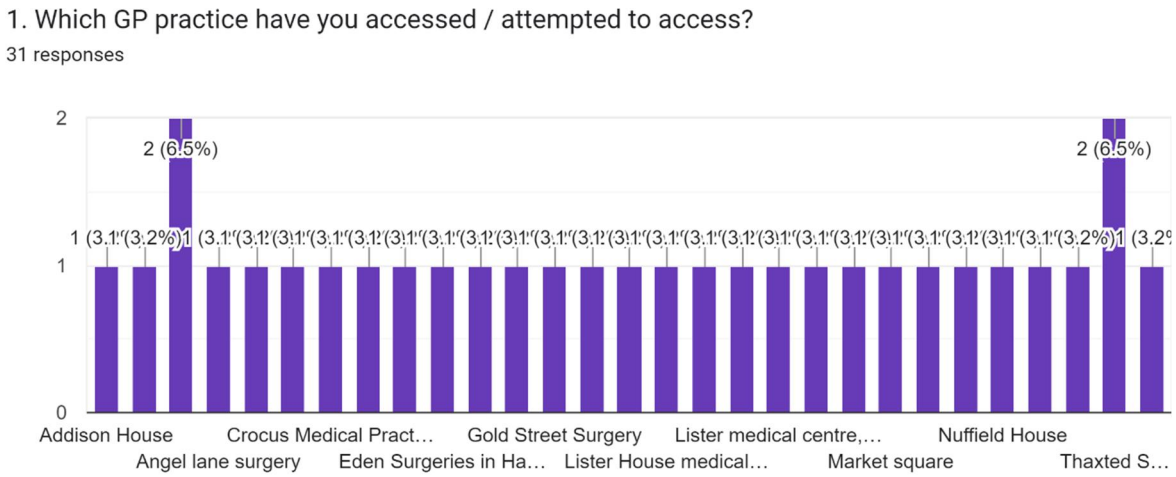
The survey consisted of 11 core questions combined with 5 additional 'free text' information boxes enabling the participants to expand on their answers to preceding questions.

It was devised to encompass:

- Effectiveness of the appointment booking process
- Type of appointment
- Quality of appointment
- Speed and quality of follow-up

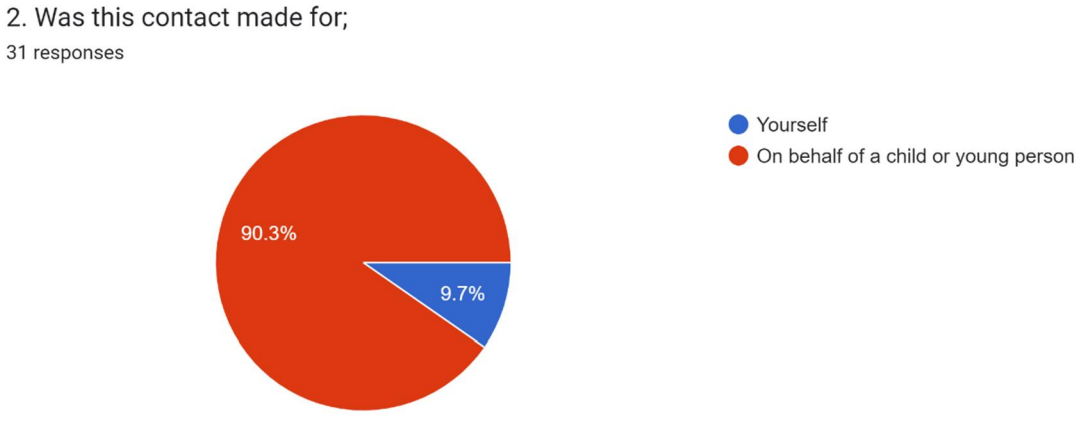
The survey was primarily in an online format but was also available to be printed off and filled out manually as required. The Information and Guidance Team at Healthwatch Essex were also available if the survey needed to be completed in any other format, such as over the telephone. The questions, and responses received, were as follows:

In our first question, we asked about the specific practice the respondents were trying to access:



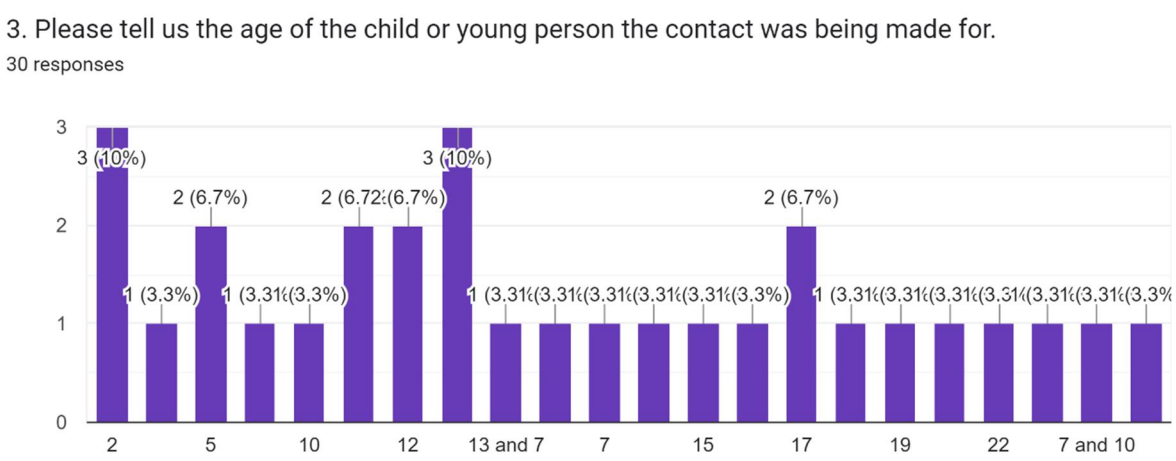
The surgeries listed were:
Addison House, Angel Lane, Beechwood, Castle Gardens, Crocus Medical Practice, Eden Surgeries, Fern House, Gold Street, Hamilton Practice, Lister House, Loughton Surgery, Market Square, Melbourne House, Noak Bridge, Nuffield House, PAH Clinic, Prince Avenue, Thaxted Surgery.

The second question asked whether they were making an appointment for themselves, or on behalf of someone else:



The vast majority of respondents were attempting to access the GP on behalf of a child.

Question 3 asked about the age of the service user:



Ages ranged from 2 to 22, with a number of people trying to make appointments for more than one person.

Question 4 was in relation to how the appointment making process went overall:

39% of respondents said the process was good or excellent, while 61% reported it poor or extremely poor.

Question 5. Following on from Q4, they were asked to expand on why they answered as they did. These were the comments:

We had an in-person consultation on the day that I called and was given a prescription for the issue'

'Always difficult to get through on phone but manage eventually. Not enough appointments'

'Took a while to get through, but I know they are very busy.'

'Although I got an appointment, I had to call around 50 times to get through!'

'The phone system in the morning was not working on 2 consecutive days. In the end I had to make a private GP appointment'

'Every time I try to call Lister Medical Centre, I cannot ever get an appointment I am always told to take an out of hours with a different service.'

'There are very low chances of getting an appointment, it's extremely difficult to get through to the reception and by the time you are connected there are no appointments left.'

'Thaxted is an exemplary surgery. We are always able to get same day appointments for both children and adults. They continued with face-to-face appointments throughout the pandemic also.'

'Unable to get face to face appointments. Can wait for up to an hour on the phone to get through, sometimes the queue is full so you can't wait for a receptionist, and it automatically hangs up'

'The system is now an online system, and you can't speak to anyone.'

'Took ages to get through on the phone and when I did, I wasn't able to make an appointment'

'I couldn't get through over the phone. Had to visit in person to make an appointment'

'Do ANY GP's work here anymore?'

'I have seen my GP around 4 times since I joined 9 years ago. I don't believe my children have seen their family GP at all. I am always given an alternative doctor and usually that is at a push.'

'They are crap.'

'I can never get through to doctors and when I do you are asked to see a nurse before seeing a doctor and it's just a battle.'

'I was on hold for an hour before I spoke to a human.'

'Always hard to get phone answered and find a Dr who knows our situation.'

'They have open access surgery every weekday from 8-10am you just turn up and can be seen by a doctor or advanced nurse.'

'I got an appointment.'

'Wait times are long but I generally always manage to get an appointment.'

'I got a telephone call.'

'It takes a long time to get through, then once you do all appointments are gone. Sometimes they fit you in with a zoom call with paramedic not GP.'

'I was advised by a GP from a different area my child needed to be seen in person. My GP practiced refused.'

'I was able to get through on my second attempt calling at 8:00am but then was on hold for nearly 40 minutes. I got offered an appointment that morning.'

'I got through but not offered face to face but did call back quickly.'

'It's a nurse you get to see not a doctor.'

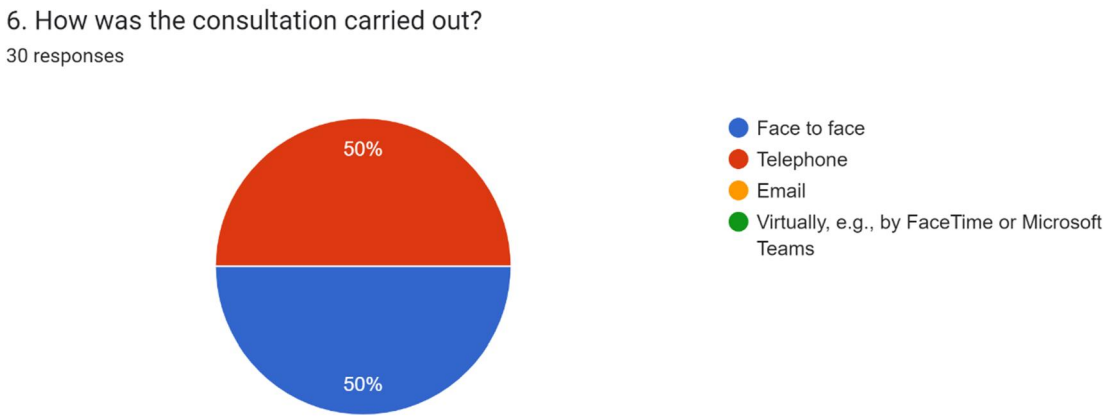
'Impossible to get an appointment that is urgent but not life or death!'

'It is sometimes difficult to get through on the phone at 8am if an emergency appointment is required the same day. However, with persistence I have managed to get through and get and appointment on all but 1 occasion. In this case an out of hours GP appointment was arranged for the following day. The reception staff are always very helpful, and we have been very happy with the care we have received from Thaxted Surgery.'

'Phone three days at the specified time 8 and 2 couldn't get a "call back" appointment.'

While there are examples here of both good and bad practice, the predominant negative issue is the double whammy of struggling to get through on the phone, and even when you do, appointments still being very difficult to come by.

The next question asked about the format of the appointment:

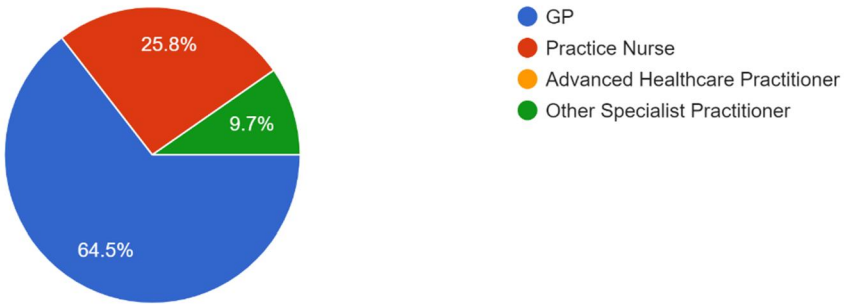


There was an even split between phone and face-to-face and no incidences of virtual appointments.

Question 7 asked who carried out the consultation:

7. Which professional carried out the consultation?

31 responses

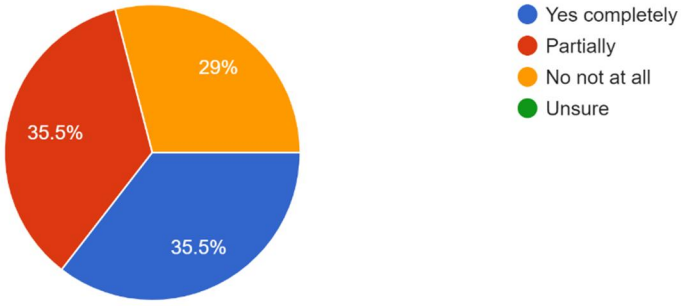


The majority of appointments were held with the GP, but a quarter of them were with a practice nurse.

Question 8 was about being listened to:

8. Do you feel that you were listened to by the healthcare practitioner?

31 responses



There was a relatively even split here, 35.5% said they were completely listened to, against 29% who said they felt they weren't listened to at all.

Question 9 asked them to elaborate:

'It was fine although a locum not my regular GP.'

'GP was led by my research & listened to me, asked questions to confirm understanding & plan implemented.'

'Took time to listen to me and my son.'

'I couldn't get an appointment for my daughter.'

'I have a chronic condition, I know when my condition is flaring, I asked for certain blood tests and stool samples to be completed and was totally ignored and was given incorrect blood tests and stool sample.'

'GPs are rushing, and I feel like they don't take a real interest in patients' problems.'

'I wasn't able to speak to anyone it was all done by text. I was only allowed to reply to one message and that was all.'

'I wasn't given the pill I asked for.'

'Had to make another appointment to speak to a DOCTOR.'

'I usually only phone if desperate but I am often felt like I should have just handled my issues with self-care.'

'Fobbed off unsure how they can diagnosis over phone.'

'It's always different doctors you have to tell the story all over again my daughter is very unwell and has been for 5 months.'

'I felt that my concerns were dismissed as me being a panicky paren.t'

'We had mental health crisis. GP who ran said nothing to do with them. It's up to child mental health team. Ring them.'

'Listened, examined and offered my options.'

'Felt a little rushed.'

'Took the time to listen and carried out a full assessment.'

'My son ended up in A&E with tonsillitis after being told it's just a stomach bug.'

'Originally seen by GP in another area who explained complex issue. My Essex GP brushed off as nothing.'

'GP dealt with current issue - sore throat/ears/headache but was not responsive to questions about the ear pain being ongoing.'

'Just told to go to A&E when it could have been looked at by doctor & better to have been seen face to face to look at extent of injury . Didn't ask for photo and didn't necessarily need A&E.'

'Referral made but 5 months on no hospital appt.'

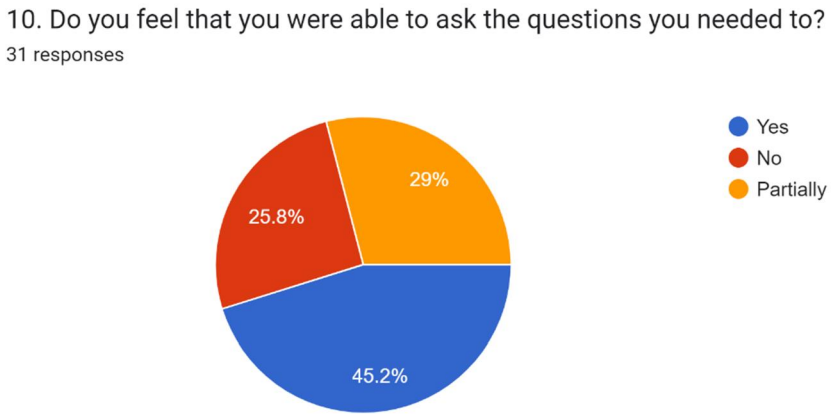
'I need to speak face to face really as I have more confidence concerns.'

'We have needed to see the GP a couple of times over the last few months urgently when my children have been unwell with very high fevers. We have also needed a non-urgent appointment with follow up blood tests for my 5-year-old. On all occasions they have been thoroughly examined and the GP's have been extremely helpful.'

'Brushed off told it was hormones.'

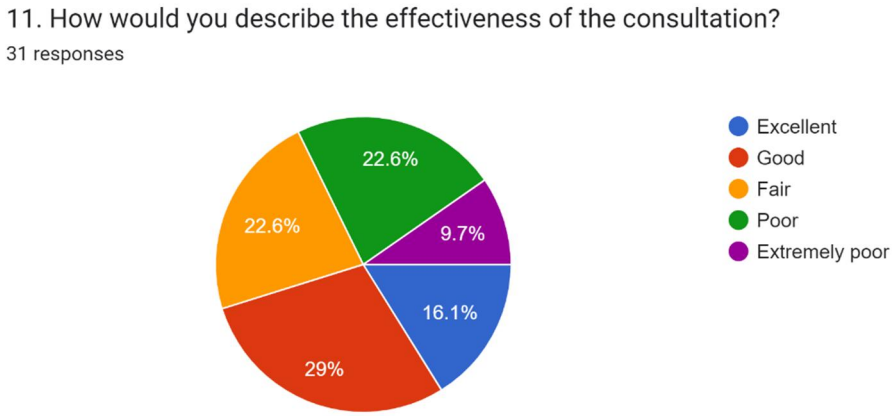
The mixture of experiences reflects the pie chart split, but there are some themes of wanting face to face and wanting to be given a little more time and attention.

Question 10 asked if participants felt able to ask the questions they needed to:



Nearly 75% of respondents felt fully or partially able to ask all the questions they needed to.

For question 11 we asked about the effectiveness of the appointment:



45% said it was excellent or good, against 32% saying it was poor or extremely poor.

Question 12 asked them to explain their answer to Q11:

'The GP only spoke to me and my husband - my daughter tried to speak, and she was not really addressed.'

'Got seen and got prescription.'

'Testing me for the complete wrong problems, have since had to contact my IBD specialist.'

'Very often I'm send away without help and then I have to try again to get another appointment. It's frustrating especially that kids are getting really poorly really fast.'

'This feels very dismissive, should be able to see someone face to face so nothing is missed.'

'I wasn't able to speak to anyone it was a text from a GP. I wasn't able to ask questions and I wasn't able to get the reassurance I needed.'

'It was quick and easy.'

'No good medication provided, even to alleviate symptoms.'

'We needed a doctor not a nurse.'

'If I get my own GP he listens. Any others and it is felt like it is swept under the carpet.'

'They cannot see my child.'

'They were reluctant to take my concerns seriously but asked me to upload a picture of the ailment for monitoring.'

'We have had a challenging time. Every team or organisation say it's someone else's responsibility. We have been let down over the years. GPS say they can't do anything, and mental health services can't do anything either. We are often told by GPs they can't help us because our case is complicated.'

'Got medication.'

'He also went and checked with a colleague that there was nothing else he could for her.'

'Ignored.'

'We left with a good understanding of current issue and how to treat but not the ongoing issue.'

'Telephone so couldn't see the injury and assess properly.'

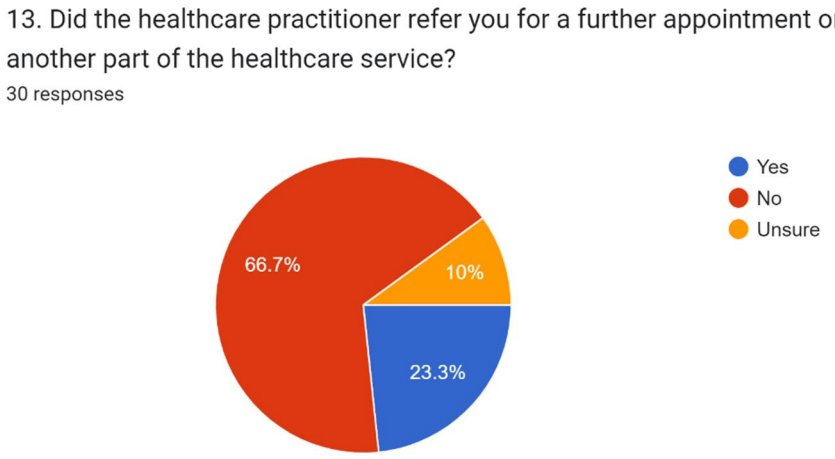
'The nurse is lovely but still within family of 5 not seen a doctor.'

'I want to see the doc face to face!'

'I can't fault any of the GPs or Nurses at Thaxted surgery. They are all extremely helpful and reassuring and when we have needed help, they have seen my children quickly and prescribed appropriate medication which has helped them to feel better.'

'Wasn't concerned at all.'

Question 13 looked at follow up care:



The majority of respondents were not referred onwards.

Question 14 asks what the referral was for:

'CAMHS.'

'To Cambridge hospitals trust - Addenbrookes.'

'To check the pill works.'

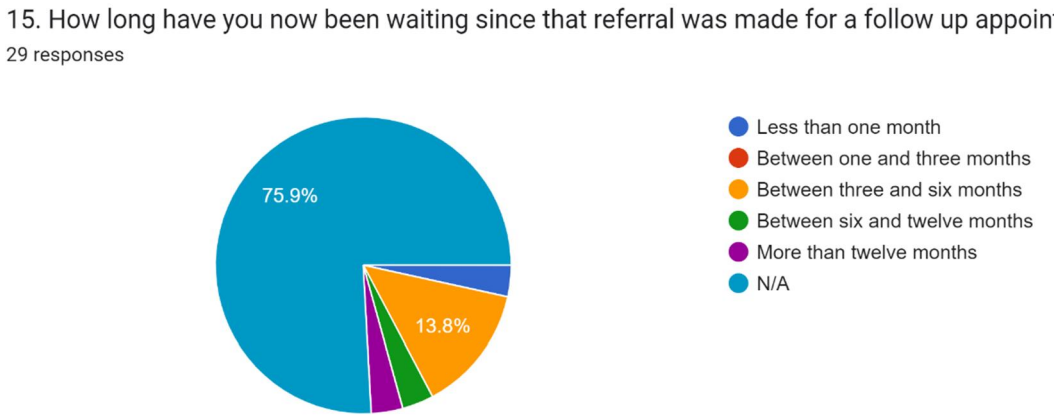
'Only when I asked, and I felt like persuading them too. Paediatrician consultant.'

'Urine sample/cultures.'

'We were offered an ENT referral if there was hearing loss but were also told it would be a long wait and with doubtful outcome.'

'Paediatric Allergy Clinic and Dietician.'

We then asked about the waiting time for their referral:



Although it's not statistically sound, anecdotally 6 of the 7 have waited 3 months or more.

Finally, we enquired about what they would do to improve the service:

'More GPs, nurses, appointments needed urgently.'

'Phone booking system, ability to get through to someone quickly.'

'Being able to book appointments far easier. The telephone triage doesn't work in all cases as when you know that you need to see a doctor face to face, waiting for a call back and then having to wait for an appointment just takes too long!'

'Crocus Medical practice need to sort out their phonelines.'

'Allow easier access to see the GP practice you're actually registered too instead of making appointments with OOHs services all the time.'

'Bring back face to face appointments. It's ridiculous to even try to diagnose a child over the phone. Make more appointments available for patients.'

'When a refer all is made, it would be good to know the length of wait and have information online regarding this process.'

'Open access to GPs.'

'Be human and speak to people. Don't use text messages, take the time to speak to the person and listen to what they have to say.'

'Just make it easier to book appointments.'

'Access to doctor appointments and medication is a huge problem. needs to be resolved asap, even if this means the health service can no longer be kept free.'

'Access to a doctor in the first instance!'

'More receptionists!!'

'Face to face appointment.'

'Ease of getting an appointment. Meeting doctor face to face. Seeing same doctor.'

'Having a service that is accessible and caring.'

'Got an appointment for an out of hours' time. We waited nearly 3 hrs. Not ideal with an ill 5-year-old.'

'We need an ENT referral but have been told its a 2 year wait!'

'Need more staff to deal with volume if patients. 1 surgery for nearly 20000 people.'

'Everything.'

'Being told at check in if Dr is running roughly to time or how many appointments behind. Waiting 40 minutes with small children is not easy especially when you don't know how long the wait is likely to be. Easier phone access.'

'Yes, an appointment at the hospital or at least acknowledgment it's being made.'

'More available appointments for young girls such as menstrual problems that cannot wait but have to wait as not deemed important enough.'

'No, we feel extremely lucky to have such excellent care from Thaxted Surgery. I have not had any difficulty getting an appointment for my children.'

'Take calls re young adults seriously.'

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. Names have been changed to protect identities.

Case Study 1

'Sam' and her family have been with the same GP surgery for 15 years. She has 2 daughters aged 16 and 18. Her 16-year-old is struggling with severe period pains, and she has also had some low-level mental ill-health, as does her 18-year-old.

"It's very hard for anyone to talk over the phone. But if you've got a teenager that's got something wrong, they really don't want to be talking to a phone to express what the problem is."
"The only way I seem to be able to get an appointment now is if I do it the online. That's not really understanding the urgency of it, or how my daughter's feeling about waiting for an appointment and stuff like that."

"Then my appointment was for three weeks. I thought, well, she's in the middle of having a period now. She's run out of her pills that help, and she's got to wait three weeks. I know things are more urgent, but it's amazing, that was quite urgent."

"It would have taken two seconds just to write repeat prescription out, and I don't know why she had to wait three weeks, because these are quite common issues that the girls have."

"Adults we can handle waiting, but teenagers, it makes things worse for them. Their minds can't control their anxieties and stuff like that."

"Because my girls have got a bit of mental health issues as well (just general every day teenage mental health issues), they don't want the doctor over the phone, they definitely don't."

"I don't think it conveys how vulnerable they are over the phone, but doctor can't see patient expressions or all they can hear is their answers. They can't see the pain in their eyes or whatever, I'm being very dramatic now, but you know what I mean."

“You just get a text saying, ‘We'll give you a call.’ But then sometimes they're at school as well and that's... I don't know. Or it doesn't even give you a morning or afternoon, it just says on that day, so I can't have a specific time anymore.”

Case Study 2

‘Natalie’ has a 17-year-old daughter who cut her hand.

“Sometimes it's brilliant. You get a call back and they ring you and you really don't need to go into the surgery or one of the clinical nurses. My youngest daughter had an ear infection, and she literally just rang me asked me to take a picture that she could see how swollen it was. And she was like, that's fine. I'll just give her antibiotics and it was sorted. You don’t have go to the surgery.”

“However, other times it’s completely different. My 17-year-old shut her hand in a car, it was spitting blood she rang me, I got home and all we wanted was for someone to have a look at it.”

“I spoke to reception, and I said, “Well, can someone ring me back to discuss it?” And the GP rang back within a few minutes. What annoyed me is my daughter's 17, so I spoke to the GP, and she was, “Oh, can you put her on the phone?” And then she just fobbed my daughter off and said ‘Just go to A&E.’ She's a 17-year-old, she's not going to push back. And she'd gone by then.”

“If your doctors are open, it should be that you can actually see them. The doctors didn't even say, ‘can you send a picture or something, and I'll look at it and see?’ Anything to try and avoid A&E if it wasn’t necessary.”

“I just think it’s unless. If it's something that isn't urgent, you shouldn't be going to A&E.”

“Can’t she have just said ‘Can you pop down for five minutes?’ Or ‘Can you pop down and see the nurse for five minutes, she'll have a look?’
And if you do still have to go to A&E, sometimes they can triage you quicker … once you go in you don't have to sit in the waiting room or wherever. They've already triaged you so they know where they need to send you.”

“Because you’re just passing the pressure from one place to another. It puts more pressure on other facilities, which don't really need that pressure.”

Case Study 3

‘Elaine’ has a young daughter with ongoing tonsilitis. It flares up regularly and she is waiting for an operation to have them removed.

“Phoning for an appointment is a disaster. I've registered for the online services. I book online because booking over the telephone is like finding a unicorn. You just can't get through.”

“Online booking is quite good, I'm quite pleased with it. I wasn't sure, but it does work quite well. But no one told me. There was a one time when I was ringing the GP every day, three days in a row because there wasn't any appointment available and finally someone talked to me. One of the receptionists said, ‘Oh, why don't you just register for online and book online, and leave us alone?’ I'm like, ‘Well, no one actually told me that there is an online system available.’”

“However, it’s got to the point that the GP is not even interested in having a look at her physically, they're happily prescribing prescriptions over the phone which from one side I don't mind in a way because she suffered with the condition ever since she was one so by now, I do have knowledge and experience.”

“Being sent off to A&E with a poorly, child only because people can be bothered. I might be wrong, but this is literally how it feels like. That they just don't care anymore, and they use an excuse of COVID just not to see patients anymore and they're talking about small children. They can get very poorly, very, very quickly.”

“I was sent over to A&E with ‘Sally’ three times, and all he needed to do (because this is what the doctors at the A&E said) is literally just see you in practice and prescribe correct medications and it would have been done. It would have been over, but they don't really seem to care.”

“Sometimes it would be nice for them to actually listen to her chest once in a while, to check maybe there's a chest infection on top of... But no, they don't really seem interested.”

“They asked me to send a picture. There was another shocking thing that the GP told me. They said, ‘Oh, can you please send a picture’ of my almost five-year-old. I mean, it's your job to see her in the practice and examine her yourself.”

“Just have a look at her throat, check her ears because when tonsils go wrong, she can have ear infection. This is how much I know about this stuff because GPs simply don't care. Just take this kid in for literally five minutes, this is how much of your time she's going to consume. Check her ears, check her throat, listen to the chest. It's literally five minutes. Then prescribe me antibiotics. Give me liquid, not the tablets.”

“This is all I'm asking about. It is as I said, small kids get very poorly very, very quickly and my GP doesn’t care.”

3.0 Key Findings and Recommendations

The are certain aspects of 'accessing' GP Services that need to be addressed

- **Appointment Making**

Nationally, 85% of people try phoning their surgery direct when trying to make an appointment.
Phone booking systems are now broken, with people stuck in long queues or not getting through at all.

Telephone systems must be robust enough to cope with demand, and to ensure calls are not dropped. There should be clear messaging for those waiting, keeping them informed.

Consideration should be given to implementing an options menu to choose an appointment for a child or young person. For example – 'Choose 3 if you want to make an appointment for a child under the age of 16'

'Phone booking system, ability to get through to someone quickly.'

'The phone system in the morning was not working on 2 consecutive days. In the end I had to make a private GP appointment.'

Alternative options for how to book an appointment should be investigated, developed, and invested in.

Those options should then be promoted as widely as possible, allowing people to book in a way that suits them. This in turn will take pressure of the telephone systems.

Online booking is already established, but it appears to not be well known about. Alternatives such as through Apps, texting including WhatsApp and others, and social media should also be explored. The online and social media world has almost universal coverage within children and young people and as such it must be invested in.

There should also be an option to walk into a surgery to make an appointment. This seems to have become overlooked by many surgeries.

'No one actually told me that there is an online system available.'

- **Appointment availability and options**

Having battled to get through, many children and young people are still finding it very difficult to get appointments.

While face to face appointments are still strongly preferred, the reality is that GPs and other surgery staff are very stretched.

Confidence in alternative appointments needs to be developed and improved. There needs to be a consistency of approach and a best practice guide for all surgeries.

Appointments need to be offered with relevant healthcare staff in whatever format is appropriate. If it can't be physically face to face then Zoom or other options should be considered, as well as telephone appointments, with the use of photos and even video investigated properly.

Investing in more non-GP healthcare professionals will mean that appropriate care can still be delivered effectively, but the burden on GPs can be eased.

'Had to make another appointment to speak to a DOCTOR.'

'GPs are rushing, and I feel like they don't take a real interest in patients problems.'

- **GP Surgery Resources**

Children and young people, and especially their parents, often need reassurance that illness and injury isn't too serious.

GP Surgeries should ensure they are well staffed with nurses, nurse practitioners and other qualified healthcare staff so they can take the burden away from GPs when appropriate.

Simple prescriptions for antibiotics, or other drugs can be expedited quickly and efficiently, and parents can have the reassurance they need from a qualified healthcare professional.

Being well staffed will also ensure that children and young people can pop into the surgery for assessment and treatment, rather than being directed to A&E.

'It would have taken two seconds just to write repeat prescription out.'

4.0 Conclusion

By listening to the lived experience of children and young people, their family, carers, and friends, it is hoped that the findings in the report will help the HWE ICB to identify areas of improvement to support their community and meet its future needs.

Adapting and moving forwards

Children and young people often have more pressing needs for immediate assessment and treatment, whether it's period pains, broken limbs or colds and flu. Parents and loved ones have high levels of concern, and the children themselves can find it more difficult to deal with and process illness and injury.

GP surgeries need to find a way to prioritise this demographic and make use of technologies to ensure they can get through, get seen and get treatment.

Surgeries should be flexible and adapt to the requirements of children and young people, offering a 'healthcare centre' style approach, where there is a mix of professionals and specialists who are not necessarily GPs, but can offer GP services where appropriate.

Birth rates and growing population in south and east England are putting more pressure on all aspects of NHS healthcare.

'Need more staff to deal with volume of patients. 1 surgery for nearly 20000 people.'

GP Surgeries need to offer a holistic primary healthcare system and educate children and young people away from thinking they have to see a GP face to face at all costs, moving them towards an understanding that there are many ways to get the right treatment at the right time and from the right person.

5.0 Terminology and Acronyms

HWE - Hertfordshire and West Essex

ICB – Integrated Care Board

ICB Constitution - is a document that sets out the objectives of the ICB, the rights and responsibilities of the various parties involved in health care, (patients, staff, trust boards) and the guiding principles which govern the service.

GP – General Practice or General Practitioner

IPSOS – A global market research company headquartered in Paris

Face to face – a meeting where people are in the same room talking directly to one another

Virtual – talking to someone directly but seeing them only on-screen

Holistic – Treatment of the whole person, taking into account all factors

Accessing GP Services in Harlow and Uttlesford, West Essex.

Sara Poole
Information & Guidance Team
For Hertfordshire and West Essex Integrated Care System
August – November 2022

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.

1.2 Background

Healthwatch Essex were approached by Hertfordshire and West Essex Integrated Care System to undertake a series of projects focussing on the lived experiences of people in the area in relation to their health, care and wellbeing. This project was focussed upon gathering peoples lived experience of accessing GP services in Harlow and Uttlesford.

1.3 Acknowledgements

Healthwatch Essex would like to thank the public who engaged with us and our network of stakeholders and partners who supported in sharing the project.

1.4 Terminology

GPN - General Practice Nurse
HCP - Healthcare Professionals
HRT - Hormone Replacement Therapy
JTH - John Tasker House Surgery-Great Dunmow
PAH - Princess Alexandra Hospital
PPG – Patient Participation Group
Triage – the preliminary assessment of patients or casualties in order to determine the urgency of their need for treatment and the nature of treatment required.
UTC – Urgent Treatment Centre

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 explore people's experiences of accessing GP services in Harlow and Uttlesford in order to inform the Hertfordshire & West Essex Integrated Care System.

2.1 Engagement methods

Survey

A survey was created and distributed via our network of stakeholders and partners, as well as on our social media platforms and a dedicated page on our own website.

Interviews

In order to gain a more in-depth understanding of GP services we conducted a number of one-to-one interviews with participants.

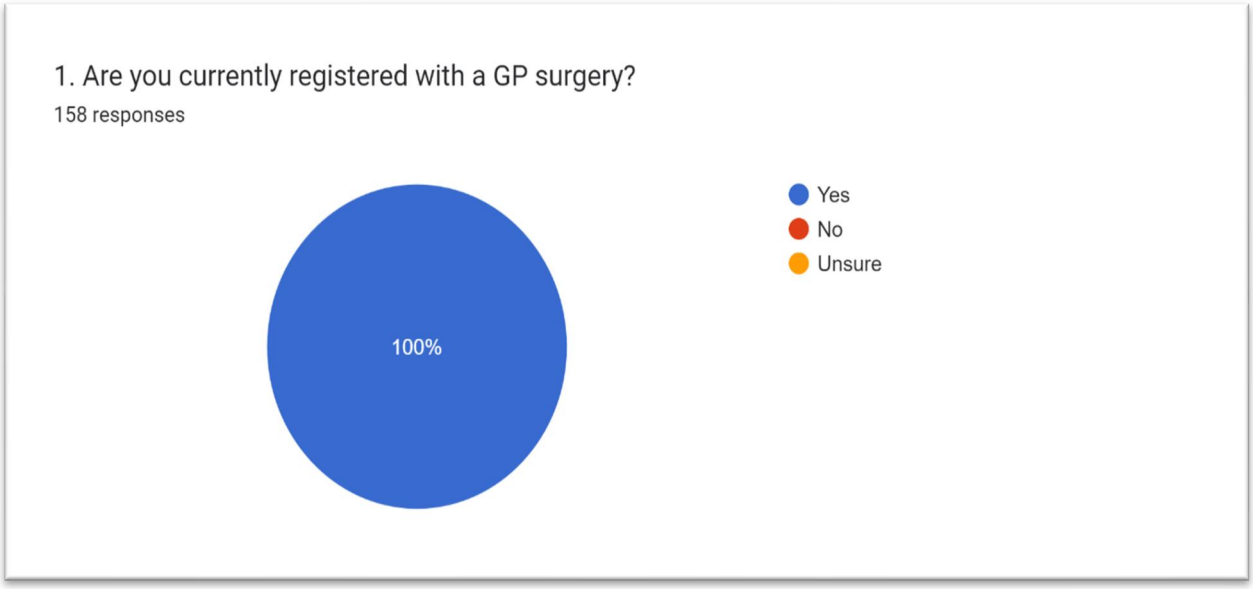
Case Studies

To further understand the experience of GP services we gathered details of lived experiences from members of the public.

3.0 Key Findings

3.1 The Survey

In order to better understand the issue of accessing GP services in Harlow and Uttlesford, we circulated a survey which garnered the following data.



Our initial question focussed on whether the respondent was already registered with a GP surgery, of which from 158 responses, 100% stated that they were.

Question two asked why people where not registered at a surgery if they had answered no to question one. No responses were received as everyone had answered affirmatively.

In Question three, we asked if respondents had experienced any challenges in getting an appointment with a GP when they have needed one, and if so, what were they? In total we received 156 responses to this question, with 31 stating that they had experienced no problems at all. Those who stated that they had experienced challenges cited the following reasons:

Difficulties with the booking systems:

'I rang 104 times before I could get through on the phone. Then I was told to try again the next day.'

'There have been multiple occasions when I've struggled to get an appointment, and some where it's been quicker to drive to the surgery rather than wait on the phone.'

'The phone keeps you on hold for over 30 minutes and then you often get cut off.'

'I can't get through on the phone most of the time and when you do get through, they have a limited number of appointments for that day, and you cannot make an appointment for the future'

'It's far too stressful trying to get an appointment via the 8am call system. I am overdue now for a smear test and can't face the appointment making process.'

‘I don’t like having to tell a receptionist my medical needs before being told who I can see, not being able to prebook appointments ahead, ringing in at 8.00am and being told your 20th in the queue and then when you do get through there’s no appointments available.’

‘There are no appointments available in advance (even telephone ones). I was told to phone on the day but by the time I get through they are all gone and its medical emergencies only. I have been going online at 7am every morning and still can’t get one. I will run out of medication before I can get one.’

‘The surgery does not answer the phone, also you cannot book appointments in advance only on the day by ringing at 8am and hoping when you get through that all appointments haven't gone.’

‘Managing long term health conditions is extremely challenging, from getting through the long waits on the phones and then begging for an appointment to either being rejected or offered a telephone consultation with nonspecific timescale. As a full time NHS clinician, I cannot cancel a full clinic myself to be on standby for an untimed call, especially when told they will only call once so if you miss the call you need to try to book a further date...back to the long call times!’

‘Unanswered phone, no admittance to the surgery, no email contact available, and then no appointments available.’

‘Very restricted times to make a booking which also don’t fit with regular working hours. Usually, I can’t get through. When I do there are usually no appointments left. When there are appointments, the assumption is automatic that I have nothing else to do that day.’

‘Getting an appointment, either for a doctor or nurse, is extremely difficult. The online form does seem to get you an appointment. Phoning takes forever and the receptionist isn't always very polite when you do get through. It really feels like the surgery is doing everything it can to keep you at bay. It's very frustrating.’

‘The telephone rate of reply is not good. Calling when you feel ill and waiting for what can be up to an hour is very frustrating.’

‘There are no appointments available.’

‘You can only get an appointment on the day, no advance booking and no appointments left after 8.30am.’

‘You can’t book an appointment in advance and it’s nearly impossible to get through when you’re told to ring at 8am’

‘You have to wait ages to get an answer, up to an hour and then there are no appointments available’

‘There are no appointments to book online anymore.’

‘At the moment you can only phone from 8am to be in a queuing system of over 20 people at times. I have tried to hang up and ring back in say, half an hour to be told there are no appointments left, and to ring again tomorrow.’

‘Ringing at 8am in the morning for an appointment to be told you’re number 24 in the queue, then after you’ve waited for 20 minutes to get to the front of the queue you’re cut off, so you try again and then 40 minutes have gone by, then you are told to ring the next day.’

‘You wait usually over 45 minutes on the phone and are frequently cut off after holding on for 20 plus minutes. When answered told all emergency appointments had gone even when I had been holding since 8am or 2pm. Consequently, I am told to call back at 2pm, always explained that the same thing will happen again. You really tear your hair out especially when calling for a poorly 87 plus aged parent.’

‘I was asked by a doctor to arrange an appointment, ‘none available’. They suggested that I try web triage - useless. We no longer have anything approaching a national health system. Some of the GPs (ALL of whom work part-time at this practice) go off to work in private GP practices in Cambridge between times. It's a travesty.’

‘Reception staff not answering or cutting you off, massive queues on the phones.’

‘There is huge difficulty getting through at 8am for an appointment. When the phone is eventually answered after 20 or 30 minutes of holding on, all appointments are gone, and you are told to ring back at 8am next day’

‘It is a challenge getting through the recorded message when I ring, only to be told to go on-line. Then, you are told only 'phone appointments are offered. This is the NHS not offering a reliable, safe medical service.’

‘The queue system when you ring is dreadful. Why hold 25 calls in a queue and then cut you off just as you get near the top as it is lunch time?’

‘Having to phone at 8am is difficult as a shift worker.’

‘You have to hold on the phone for ages only to be told nothing available.’

‘You spend a long time holding on the telephone in a queue and get cut off twice, then having to call back and re-join the queue at the back.’

‘Appointments cannot be made in advance - you must call after 8am to try to make an appointment for that day. You will then often either be added to a long call queue ('Number 21...") or told that the queue is full, and you should try again later.’

‘Appointments for the day are released at 8am. They can be accessed by phone (impossible to get through as lines are continually engaged and appointments are taken quickly) or online. Again, appointments are snapped up within a couple of minutes so if you're not quick to select a doctor or appointment and write in the reason for the appointment, they're gone. Telephone appointments are not kept to time and can be earlier or later than the time chosen so that appointments can be missed. Appointments for doctors are by telephone with a follow-up appointment for examination if necessary.’

‘It’s impossible to get through by telephone but I can use the website to access which is responsive within 48 hours but not accessible to all.’

Lack of available/prompt/appropriate appointments:

‘I was offered a phone consultation but then asked to come in after that as the phone is not sufficient but that wastes time all round due to there being two appointments. It would be better to be seen in person initially, but you are not able to get an in-person appointment.’

‘Six weeks wait for a non-urgent appointment. Then given a phone consultancy appointment and photo for a lump, which could not be seen in a photo.’

‘My mum was having some breathing difficulties, but as soon as the surgery answered the phone, the first thing they said was that there were no appointments available, and they wouldn't be budged. I had to ring 111 who told me to say that they'd instructed me to call my GP within the hour, which I did and was then able to persuade them to let me speak to someone. However, no one was available to see her.’

‘I was asked to arrange a medication review. I was told the in-practice pharmacy could do it but they told me they were too busy and would call when they had capacity. That was over a year ago.’

‘I have to see a paramedic rather than my GP. You can only phone up on the day to get an appointment.’

‘I am unable to get a face-to-face appointment with the GP’

‘I cannot get through to the surgery or can only get a phone call, no face-to-face appointment. I want to speak with a doctor not a nurse or some other healthcare assistant.’

‘I required an appointment and the first available was three weeks later. The situation was time specific, and I was extremely concerned.’

‘The GP was unwilling to see a sick baby in person. They were berating us for being concerned.’

‘I was only offered phone appointments at my surgery until I pushed to actually see a doctor, despite being able to walk into Herts and Essex Hospital and see someone at a clinic no problem.’

‘I can only get a consultation over the phone. This consultation can only be to discuss one set of symptoms and I am not treated as a whole person.’

‘I recently experienced a four week wait for an appointment for post menopause bleeding, NICE guidelines are two weeks.’

‘I've been told there are no GP appointments for the next couple of weeks and that I'll be seen by the nurse instead. When I've said that I'd prefer to see a GP they've somehow been able to book me in with a doctor.’

‘The only option is a telephone consultation and then if the doctor feels they need to see you then you will be offered a face to face.’

‘I was waiting two weeks for an appointment then having a phone consultation and sending photos before the GP would give a face-to-face appointment.’

‘Being told I would need to wait several weeks, and only then would it be a telephone consultation. I gave up.’

‘Delays of weeks when critical decisions need to be made.’

‘I can't get an appointment with a GP; I have to see a paramedic first who then says, ‘it’s not my field you need an appointment with a GP’. WASTE OF EVERYONES TIME.’

‘Not getting an appointment after ringing for hours plus, then being told my issue wasn't concerning enough and to ring again tomorrow. I have repeated this process on multiple occasions.’

‘14 day wait for a telephone consultation.’

‘There is a month wait even for a telephone consultation.’

‘Waiting times are excessive and only telephone appointments available. The receptionist asks what the issue is which feels uncomfortable.’

‘You are unable to book non urgent appointments.’

‘I have struggled to get appointments for my baby when I’ve needed them or for myself for a contraceptive review.’

‘There is a week waiting list for a phone back.’

‘You can only get telephone appointments.’

‘There is a three week wait for a face-to-face appointment.’

‘Issues are the inability to get through on the phone lines, and not enough availability. It’s more troublesome, having seen the GP who requests you return in a month for a follow up, reception can’t book forward appointments, you have to ring on the day, then you enter the cycle of my first point.’

‘I am not able to book future appointments for medication reviews.’

‘There are no appointments available in the next few days – they are only bookable far out which is not always what you need. You are offered a phone consultation but then asked to come in after that as phone is not sufficient but that wastes time all round due to there being two appointments. It would be better to be seen in person initially. You are not able to get an in-person appointment and not able to book online either. Have to phone and if you are late calling in the morning you can’t get an appointment.’

‘There were only telephone appointments, and they take at least three weeks’

‘I received a triage call which wasn’t satisfactory.’

‘I am used to delays for incoming calls - the problem is getting a face-to-face appointment.’

‘I was only offered a telephone appointment which was in five weeks’ time, and only the date was offered, no specific time, and I was told it would be at any time of day on that date.’

‘There are rarely any appointments available, and you have no hope of seeing the GP of your choice.’

‘Even if you get an appointment, doctors are not seeing patients face to face!’

‘I have had problems getting an appointment to speak to a doctor around my symptoms and eventually got a phone appointment after waiting two weeks where she was not interested and asked what I wanted from her which is a bit strange, I requested to have my bloods taken and when looked up my blood results it stated I had stage 3 CKD also my hormones had not been completed. I called the GP again to say I have not had the correct bloods done and requested another test. When I went for my bloods, I was told that a retest of my bloods had been requested but I had not been informed so had them done again. I have called my GP to discuss my results as they did not call me and had a doctor called me back to say they

was a duty doctor, and my own GP would speak with me and make a plan. I have been left with no information and again left concerned about this condition with no answers. I have asked for a face-to-face appointment to speak about this and told a doctor will call back.'

'I was told by a receptionist that I couldn't have a face-to-face appointment only a phone one with doctor. I ended up having a phone appointment, then face to face...twice as much resource used than if I had been seen initially as requested.'

'It is almost impossible to physically see a GP. Telephone conversations are OK, but only if you are not really ill! A close friend in his 80s nearly died through not being referred to hospital with a blocked bowel A face to face consultation would have spotted this. He is lucky to be alive, he underwent emergency surgery at Addenbrooke's. Most of the GPs are part time some allegedly, and also work for private GP practices in Cambridge.'

Dissatisfaction with the quality of service offered:

'Phones unanswered, phone lines continuously busy, receptionists wanting too much information before passing on information, only a phone call possible with a GP. No face-to-face appointments in two years.'

'It's very difficult to even get through on the phone and due to too many patients being on the books and not enough GP surgeries in Uttlesford, surgeries prefer telephone appointments over in-person.'

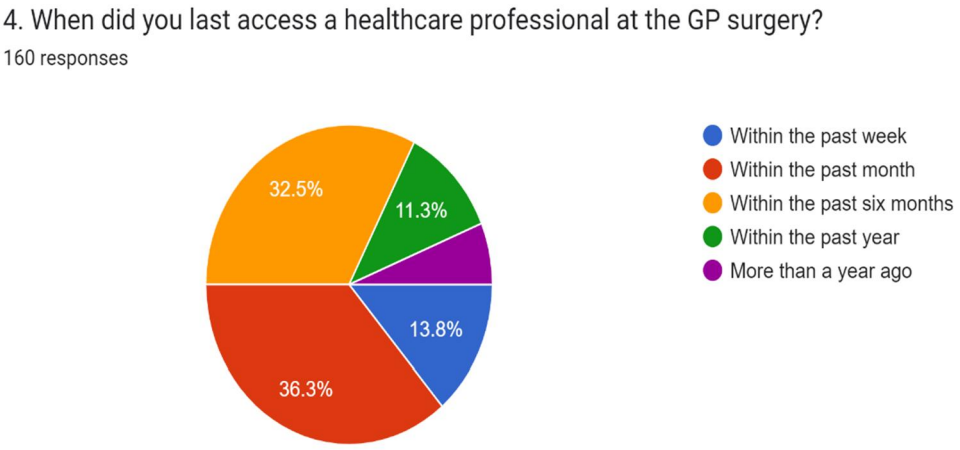
'I have not been able to see a GP for over two years. The first problem is getting past the rude, obnoxious, receptionists. The second problem is a failure to triage patients. The third and key issue, there are far too many part time female GP's - this is destroying primary healthcare. The fourth is that primary healthcare is run by, and primarily for, females.'

'Dreadful receptionists and part time female GP's - they are destroying primary healthcare.'

'It can take days to get through to a GP. There are insufficient services for the area. Stop building more and more homes and none of the services to support those homes. Existing services are just being continuously stretched.'

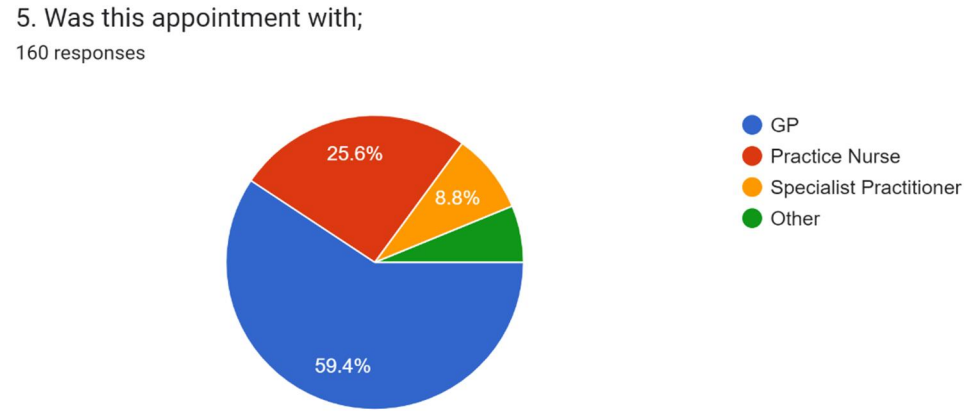
'I run Harlow Stroke Support - rehab centre and have had many members not being able to ring for an appointment. Some members cannot speak, but they are still offered over the phone appointments, it's silly.'

We then asked in Question four when the respondent last had an appointment with a healthcare professional at the GP surgery.



Of the 160 responses received, 58 accessed the GP surgery in the last month,52 within the last six months, 22 within the last week, 18 within the last year and 10 were more than a year ago.

Following on from this, we then asked which health professional the appointment was with:



Of the 160 responses, 95 had had the consultation with a GP,41 with a Practice Nurse and 14 with a Specialist Practitioner. 10 respondents indicated that their consultation had been with another type of healthcare practitioner.

We expanded upon this by then asking the respondent if they had been satisfied with this arrangement. Of 150 responses to this question, 65 affirmed that they were satisfied in feeling that the appointment was with the appropriate healthcare professional. Conversely, 33 stated that they were not happy and dissatisfied that the appointment was, in their opinion, not with the appropriate healthcare professional. 52 respondents stated that they

would have preferred to have seen their allocated healthcare professional face to face rather than hold the consultation over the telephone. Some also expanded further on the reasons for their answer, including:

‘I would’ve preferred face to face rather than a phone diagnosis.’

‘It was a telephone call with a GP which was appropriate.’

‘I would have like to have seen a GP first.’

‘I would have preferred face to face instead of telephone consultation.’

‘I would have preferred to see a GP’

‘I didn't see anyone of course, only a quick telephone call.’

‘Not happy at all.’

‘I don't mind who I see as long as they are qualified and experienced to deal with me without having to refer me on to a colleague via an unobtainable appointment.’

‘The GP had sent me to another branch of the surgery for blood tests. The nurse clearly thought this was entirely inappropriate.’

‘For what I needed it was relevant to speak to a GP.’

‘I should have seen a doctor as it was a heart issue.’

‘Seeing the nurse on this occasion was appropriate.’

‘I was extremely unhappy.’

‘No, telephone only was offered. I needed face to face.’

‘I saw a locum doctor, but I had to go to the surgery as I couldn’t get through on the phones, I was so ill I was hospitalised for 16 days.’

‘I didn't 'see' a GP at all. GPs say, 'Go to A&E', where there is a 10-hour wait in chaotic conditions. It’s a totally inadequate service as 'care' sometimes falls between two commissioning groups.’

‘When I arrived, I was informed that they didn't have any staff available. This for a fasting lipid, which I had booked; it involves fasting for 12 hours before the sample is taken. I decided to be difficult, rather than compliant, and eventually go one of their "paramedics" to take the blood sample; there were at least a dozen staff in the centre, chatting to each other and generally socialising (and ignoring me, the ONLY patient in the building at that time). Really average; and it used to be such a good GP practice. It changed hands and all of its staff - now rubbish’

‘This is the fifth GP I have spoken with. Where agreed actions had not taken place. Then any attempt to get the same GP again is impossible.’

‘I was happy to have got to see a GP face to face finally but couldn’t access the follow up appointment she requested’

‘I had to fight to book a future appointment after hospital tests and had to wait six weeks.’

‘No – I am always offered an appointment with a nurse practitioner initially rather than a doctor. Requests to see a doctor are not fulfilled.’

‘Completely inappropriate. I contacted them to get the result of blood test. I was told that the blood test was fine. Then I received a text message to say to make an appointment with a practice pharmacist. They wanted to put me on statins without any decent conversation with an HCP. But then you make money off of statins. I was not even told how high above normal my cholesterol was.’

‘I was very happy to see a physiotherapist after a fall four weeks ago - the first face to face consultation for the resulting injuries.’

‘I saw the practice paramedic, but he had to twice go and get advice from a doctor.’

‘I was very happy to see the Practice Nurse as she is extremely experienced around the subject matter for which I was seeking advice.’

‘I saw a trainee doctor. I hope he knew what he was saying. He was from Blackburn, told me to take a pill with my tea. Tea in Blackburn is supper in Loughton.’

‘I was not happy as I was not given a specific time for the telephone appointment, so I had to wait in all day. The doctor was extremely condescending and told me she was prescribing medication which I believed was totally unnecessary, and felt it was inappropriate to prescribe without even seeing me or even asking me appropriate questions to assess. I refused the medication without a face-to-face appointment which I have still not been able to obtain. She told me my decision was stupid.’

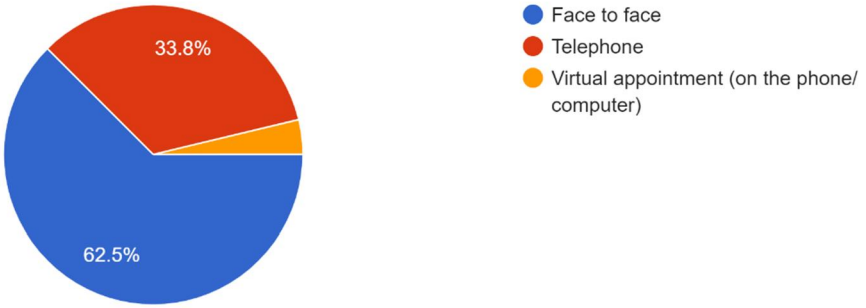
‘I needed to see the specialist dermatology GP but when l tried to book an appointment with her l was told that l couldn’t have an appointment and asked to fill in an online form and send a photo of the area l was concerned about instead. A GP than rang me but couldn’t see me so made an appointment with another GP who looked at the skin lesion then told me that l needed to see the specialist dermatology GP. What a waste of time for all concerned.’

‘The practitioner was professional and helpful, but we are attempting to run a proper health service by telephone and written notes on a computer.’

In Question seven we asked the respondent by what medium their last healthcare consultation took place.

7. Did this interaction take place by;

160 responses

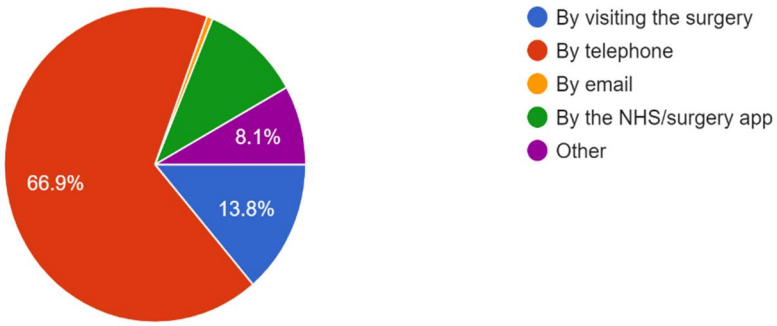


Of the 160 responses received, 100 were face to face, 54 by the telephone and 6 were by virtual means.

We then asked how this appointment was arranged.

8. How did you book this appointment?

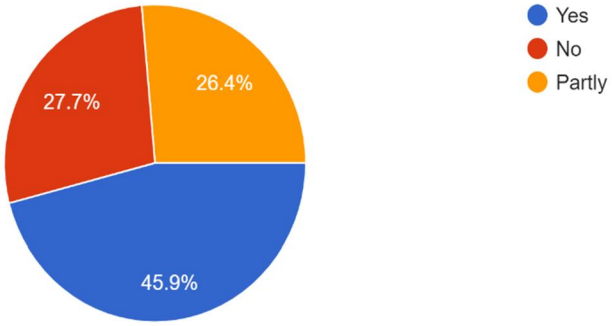
160 responses



Of the 160 responses received to this question, 107 had booked the appointment by telephone, with 17 doing so via the surgery or NHS app, 22 by visiting the surgery and 13 via other means.

We then followed this question up by asking if the respondents were satisfied with the various aspects of the process.

9. Were you satisfied with your appointment, including the booking process and care provided?
159 responses



Of the 159 responses received, 73 stated that they were satisfied, 42 were partly satisfied and 44 were not satisfied. In order to understand this further, we asked respondents to explain why they gave this answer. Responses included:

'Having to wait 45-60 minutes to get through is unacceptable.'

'I just wanted a new prescription for HRT. It was sent straight to the pharmacy a few days later. Super-efficient.'

'I had to be very insistent, and the receptionist was rude.'

'I would've liked an examination rather than the doctor just asking questions.'

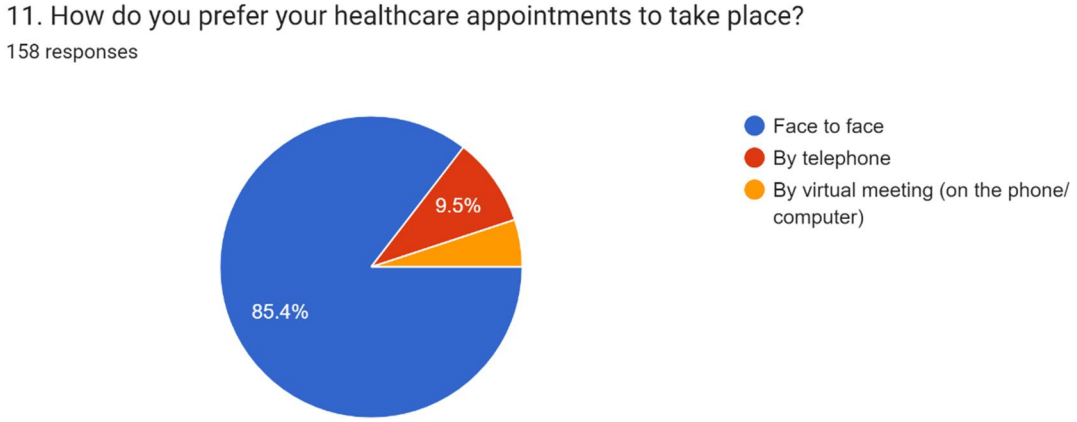
'Doctors are doing their best and it's not their fault, but I was rushed through on the phone, my prior medical history not consulted and would have preferred to have been seen in person.'

'The hospital should have asked the GP to get in touch with me, but I had to do it, sheer lack of communication.'

'The issue was about existing HRT treatment and I felt bullied.'

'I was injured and needed treatment and was told to rest the injury. Having continually tried to see a GP and unable to get a face-to-face appointment, I paid to see a private physiotherapist. The physiotherapist suspected an underlying problem and gave me a referral letter – yet still I couldn't see a GP. The private physiotherapist managed to arrange a private MRI scan, this identified significant soft tissue damage and bone fragments in my ankle. I tried to get a GP appointment, without success. I was limping for over two years, my fitness and wellbeing were significantly impacted, and I still can't see a GP and am £1,200 out of pocket.'

We then asked respondents how they prefer their healthcare appointments to take place. Of 158 responses, an overwhelming 135 said that they prefer their healthcare appointments to be carried out face to face. Fifteen stated that they preferred a telephone consultation and eight preferred the option of a virtual consultation.



In question 12 we asked respondents if they had any other feedback that they would like to share about seeing a GP. 126 responded to this question and there were a wide range of comments made:

'I think my GP surgery at Elsenham is great, using different ways to help us patients and not wasting GP time.'

'I am concerned at the number of new houses being built in and around Dunmow, where I live, and the number of surgeries and GPs has remained the same for the past 40 years.'

'JTH in Dunmow is an excellent practice. There were tough times re Covid. Several GP's and the GPN have retired; some age-related, others stress of Covid and demands put upon them beyond their control. Decades ago, governments were warned that there would be a shortage of GPs and GPN's due to retirement age and little or nothing has been done about recruitment issues! So, this is a fact that there is a shortage of these HCPs in practice. My surgery have full complement of staff in those areas probably due to the ethos of the practice which I was fortunate to work for 27 years!'

'I am disgusted. I was sent to A&E after a telephone consultation, to wait for four hours at A&E/ Urgent health care to have the GP immediately tell me I had shingles. This could have been diagnosed by my GP surgery if they had just looked at it. This wasted hospital time, also as shingles is contagious, I was in a waiting room packed full of unwell people who could possibly have caught this from me.'

'The new booking system at The Hamilton Practice works well; no longer staying on the phone waiting for 25 minutes.'

‘It’s hard to book appointments other than ‘on the day’ appointments. It just seems like patients are an unwanted inconvenience.’

‘Uttlesford needs many more GP surgeries - it can’t cope.’

‘The use of virtual appointments and sending photos where appropriate is quick and easy.’

‘Why can’t we book future appointments for non-emergency appointments like we used to before Covid?’

‘A less stressful appointment making process is needed and we should be able to book in advance for non-urgent.'

‘I don’t want to be fobbed off with seeing someone else or having a phone consultation when I know I need to see the GP.’

‘Weekend and evening appointments would be a lot easier for those who work.’

‘Advertise that they have evening and weekend appointments but I am never offered them to book.’

‘A receptionist rang to say that a GP needs to talk to me about blood test results and said they would ring me in a month. Again, if I am at work, I can't answer the phone, as no time is specified.’

‘Following a recent visit to A&E - information given to me by the surgery that directly contradicts what I was told in A&E, and the surgery refused to follow up by organising a test that A&E recommended. By text, the surgery told me to Google the health matter if I wanted more information!’

‘I appreciate the challenges the NHS is under. However, I do not like the hostile and rude attitude of those who act as the GP’s gatekeepers.’

‘The sooner we can go back to the way of working before the pandemic the better. I cannot see how telephone calls can judge what the medical conditions are without being physically seen. Especially if it turns out to be as serious as cancer!!!’

‘I am satisfied with the service given in Thaxted surgery.’

‘It’s a very professional service each time and I get my blood results back the same day as I am using My Chart on my telephone.’

‘I rarely see my GP and will only go when I have tried all other options.’

‘Please make it easier to get through to surgery.’

‘It just seems pointless nowadays if the issue is a pertinent one and time specific then what’s the use in an appointment three weeks later when you could be dead or better already?’

‘Please make the surgery be more approachable. I don't mind a triage system at the reception / telephone answerer, but it feels like they don't want you to get an appointment or phone call or see anyone. It's frustrating. Is it the surgery? Is it the number of new houses? It's just difficult to easily access what you want. My midwife said if there were certain symptoms I noticed in

pregnancy that I should contact the doctor, and my heart sank because I didn't think I'd get the care / answer / appointment that I might need. It shouldn't be like that.'

'Having to talk to different GPs on different days and explain the whole thing again and again during my child's illness is not great.'

'I understand how busy and stretched they are. With all the development of new houses being undertaken in Uttlesford the current GP provision is too low.'

'It would be great if I could actually see one when I need to. This would probably have meant I would have gotten the treatment I needed in the first place rather than someone guessing what was wrong with me over the phone and having pills thrown at me in the hope I went away.'

'I feel that GPs rarely look at the whole patient as a person and seem to only look at a single symptom.'

'They are doing their best but having had to turn some of the internal space into additional surgery rooms the waiting room is cramped, and you have to queue outside for the dispensary window. There is such a high turnover in doctors you rarely see the same one twice and there just isn't enough appointments for a growing town. This is only going to get worse without proper investment, developers should be made to invest in local facilities, but they don't.'

'Getting an appointment is a nightmare. Some GPs also are not very well trained to work with children with autism.'

'I have been with my GP practice for many years, and I have not received the care I believe would have changed my life or the way I have had to live. More emphasis on listening and empathy on some of the things I have explained would have helped. I have begged for help and after 30 years I was referred to a specialist who was appalled that one of my life changing problems had not been addressed and he sorted the problem for me and wrote to the GP and stated he was upset that a patient had been left so long without being sent down this simple route. Adding to my medical history is mental health, some of which has been caused by a similar outcome but with my children both of which nearly lost their lives due to not being listened to. This is a very serious problem and has to change and I believe in the bigger picture would save a lot of time and money over a longer period of time. But these stories need to be listened to properly!'

'Allow a patient to discuss all things, not stop you short and deal with only one. If you do finally get an appointment with a doctor don't be telling them what's up without them looking it up online or even having read your notes to see what else is going on. It can be very rude.'

'It's impossible! There is no continuity of care, and you never see any of the partners anymore and that's if you can get past the reception staff after holding on for almost an hour. It's so disheartening when you are number 30 in the queue. Why can they not take on more dedicated receptionists to help this situation?'

'People's personal information like name and contact details aren't protected well enough. The reception at Newport Surgery in Newport, Essex is inside the waiting room and everyone in there can hear the conversation between a patient and the receptionist. Names, phone numbers and addresses are all out there.'

‘Delays in getting consultations or appointments is unacceptable.’

‘It’s extremely frustrating not being able to see a GP, it’s frustrating that you have to tell the receptionist why you want an appointment, it’s not their business as to why you want to see a GP.’

‘It takes an age to get an appointment with anyone - excuses given by the receptionist about no-one being available, very busy etc. etc., don't seem to hold up as the waiting room at the surgery is always empty. The reception staff, who have no medical qualifications, seem to be making clinical decisions on whether you should be allowed to see anyone. It’s unacceptable’.

‘GPs are sympathetic if you get a face-to-face appointment. But there has been ONE in the last three years. CCGs and specialists don't talk to each other.’

‘More GPs should be working face to face. It would take the pressure of hospital and A&E.’

‘Ten minutes is not long enough for an appointment.’

‘Rude, unhelpful, and usually inaccurate. I have had one decent experience from meeting with a GP and it was due to my eating disorder, so I was put in touch with a specialist. Every other time has been confusing, information has not been passed to me, my concerns or legitimate illnesses are brushed under the carpet alongside with the GP often being quite demeaning. Nurses however are wonderful.’

‘Telephone appointments are being offered to people when they have physical issues like unusual moles and skin cancer. Inevitably they then need a second face to face.’

‘Text messages were sent out confirming an appointment but on arrival for a face to face with a nurse I was told I had no such appointment. Having proved I had received confirmation by text I was told that the receptionist who sent it wasn't in on that day so couldn't check the situation with her. I had to wait three weeks before another appointment was possible.’

‘It is far too difficult to see a GP; first the only appointment is by phone then a follow up face to face, but it can take weeks. Mostly you are referred to 111 or A&E.’

‘Getting results of tests is a nightmare. You have to call after 2pm. I rang to get the results of X-rays and bloods. I was told by a receptionist ‘all OK goodbye’ which feels very unsatisfactory when I would like to discuss as I am obviously not alright – I am in pain!’

‘Whenever I have contacted the practice, I have been redirected to A&E when it was not necessary, and this was confirmed by A&E staff.’

‘The Crocus Medical Practice has gone from being ‘best in class’ to being very average. The staff are individually competent, but the patient-centred ethos has gone completely. It is run for the benefits of its staff. The patient seems to be an irrelevance - a nuisance, even.’

‘It's disgusting that seeing the GP has turned into a lottery. It is impossible to make an appointment to see a doctor in the future, for example if you need a health check. The receptionists are very rude too.’

‘I am lucky to belong to a super-efficient, super caring GP practice.’

‘I am extremely happy with the service from our surgery.’

‘The GP service at Felsted is inadequate for my personal circumstances. Registered home visits were requested as the surgery cannot accommodate wheelchair access. They have not taken this into account no matter how many times they are reminded.’

‘I find it inappropriate the amount of information I must give the receptionist (unqualified health professional) in order for her/him to make my appointment. It’s becoming impossible to access a GP appointment.’

‘Elsenham surgery is 100% effective.’

‘Computer systems need to be updated and synchronised with hospitals as I lost my baby last October at 26 weeks, but my GP surgery (dispensary) refused me medication I’ve been on for three years as I was pregnant according to their computer two months after I lost my daughter – this was very distressing and ended with me having to get my bereavement midwife involved to speak to them. All they did was blame the computer.’

‘It’s an excellent service once I see a GP. But difficult to see the same GP on each visit.’

‘Receptionists are given too much control over determining a person’s ability to see a doctor. They are completely misguided on different needs for seeing a GP over a nurse practitioner. Stop selling people short. Maybe we should be able to have a scheme to rebate on our National Insurance when the system continues to let us down.’

‘It's impossible. There's now a health problem which should've been picked up earlier.’

‘It’s difficult to get a one-off appointment, face to face and triage calls are booked weeks in advance when you need to actually see a GP quicker. Things are by no means back to normal. Yet vaccine appointments are plentiful.’

‘My main worry is the extent to which my GPs are now using phone. At the start of the pandemic, I was diagnosed with shingles remotely - I had no smart phone so could not comply with the request to send a photo. I don't object to phone triage but worry that so often no face-to-face appointment is offered.’

‘I need an MRI scan. My GP cannot do this so goes via the physiotherapist delaying it by three weeks.’

‘Once you get an appointment the care is excellent.’

‘I was discharged from hospital at the end of May following strokes, I have untreatable stage four cancer in my liver which has spread to my lungs. It took two months to get a follow up appointment with my GP who had clearly not previously read my discharge notes and referral requests made by the hospital. I am disgusted by level of service from my surgery and GP.’

‘More needs to be done to create more GP surgeries for the growing number of people in the area. We have many new houses and no more GPs; the service is being overwhelmed and it's not their fault.’

‘You’d be lucky to actually see them.’

‘Most of the GPs work part time and they cannot cope with the volume of people living in the area. Receptionists are aggressive and won't listen. Quite a stressful experience just to get an appointment.’

‘It should not be as difficult as it currently is.’

The final five questions of the survey asked for more information about the respondents:

Some respondents used this space to leave further comments/views:

‘I have osteoarthritis and am pre diabetic. I struggle to see a GP to keep updated on the progress of my conditions.’

‘I was told when my call back would be, rather than arranged. This call back was to discuss blood results. Luckily when they called, I was able to take the call; my job does not always allow this flexibility, due to the work I do. To make an appointment face to face or phone consultation at a time that is mutually appropriate would be much more efficient.’

‘At 76 I am understandably going to suffer from several conditions especially as my history of numerous pregnancies, and an early accident would have left their mark. I lead a healthy, active and still productive lifestyle and I would like to think that I still qualify for decent healthcare especially as I do conscientiously follow healthcare advice diet lifestyle etc. However, I feel in the current NHS climate I feel I am on the do not treat list let alone a Do Not Resuscitate policy list. Friends of my age in other practices and different areas receive considerably more care than I do for much lesser ailments. I have had to demand a referral, asking if I could pay for the investigation, after over six months waiting and I was told ‘it's a good job you are here now’ as my problem needed urgent treatment. I feel that my severe back and hip pain is only going to receive any attention if I ask to be referred and pay.’

‘I suffer with depression, rheumatoid arthritis plus others. I very rarely visit the doctors as I worry that my situation doesn’t warrant a GPs appointment.’

‘I am categorised as 'vulnerable' since I have had blood cancer and had a stem cell transplant. This seems to make no difference as to whether I can get an appointment at the surgery.’

‘I am a carer for a young woman with multiple health issues and a recent mental breakdown. I am beyond disappointed at the lack of co-ordination and timely responses from health services. We need holistic, timely intervention on complex conditions, not just remote dispensing of one drug after another.’

‘I have an eating disorder, and last year I fell downstairs with concussion and a damaged calf muscle. I used to have regular blood tests before the GP surgery stopped calling. They brought

me in on one occasion, I took the day off, and then I got told they made a mistake, and I shouldn't be there.'

'I am a PhD scientist and an experienced local councillor. I am now "elderly" but worked for 50 years in science, technology and problem-solving for multinational companies and consultancies. I know about organisations - we used to trouble-shoot them. The NHS and the GP practices are basket cases - the whole system needs a root-and-branch reform. it is no longer fit for purpose. It is a disgrace that so many are now forced into using private medicine to get what they have paid in for over decades in their taxes and NI contributions.'

'I am in good health luckily but have decided to pay for private HRT because I cannot see a doctor face to face.'

'I am confident with booking appointments online and use this facility at my GP practice so that I don't have to wait on the telephone. I work in the healthcare sector, and I am therefore able to navigate the system better.'

There were a relatively even number of responses from the older age groups. Of the 160 respondents:

44 were aged 55-64 years old

35 were aged 45-54 years old

33 were aged 65-74 years old

21 were aged 35-44 years old

19 were 75 plus years old

6 were 25-34 years old

And two people preferred not to give their age.

Overwhelming responses were from females; 126 identified as female, 30 males, two preferred not to say and one identified as nonbinary.

147 respondents stated that their gender was not different to the sex they were assigned at birth. Six respondents stated their sex was different and one preferred not to answer.

134 people stated their ethnic background was White: British/English/Northern Irish/Scottish/Welsh. 15 stated their ethnic background was White-any other white background. Six people preferred not to say, two were White Irish, one was Asian/Asian British, one stated other Asian/Asian British background, one was any other ethnic background, and one was mixed ethnicity-Asian and White.

74 respondents stated that they were not carers or considered themselves to have a disability or a long-term condition.

61 considered that they did have a long-term condition.

24 considered they were a carer.

17 considered they had a disability.

6 preferred not to say.

3.2 The Interviews

We followed on from the survey by carrying out a number of one-to-one interviews with members of the public. Some examples are detailed below.

Interview 1 – Brenda - Lister House Surgery

'For a long time even before COVID, it was difficult to access GPs. If you phone up, you're put in horrendous queues; you are 38 in the queue. During COVID, that was even worse. My surgery is about 15 minutes' walk away so it's no problem for me to walk down. And when they were in the middle of doing all the jabs and they were very reluctant to let you in, I can't remember if they let you in at all, I honestly can't remember.

So, I've always found it a problem to access GP services to the extent that I've sort of given up. And I had an incident in May, June time, where I really felt the need to access GP services, and I couldn't. And the short version of this is I went through the NHS 111 website, who told me to go to A&E, which I did. And it all went completely pear shaped from there. And I knew I had to go back to the GP and sought this out and I just gave up. I even thought about writing them a letter. I thought, I can't be bothered. I'm just going to try and manage this myself if things don't get worse, okay, I'll carry on. Unfortunately, they haven't got worse.

I think what really pisses me off with the whole system is that the surgery is just a part of it and that it's not joined up. I get that I mustn't waste anyone's time and I'm very sympathetic to how busy people are. I know people who work in A&E and PAH and I know it's horrendous. And I don't want to waste anyone's time. So, I went through NHS 111 in desperation and that was

good. And they said, “Yeah, go straight to A&E,” which is good. And I saw a doctor and he sort of said, “Well, it's not an emergency, if you're still suffering tomorrow, come back.” I was still having problems so called 111 again and they said, “Oh, we think you should see your GP within seven days, go and make an appointment.” So, I tried, I managed to get hold of the surgery, and they say, “Oh, well, we can't give you an appointment for three weeks.” And I said, “But another part of the NHS is saying, I've got to see someone.” So, it's this sort of contradiction between them, they don't seem to be working together. And if you can make communications, it's all very dismissive. And making communications in the first place is bloody difficult.’

Interview 2 – Kamilla - Stansted Surgery and The Eden Surgeries

‘The surgery that we’ve moved to is Stansted Surgery. We moved there a couple of months ago, and it’s all been really positive, if you ring, someone picks up the phone really quickly, you get to talk to somebody, you get appointments. I’ve been in to see a nurse about something and had a really nice unrushed appointment with her. It was just really positive. I’m pleased that we’ve made the swap. My son is the only one who’s left at Eden Surgery in Hatfield Broad Oak, but he’s moving to university at the weekend so that’s why I haven’t moved him because he’ll be going to the GP surgery there. So, moving on to them really, which is one of my main gripes.

We’ve been with them since we moved to the area, probably about 12 years ago, and the experience previously hasn’t been too bad, there’s always been a bit of a wait on the phone and bits and pieces, you finally get to see doctor, but it’s got worse over the years. Obviously, the pandemic hasn’t helped, but it wasn’t great before then. The main thing really is you have to ring at eight o’clock in the morning if you need an appointment, which is absolutely fine. On several occasions we’ve had to do that, we don’t go to the doctors very often at all, but when we do it’s usually because we need to go. I don’t know if I put my background, I’m a health visitor, so I know the pressure on NHS services, we don’t waste their time. But the phone is the main gripe really, it rings and rings and you’re in a queue for anywhere up to two hours.

My daughter’s been on the phone for an hour and forty minutes and finally got through and was told you should have rung at eight o’clock. We’ve also been told on another occasion well you should just drive down. But we live in a village and they’re in a village, and it’s not far, about a seven-minute drive, but that shouldn’t be… if you’re ill, you shouldn’t be told that you should, or get someone to drive down for you. And that’s not just the one-off thing. We’ve been 25th in the queue, got down, waited and waited, and got down to one, and then it’s been on one for 45 minutes and then just cuts off, which is just crazy. It is virtually impossible to see anybody, which isn’t useful. You need to know that you can see somebody if you really need to. And I know a lot of people are just treating A&E as a GP practice, but with situations like that it’s not surprising, we personally wouldn’t but what are you supposed to do if you can’t.

There’s a couple of doctors at Eden that are really nice, that I’ve gotten on really well with, but it’s so hard to get an appointment that you never get a choice as to who you see. And then at least one, who’s one of the partners, who has been very rude on a number of occasions to me. I’m not a rude person, I try and appease people and I’d never be rude to anybody, especially not professions, but she’s supposed to specialise in mental health issues, and it was surrounding a mental health issue and a medication issue, and she slammed the phone down on me.’

Interview 3 – Ross - The Hamilton Practice

‘Originally, to make an appointment, you'd have to phone up and just join a queue and you'd have to phone say, eight o'clock in the morning, and be in a queue of 20 or 30 people; that was the old system. Now they've switched over to a system where you use an app, so essentially, you go on the app, you fill in a small form as to what you want, why you want it and they say, yeah, clinician will then look at it and triage it and you should hear back within two or three days. Which does happen. Obviously, if there's an emergency, you know, 999 it or you triple one it so not trying to circumnavigate emergencies as such, I think if you don't have the ability to use a smartphone, you can stay online, and someone will eventually pick the call up but when I've used it, I have had a response normally within a day and they've been booked me in for an appointment so from my side, it seems to work quite well.’

Interview 4 – Joan and her sister Heather - Nuffield House Surgery

Joan had the support of her sister to fill out the survey. Joan has stage four liver cancer.

‘It goes back to the 17th of January when Joan had pains in her stomach and phoned 111 who said it was wind.

Two weeks later she's phoned the doctor because she wasn’t feeling any better and he said, “It's not wind, you need to come in.” She's gone in and had a blood test and then seen the doctor the next day, the GP who said it was cancer. Okay? It's not good to say that. Then she was referred for CTs, biopsies, back to the Williams Day Centre at Harlow for chemo and stuff like that. She had all that. No contact with the doctor whatsoever until the 21st of June.

Then Joan had a stroke at the end of May and was in the hospital for a week. When she came out, she was given a discharge note with what medication she was on and various referrals that the doctor needed to make for her. Three weeks later, none of that's happened. She's had the stroke, nobody's seen her, nobody's spoken to her, nobody's done anything.

I called the surgery about a week after Joan came out of hospital to see if she could be seen by the GP as a follow up. And I was told that they'd got the discharge summary and the doctor was looking at it and he would be in touch to make an appointment, and that didn't happen. So, on the 21st of June, we insisted on Joan seeing a doctor. It was quite difficult to get that appointment, but we did. In fact, in the end, all three of us sat in front of her GP.

The appointment was for 11.50am. Someone else went in at 11.50am and didn't come out until 12.20pm. We then went in; he didn't really take any notice. He got on the screen, the discharge notes were there but he hadn't looked at them, hadn't read any of them. He didn't know what we were asking for. And at half past 12 he said, “I'm going to have to go, I've got a clinic.” So, we just carried on talking and ignored him. He said it again and we still ignored him. We'd had an appointment at 11.50am and he hadn't even looked at Joan’s feet that were so swollen she could hardly walk. They were painful. They were keeping her awake all night. We didn't know whether it was any of the medications she'd been given. He didn't go through any of that. And then, before we'd said anything, he'd already issued a prescription to the chemist. But then he

had to alter it because he changed one of the pills. So, he issued another one. And then he had to give us some more water pills. So, he issued another one. By the time we got to the chemist we didn't know what we were supposed to be having or not, and they've only got our word for it, what we wanted and what we needed. He gave Joan water tablets for two weeks on a non-repeat basis. And then there was absolutely no follow up for that for about eight weeks.

So then from the 21st of June when we saw her GP, there was again, really no reactions or follow up until she got in to see the locum GP on the 9th of September, who has actually been very good and has moved things forward. But basically, there's no coordination from the surgery at all. And the referrals were all messed up. I mean, we ended up going into London. Two of the referrals were made, one for the eyes because Joan had lost some of the sight in her eye, the other was for a stroke clinic. There is a stroke clinic at Princess Alexandra Hospital here in Harlow. The GP sent us to a London hospital and the first thing the consultant said in London was, 'Why did you elect to come here?' And we both said, 'We didn't.'

It has been a constant fight to see the GP and to get the referrals that Joan needs.'

Interview 5 – Anil - Crocus Medical Centre

'The whole place seems to be run for the benefit of the front office staff. You're capable of walking in there as a sole patient standing in this empty waiting room in front of a desk which has three people on it, chatting to each other and they'll ignore you. You can't phone them, you get a recorded message saying you came to the wrong place: 'Because of Covid, we can't do this, we can't do that, we can't do the other' – and I'm sure this is the standard message that all GPs have - and if you're willing to wait it out until the end, they might say: 'well, what do you want?' Basically, it's a long spiel where they'll say: 'we don't do anything, go somewhere else, dial 111 or go to a casualty or something like this.'. And essentially, we no longer have a health service.

This large brand spanking new GP service building in Saffron Walden is largely empty. It has three women on the front desk; it seems to be exclusively staffed by females, it's not a problem but they do seem to organise the thing around their own needs. It's not patient-centred, in any sense. And the previous practice was patient-centred; I don't see how you could run a health practice in any other way, but this one is run for the benefit of the front office staff. They just want to get you off their books, there's very little service, and there's only ever one GP in that building at any one time.

And so, last time I visited, it was for a blood sample. For fasting lipids, you have to prepare for those 12 hours in advance, nothing wrong with that, I arrived in plenty of time, only to be told, 'oh we can't do anything, we haven't got any staff'. They hadn't bothered to tell me; I'd just rushed up there. I said: 'Look, this is fasting lipids, you have to prepare for it, surely there is somebody in this building who could take a blood sample?' Silence. And then there's lots of running around, and eventually they found the paramedic; what's a GP surgery doing with a paramedic? In fact, the ambulance place is just behind them so they may have gone and got one of them. And this guy took my blood sample, and it was all okay, fine. But if I hadn't stood there and insisted; they would have sent me away.

Crocus Medical Practice has become a joke, basically. It's got a very expensive building paid for out of the public purse, which is empty, you can't get to see a doctor, and essentially it is not fit for purpose. We don't have a health service in Saffron Walden anymore.'

Interview 6 – Judy - Nuffield House Surgery

'I'm autistic so I sort of tell it how it is and I guess that means I have expectations, particularly of professionals so if you're the doctor, you're there to care for me, I expect you to show some signs that you're caring for me so if I turn up at the surgery saying, 'good morning doctor' and they're sitting at their computer which is not in front of me but to the side and looking at the computer, I'm sitting there on the chair going, 'hello doctor I'm here, your patient has arrived, would you like to interact with your patient rather than with your computer?' So that's my sort of starting point. I think always I have found that problematic, I have had two GPs who were not like that. One was fresh out of medical school, and I came in and he went, 'good morning!' and, 'how can I help you?' I was like, 'Jeez! Wow! You're only fresh out of med school' and he was very kind and I talked to him about my various mental health issues, and we agreed on a course of action.

At that point, I felt 100 times better than when I walked in and then he said, 'if you need to talk or if I can help you again just give me a call and we'll arrange an appointment' and of course I never did, because just that response, as I said just made me feel so much better. I thought, 'right okay, there's my safety net, it's there if I need it' and then he left because they do the rounds and they're only there for a limited time. I recently spoke to my current GP on the phone because that's the system now but he sort of said things like, 'I'm here for you', all the right noises and yeah, I subsequently went in and spoke to the receptionist and she said, 'oh yes, Dr Miquel he's very popular' and I thought yeah, because he's like a proper good GP, he actually talks to you like he cares, he talks like he knows something about his subject, he talks like you might actually get a useful diagnosis or some help so yeah, so he's my GP now.'

Interview 7 – Susan - Newport Surgery

'I've got nothing but praise for them, they are amazing. I try not to go to the doctors, especially over the last few years. I had the most awful chest infection and I've had them before that got to the point where it was really quite bad and quite scary to be honest with you. So, I had a really bad cold, it wasn't COVID, I haven't had COVID, but it was a really, really awful, really bad cold, and it went to my chest and so I thought, I need to see the doctor. It was coming up to the weekend and I thought I don't want to go through the weekend without antibiotics if it's bacterial. So rather than ring them, because I know they're really busy on the phones and you hear stories you can't get through. I went round there, because I'm only around the corner, so I went up there for eight o'clock when they opened, and I asked if I could see a doctor and they offered me an appointment with the nurse practitioner. I said, 'Yeah, great that morning', and I think it was only literally about an hour and a half, two hours after I'd gone to get an appointment.

I live on my own and it can be quite scary when you're not well, and especially with a chest infection, you know things are always worse in the middle of the night when you can't quite, you know, you don't really see clearly. I remember I said to the nurse practitioner, that I feel

absolutely awful, and I'm really scared that it's going to go to my chest or if it's on my chest already, and she said something like, 'don't worry, I've got you', or something like that but it was really lovely. I've never met her before, but she was just so nice and put me on some antibiotics and unfortunately, that didn't really help much but so I went back the following week. Again, I went up to the surgery, I think it was Thursday of the following week because I knew again, we were coming into the weekend, and I had come to the end of the antibiotics and I saw her again which was great that morning, and she said, 'oh, sometimes, you know, certain antibiotics don't work, we'll put you on some stronger ones.' She did all the normal observations, checked my blood pressure and listened to my chest and she said, 'oh my God yeah, I can tell it's not very good I'll put you on some different ones'. So, I said, fantastic. Got those, and then came away.

Anyway, a week later, having come to the end of the second lot of antibiotics, I still wasn't feeling great, and my chest wasn't particularly any better. So, I went back again for the third time. I went and waited outside for them to open because I wanted to see somebody, and this was on the Friday. And I managed to see the nurse practitioner again, and she was really, really lovely and she said 'okay, we might need to look a bit deeper into this. So, we'll do a sputum sample, I'm going to refer you for a chest X ray. I'm going to put you on some stronger antibiotics.' I got the appointment for the chest X ray, I think by the Monday or Tuesday, the following week, so I went through that and the sputum sample, I've got the results of that. I just got a text message to say that that was clear. So obviously, it was a viral infection, but a really horrible one but I just felt that she in particular was just really lovely.'

3.3 The Case Studies

In addition to these interviews, we also gathered a number of case studies for additional insight into the lived experiences of the people of the area.

Case 1 – Lewis - Addison House Surgery

Lewis has had no face-to-face contact with anyone from the surgery for three years.
Lewis takes blood pressure medication; he did have a medication review booked but they phoned three hours early so he missed the call and is still waiting to rebook. The surgery is trying to get people to book appointments online via Doctor Link but Lewis said it doesn't work.

Case 2 – Gilly - Newport Surgery

Gilly has been with her current GP for 20 years.
She finds the receptionists pleasant. She feels that the new male receptionist is a little inexperienced and sometimes offers things that he can't actually provide.
There are issues with the pharmacy, lots of errors regarding medication; she feels the system could be improved. It was not noted that a controlled drug needed to be collected along with other medication, so it always has to be asked for. She feels there could be a sticker or

something on the non-controlled medication to remind staff that there is other medication to go with that one.
She would like test results to be communicated via a text message, especially if there is nothing to report so she then doesn't have to chase it up.

Case 3 – Chloe - Crocus Surgery

Chloe feels that access to the GP is not great, she feels she gets palmed off to the paramedics. She did have a recent appointment at the other branch of the surgery and said that was very positive. She feels the GP's just look at the symptom right in front of them at the time and not the whole person. She was sent to A&E to get an MRI scan as the GP said that would be the quickest way.
It takes at least one hour on the phone at 8am to try and get an appointment and the GP will only deal with one issue at a time.
Chloe said that one GP she saw was very difficult to understand, he wore a facemask and had a very thick accent. She said that she kept telling him that she was struggling to understand but he didn't slow his speech down or change his tone.
There are issues with updating her medication following a hospital procedure. She said she is still having to chase it up each time she gets a prescription.
She feels the reception staff are very arrogant and obstructive.

Case 4 – Barry - Ongar War Memorial Medical Centre

What works well:
Barry feels very well looked after when actually seen by a doctor.

Issues:
Getting through to make an appointment – you have to phone at 8am and 1.30pm. All online appointments are gone within one minute.

There is no ability to pre book. Barry has raised this with the practice manager but no change.

He frequently sees different GP's, having to explain his history to each one. He feels much more confident when the GP knows him as a person and his history.

Referrals for eyes and orthopaedics-why are these vetted by an outside company- before being sent to the hospital department? This seems like a waste of time, as surely just the GP making the referral should be enough. This surgery already checks referrals inhouse before being sent off.

Case 5 – Mina - Dunmow Angel Lane Surgery

Mina is a carer for her elderly parents who with live with her and her husband. Mum is 86 years old and has dementia, epilepsy and reduced mobility following a broken hip last year. Dad is 90 years old and has dementia.
About two months ago Mum had a wheezy chest, so Mina called the surgery, and the phone was answered straight away, and she was told there were no appointments left. There was no hello or anything just straight into that statement. Mina had to phone 111 for advice and they told her to phone the surgery back and ask to talk to a GP. The GP phoned and said it sounded like hay fever so prescribed some medication for that, he also arranged for the surgery paramedic to visit the next day. Mum did not improve so they had to call for an ambulance. Mina tried to cancel the surgery paramedic visit the next day but was on hold for 45 mins before being cut off, in the end she physically went to the surgery to tell them as she didn't want a wasted visit. Mina feels that she shouldn't have to beg to talk to a GP if she has concerns for her elderly parents.
However, there are good pharmacy service who are very helpful.

Case 6 – Angela - Newport Surgery

Angela said that her overall experience with the surgery was good. She feels the staff are overworked. Her suggestions for improvements were:
More information on the surgery website.
More self-help leaflets in the waiting room.
Reinstate the ability to book appointments online-this was stopped during Covid.
Patient access/NHS app – an explanation is needed as to what is the difference.
Waiting room could do with a facelift, there is dated décor and chairs too close together.
Angela feels if more people took general responsibility for their health the NHS wouldn't be as overloaded as it currently is.

Case 7 – Jim - Lister House Surgery

Jim has been with his GP surgery for 49 years. He is a full-time carer for his wife.
He hasn't seen a GP face to face since before Covid. He has various health issues that his own GP is aware of and has talked to other medical staff but not his own GP. Getting through to the surgery is his main issues, as you can only book appointments via the phone. This is not practical for him as he can't spend lots of time on the phone due to his wife needing him. He has tried to use the NHS app but is unable to access his records or book appointments. He has told the surgery he is a carer, but he said this has made no difference.

Case 8 – Diana - Thaxted Surgery

Diana is a former nurse; she has stage four cancer and is having palliative care.
She feels that she has a fantastic surgery and waits no longer than five mins for the telephone to be answered. They will ask for basic information to make sure they put her through to the right clinician. She has her GP's mobile number so she can call if she has any questions or concerns about her care/treatment.

She uses the 'My Chart' system, which is linked to Addenbrookes Hospital. Diana is able to look up her medical reports and blood test results. She finds this very useful. Diana feels very lucky to be at this practice.

Case 9 – Ross - Crocus Medical Centre

'My practise is absolutely terrible.'
Ross is unable to make advanced appointments. He has to phone at 8am and is on hold for 30minutes plus and then there are no appointments left when he does get through. Ross is a shift worker so is not always able to phone at 8am.
He recently cut his finger badly and went to hospital; he was told that he needed his finger redressed every day but when he called the surgery, they just said they couldn't do that until he insisted and had to repeat what the hospital had said.
He has had a text from the surgery saying that he needs a medication review and blood test. He has spent a week trying to get through to make an appointment but no answer. His worry is that the surgery will stop his medication if he doesn't have the review even though it is not the GP who has prescribed the medication but the consultants at Papworth and Addenbrookes hospitals.
The surgery has an appointment app but it doesn't work.
No one doctor works at the surgery full time.

Case 10 – Gemma - Church Langley Medical Centre

Gemma wanted to talk to the GP about her worries and concerns around the menopause; she has been bleeding for 5 weeks and was in a lot of pain. She had to wait two weeks for a telephone appointment, she said that she tried to explain how she was feeling to the GP but felt they were not listening. The GP asked, 'what do you want me to do?' She asked for her hormone levels to be checked at her blood test the next day (this was already booked for a pre-existing condition). She had the blood test and when she looked at the results on her NHS app the hormone levels had not been checked as she asked. She had to phone again, with a one and a half hour wait to get through to try and rebook for another blood test.
The blood test did show up possible kidney issues; it said to retest in a couple of months, but the GP said nothing to Gemma about this. She was very worried and tried to talk to the GP who said it was only just in the range and to look at the NHS website for advice. This was after being told it would be a six week wait for a telephone appointment, but she complained and got one for two weeks' time.
Gemma is not happy with the service. Her Mum died at 65 years old from bladder cancer after one year of being told by the GP that she had urine infections, but she actually had a tumour in her bladder and the cancer had spread. She had not been physically seen by a GP during this time, just telephone appointments. Gemma's dad has leg ulcers which are not healing after several courses of antibiotics, she that the GP has said he can't have anymore and to wait and see what happens.

Case 11 – Bethan - Old Harlow Health Centre

Bethan has been a patient at Old Harlow Health Centre for a number of years. She said that she has nothing bad to say about the surgery. She is able to get through on the phone quickly and is given an appointment on the same day, usually within a couple of hours. Cervical screening continued during the pandemic which she felt was really good.
Bethan feels that due to the surgery being owned by the same GPs for a number of years and the same GP's working there, gives a high level of consistency and the ability to build relationships. She said that they know her family history and remember that her mum passed away recently so they always ask how she is doing and not just deal with the reasons why she had an appointment, an holistic approach.

Recommendations

Difficulties with the booking system:

- Greater flexibility regarding accessing appointments - not restricting the time when patients can phone for one.
- Being aware that not everyone has access/skills to use digital formats.
- Easier ability to book future appointments for medicine reviews, blood tests, routine screening etc.

Lack of available/prompt/appropriate appointments:

- Improved triage systems so patients are directed to the right clinician for their needs the first time.
- Expand opening hours to offer more flexibility for patients who work/have caring responsibilities etc.
- Increase the diversity of clinical skills for available staff in practices.
- GP Care Advisor roles in each practice who can assist with non-medical issues-benefit advice, basic memory assessments, referrals to other agencies etc.

Dissatisfaction with the quality of service offered:

- Improved training for frontline reception staff-communication skills, awareness of various conditions-autism, dementia, mental health, stroke, trauma etc.
- Making sure future services meet the needs of the expanding population.
- Increasing the number of face-to-face appointments available.

4.0 Conclusion

Our engagement with the people of Harlow and Uttlesford in west Essex focussed on the question of how GP access is for patients and garnered in excess of 160 responses. Whilst a number of individuals were generally satisfied with the service provided by their GP surgery, many took the opportunity to express their concerns and dissatisfaction around a number of issues.

The issues raised mainly centred around the availability of appointments, which was frequently felt to be insufficient, particularly to see a GP, and the system for booking an appointment, which was felt to be convoluted and not person centred. Phoning a surgery at 8am and having the possibility of being on hold/in a queue for hours does not work for many individuals; those who work-especially shift workers, have caring responsibilities, difficulties in using a phone system, pre-existing health conditions etc. Many do not have the time or ability to wait for their call to be answered and then have the high possibility of having to try again the following day or for numerous days until an appointment becomes available. Many residents stated that when they finally got to see a GP then the service was fine, but it was getting the appointment that was the main issue. Staff attitudes were another often mentioned bone of contention, particularly around the manner of receptionists and those involved in surgery triage systems, and quality of service provided, including inefficient referrals and diagnoses.

It is clear that the Covid19 pandemic had a huge impact on GP service provision, with many respondents stating that they were sympathetic to the pressures on the NHS and appreciative of the adaptation and continuation of services. However, it was also clear that many felt some surgeries were overly reticent to 'get back to normal', with particular issue around the lack of face-to-face appointments, which a large percentage of respondents felt could not be adequately replicated in a telephone consultation. Not having the ability to see the same GP each time, having to explain their situation and past actions to a new person each time was very frustrating for respondents.

The impact of the digitisation of services, such as the dependence on the telephone system for booking appointments and high proportion of consultations still being carried out virtually or via the telephone, must also highlight the risk of those individuals not digitally connected not having equitable access to primary care services. Similarly, parallel issues will be faced by a significant number of those with sensory impairment, learning disabilities, mental health issues and other conditions which fare best in face-to-face interactions.

Interestingly, many participants referred to the positive effects of consistency in the GP or other healthcare professional that they see. The issue of unfamiliarity with their case and having to explain their situation and symptoms over and over again was not well received, whereas regularity in the person offering support promoted feelings of being understood and regarded as a person. This is supported by the findings in Continuity of GP care reduces acute hospitalisations and deaths, study finds - Pulse Today (5th October 2021), where it is stated that 'long-term continuity of GP care is 'strongly associated' with lower mortality and reduced need for acute hospitalisations and out-of-hours services.' The research, published in the *British Journal of General Practice* (5 October), found that when someone has been treated by the same GP for more than 15 years, the probability of these occurrences decreases by 25-30%.'

healthwatch Hertfordshire

Accessing GP Services: Views from Broxbourne Patients

Engagement: August – October 2022
Published: (xxx)

Contents

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 (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 representations 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 GP services.

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, 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 August to November 2022 the Director of Primary Care Transformation at the ICB has requested Healthwatch Hertfordshire and Healthwatch Essex to explore access to GP services with a specific focus on engaging with:

- Parents, carers and children and young people
- Residents living in the Borough of Broxbourne (and Harlow and Uttlesford for West Essex)

Reasons for exploring access to GP services, as well as these specific groups, are outlined below.

Please note a separate report has been published which outlines the findings from our engagement with Hertfordshire's parents, carers and children and young people. This report can be found on our website.

Background

National Context

Before the Covid-19 pandemic, GP practices across the county were facing significant and growing strain, with increasing staff shortages and workloads, rising patient demand and struggles recruiting and retaining staff. This started to have a negative impact, with patients finding it increasingly difficult to access their GP practice – whether this be for an appointment, information and advice, or general support. Patients were also seeing a reduction in choice when making an appointment, with many not able to choose the location, time or date of their

appointment, the type of appointment they received, and changes to which healthcare professional they could see or speak to.

The Covid-19 pandemic only worsened these existing pressures and even now as we learn to live with Covid-19, GP practices are still facing increased workloads and higher consultation rates than ever before. As a result, patients are struggling even more to access their GP practice or to get an appointment, and patient choice is further restricted.

The pandemic also necessitated new ways of working, including a rapid uptake of digital technology and services to deliver care, for example through the use of remote consultations and online booking systems. Although this has provided a number of benefits, patients had concerns that face to face appointments in particular would be replaced with online or remote alternatives.

This decline in patient satisfaction with GP services is reflected in the results of the national GP Patient Survey (2022)[4] which highlights a significant decrease in the number of people stating that they had a good experience when accessing GP services, with many noting a lack of choice, availability in appointments, and increased difficulty getting through to their GP practice. Particularly concerning is the rise in the number of people who are avoiding accessing their GP practice despite needing care. This could have a significant impact on people's long-term health and could lead to an increase in demand elsewhere in the NHS, such as in A&E, evidence of which we can already see.

The following is reflected within the recent Fuller Stocktake report published in May 2022, which also outlines the opportunities Integrated Care Systems have for integrating primary care and improving the access, experiences and outcomes for communities[5].

Local Context

Although access to GP services is an issue across Hertfordshire, a particular area of concern is the Borough of Broxbourne. Compared to national and local data, people registered with a GP practice in this area tend to find it more difficult to get through to their GP practice and are more likely to have a poor experience when trying to access GP services. They are also less likely to be offered any choice when making an appointment, and are more inclined to avoid accessing their GP practice entirely.

Aims

The aims of these engagement projects include:

- Identifying the barriers people encounter when accessing GP services

[4] GP Patient Survey 2022 results - GOV.UK (www.gov.uk)
[5] Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)

- Understanding the challenges people face when making an appointment with their GP practice
- Exploring the factors preventing people, despite needing care, from accessing GP services
- Understanding how the use of technology is being used and whether this is hindering or supporting access to GP services
- Making recommendations to the Hertfordshire and West Essex ICS Primary Care Workstream with the aim of ensuring greater ease and confidence when accessing GP services

Methodology

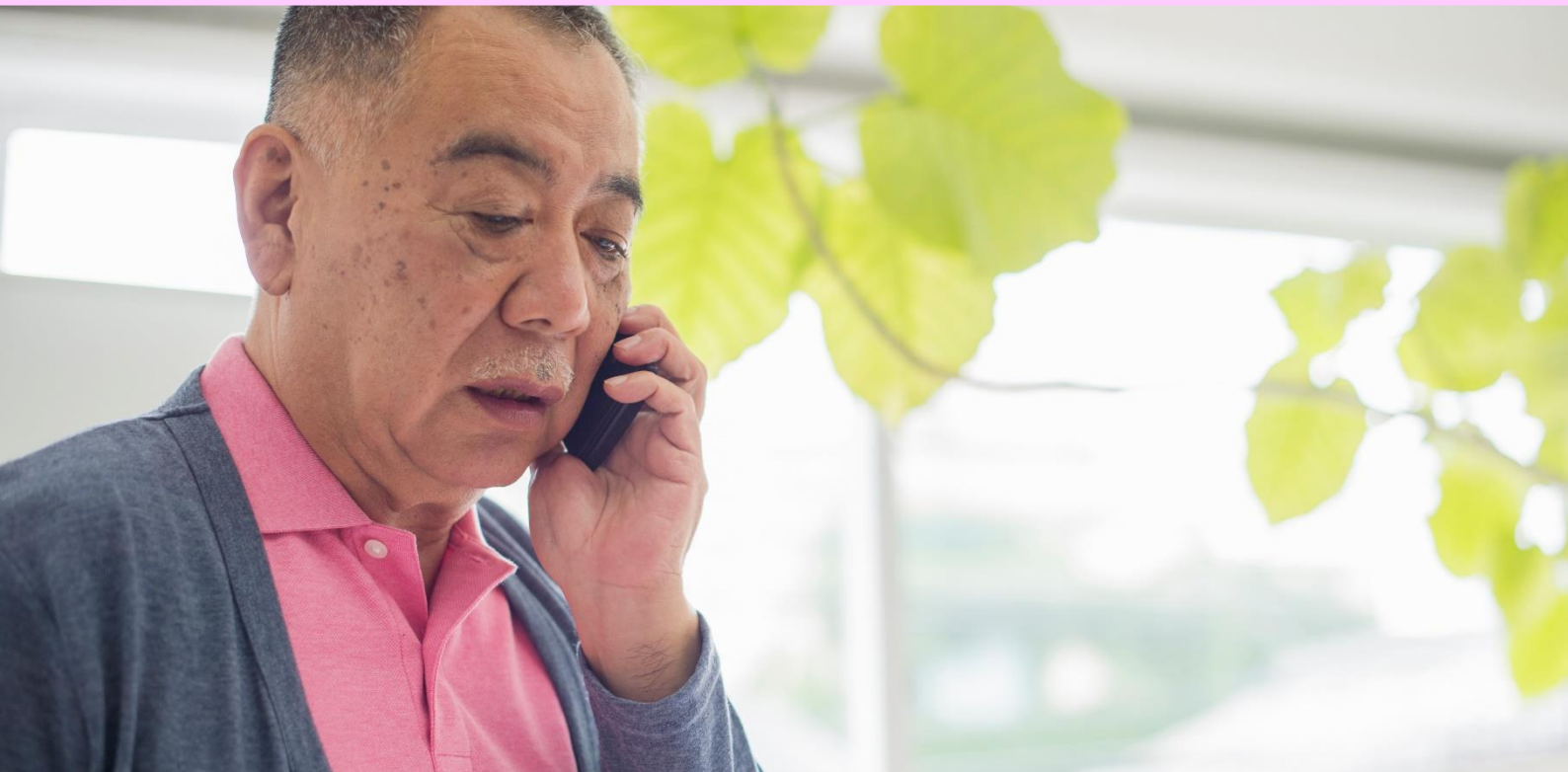
To explore the above aims, Healthwatch Hertfordshire created an online survey for residents who live in the Borough of Broxbourne. Participants had the option to request the survey in an alternative format to suit their needs, and/or contact us for support.

Although there was the option to request the surveys in an alternative format, all respondents completed the survey online. This indicates that all of the respondents not only have access to online technology, but also feel competent using it. We would recommend that the Hertfordshire and West Essex ICB looks to engage with those who do not have digital access to ensure their experiences and views are heard.

The survey asked questions about experiences of accessing GP services, barriers preventing people from using their GP practice, experiences of using online services, and how GP access could be improved.

The engagement period for this survey ran from 15th August to 17th October 2022. The survey was promoted via social media and shared with NHS and other statutory services and the voluntary, community, faith and social enterprise sector across Hertfordshire to share and distribute via their networks, contacts and social media channels.

Key Findings: Views and Experiences of Residents Living in the Borough of Broxbourne



Demographics and Context

In total 119 respondents shared their views and experiences with us[6]. 12% were aged between 18 and 34 years old, 33% were aged between 35 and 54 years old, and 39% were aged between 55 and 74 years old. 14% were aged over 75 years old.

71% of respondents were female and 25% were male. 79% were of a White British background and 14% were from of an ethnically diverse background[7].

17% of respondents identified as a carer, 11% considered themselves to have a disability and 30% considered themselves to have a long-term condition.

Respondents shared which GP practice they are registered with. The full list of GP practices can be found in the appendix.

It is important to note that we do acknowledge the significant challenges faced by GP practices and the findings highlight good practice as well as areas for potential improvement.

Making an Appointment

The majority of respondents had a recent experience of trying to make an appointment with their GP practice, with 91% having tried to get an appointment in the last six months.

75% of respondents tried to make an appointment with their GP practice by phone, with only 13% using online services and 8% visiting their GP practice in person.

For those who tried to make an appointment by phone, 26% said it was "easy" or "very easy" while 64% said it was either "difficult" or "very difficult". For most respondents, this was because the phone line was engaged or because they had to wait a long time to get through to a receptionist, with many waiting on hold for up to an hour.

"Consistently having to redial for 30 minutes which is generally the case whenever calling."

"I called at 8:00am dead on and was on hold for 40 minutes."

"Not even engaged, the phone does not even connect as the line is so busy."

"The phone is continually engaged. Takes at least an hour to get through to a receptionist."

[6] Percentages do not always add up to 100% due to some respondents choosing not to share demographic data with us.
[7] Ethnicities engaged with included: Black African, Gypsy, Roma or Traveller, White Irish, other White backgrounds and ethnicities not listed as options.

One respondent shared that they cannot visit their GP practice in person to try and get an appointment because they need to stay at home to care for their husband who has dementia. Their only option is to try contact by telephone, but they often cannot get through, which they find very distressing.

"They never answer the phone. You get as far as number 2 in the queue then it just rings and rings. If you go round there you are told to ring before 8:00am the next day. No point as the same problem occurs. I cannot go round there before 8:00am to try and get an appointment as I have a husband who is disabled and has dementia at home and I cannot leave him."

Another respondent said they cannot try and get an appointment by visiting their GP practice in person because of their disability. This means the respondent has to rely on trying to contact by telephone and they often cannot get through. This is frustrating for the respondent and they feel that appointments are being taken by those who are able to walk into the GP practice.

"The phone line is constant. You have to ensure that you call dead on 8:30am to even get a chance of getting through. Then when you get through often the appointments are already taken by people that have walked in the surgery that morning as they are allowed access earlier. I am disabled and I am unable to queue at the surgery to get an appointment and I should not have to."

Some respondents had waited on hold or in the telephone queue only to be told that there are no appointments available once they eventually got through to a receptionist. In some cases, respondents tried various routes to try and get an appointment with their GP practice, but were still unsuccessful.

"Spend hours on the phone from 8:00am hearing the same message but when you finally get through there are no appointments left. Told to try again at 11:30am when the same thing happens."

"Tried to phone at 8:30 and waited 30 minutes on the phone and was told all appointments were taken. Next day I went to the surgery and was again told all appointments were taken and informed there are 3 ways to get an appointment. By phone, internet or waiting outside from 8:30am. As I start work at 8:00am I could not do this. Then tried for 3 days on the trot to get and get an appointment. The phone system needs to come into this century. This is not acceptable by any means."

"Waiting on the phone is dreadfully long – I have to go in person to make an appointment (in some cases I'm still told there are none) or I'm on hold for between 30 to 45 minutes and then there are no appointments available."

For a large number of respondents, their only option is to call their GP practice should they want an appointment. Respondents said that they need a variety of routes, including the use of online services and visiting their GP practice in person. Having more than one route was particularly important to respondents with work or caring responsibilities.

"It took me over 30 minutes to get through. I had actually been to the surgery and was told I couldn't make an appointment in person and that the phone lines were busy. 30 minutes later (in which time I had walked home, got in the car and driven back to the surgery) I was still on hold. The surgery once again told me the phone lines weren't busy!"

"The race to get through with the rest of the population at 8:00am to try and get an appointment is terrible. Some of us work and are travelling at this time or if we are ill we might be asleep after a hard night. It feels like we are an inconvenience to the system."

"Told to book online but I wasn't able to. Also told that I can't make an appointment for my husband over the phone and that he has to make it himself. He works from six in the morning until three in the afternoon, he is a binman, so it's impossible to make calls as he has to hang on until they answer."

"Don't just make people phone at 8:00am to make an appointment. This is the only route offered to make any appointment."

However, respondents who tried to make an appointment with their GP practice through online services tended to have a more positive experience, with 60% receiving a response from their GP practice either on the same day or the next day.

Choice in Appointments

For the respondents who were given an appointment with their GP practice, 45% were not offered any choice when making the appointment.

Only 10% could choose the type of appointment they were given – whether this be a video call, phone call or face to face. Most respondents were frustrated that they could not choose to have a face to face appointment, particularly given the severity or nature of their symptoms.

"I wasn't offered a face to face appointment. I was told that I would receive a phone call. I felt that I needed to see a GP or prescribing nurse in person. This wasn't offered as an option. I was requested to send photos which I did not feel was adequate for the problem. I was then assessed based on photos which did not show the full extent of my issue. I was diagnosed using an inadequate photo."

"I had a post surgery infection and was offered to send photos and a phone call. I was then prescribed cream but ended up having to go in for an appointment at the GP a few days later and needed antibiotics because the infection was worse. Someone should have seen me the first time."

"You are only offered a telephone appointment and how can the doctor diagnose or see anything through a phone?"

"I was advised that a doctor would call me for a video appointment, but not given a time and I had a bad back so really needed to see someone."

One respondent shared how they have been diagnosed with a new medical condition without ever having a face to face appointment with a GP. Not receiving a face to face appointment made the respondent feel unsupported at a time when having reassurance was essential.

"It is unfortunate that the care provision now feels so remote. I have recently been diagnosed with a new medical condition without seeing a doctor in person. It would have been reassuring on so many fronts to have been offered an appointment in person to discuss matters in person rather than receiving a diagnosis over the phone, not least to give me confidence that the doctor actually had knowledge of who they are talking to beyond a name and medical history."

19% of respondents were able to choose the time or date of their appointment, and just 6% were able to choose which healthcare professional they could see. Respondents were disappointed that they were not offered greater choice when making an appointment with their GP practice, particularly those with a disability or a long-term condition.

"Although you might be offered a date for a telephone appointment, you never get a choice of time. Plus if you miss the call you have to start the whole process again! Everything is done for the benefit of the GP not the patient."

"Due to having specific conditions I like to see my GP as he knows about my case but it is very hard to get an appointment with him, and there is only one other doctor that understands my condition at the surgery."

"It's extremely difficult when seeking an appointment to see a doctor previously seen on the same matter."

Similarly, some respondents felt that they were not offered an appointment soon enough, with many having to wait several weeks for an appointment, whether this be face to face or a remote consultation.

"Appointment was too far in the future. Nearly a month wait for a heart issue."

"Had to wait at least two weeks for a face to face appointment."

"Unless an emergency it was three weeks until the next appointment."

"They told me I'd be looking at five weeks for the appointment."

However, 28% of respondents were not offered an appointment with their GP practice. For the majority, this was because there were no appointments available, even weeks in advance.

"The GP had asked me to make a follow up appointment specifically with them but there were no appointments despite me ringing at 8:04am."

"I needed an urgent appointment but none were available."

"No appointments available. Ring next day and the same story. Next day and the same story and repeat."

Positive Experiences

It is important to note that unsurprisingly, most respondents who completed the survey shared their negative experiences, and their desire for improved services. However, we did hear examples of good practice which included GP practices providing appointments when needed, offering support to respondents and reception staff and healthcare professionals listening and respecting their concerns.

"It is an excellent surgery and has worked hard to care for patients with annual reviews where appropriate. We know of practices that have failed to do this."

"It is an excellent practice. I have been with them for over 50 years and really can't fault them."

"The care given by the surgery is always good and once I do get to speak with a healthcare professional, I'm always happy with the care received."

"We have consistently enjoyed first class treatment at our surgery. It is a shining example to all."

Improving the Process

Overall 32% of respondents said trying to make an appointment with their GP practice was "good" or "very good" while 57% said their experience was "bad" or "very bad".

When respondents were asked how the process of making an appointment could be improved, a large number said that telephone systems need to be improved to enable easier access to their GP practice. Respondents also felt that they should be able to call for an appointment at numerous points during the day, and not just in the morning. This was particularly important to respondents who work or have caring responsibilities, to enable greater flexibility.

"Trying to call every morning until I can secure an appointment is disappointing to say the least. This current telephone system can't continue."

"You should be able to get an appointment after the surgery opens and not have to be one of the first callers."

"Not requiring people to call at random times which discriminates against shift workers."

"No one answers the phone unless you manage to get through when the lines open at 8:30am. This can't continue, the lines need to be better."

"It can be impossible to get through. It's also not unusual to be cut off and have to keep redialling which is very time-consuming and frustrating. The system needs an overhaul."

Similarly, most respondents would like access to a variety of options when trying to make an appointment with their GP practice, including the use of online services and visiting their GP practice in person. Respondents do not want to have to rely solely on the telephone as their only communication route, particularly when it is often unreliable or inaccessible.

"Being able to make appointments in person as well as over the phone."

"I work full time and before Covid-19 I was able to use online services which was very useful as I could choose an appointment from a selection offered."

"Put the appointments back online to book as per before Covid-19. Not calling everyday at 8:00am to see if they've got anything."

Respondents also felt that there needs to be more appointments available, including the ability to book an appointment in advance, particularly for routine and non-urgent matters.

"There should be more appointments available, the limited service offered at present is just not good enough."

"To be able to make future appointments for non-urgent appointments. It's frustrating that you can't book appointments in advance."

"Have dates further in the future available for routine checks."

"Have bookable appointments that are not for emergencies e.g. to discuss a possible diagnosis that doesn't need immediate attention."

A large number of respondents also said that they would like to be offered more choice when making an appointment with their GP practice – whether this be the type of appointment, the time or date of the appointment, or which healthcare professional they can see. At present, this choice is rarely offered to the majority of respondents which they find inadequate.

"I feel really sad that our GP services have become so inadequate recently. I do not understand why they limit appointments so much nowadays. I'm sure they will be missing important diagnoses."

"Option of face to face is needed. Having a telephone appointment before a face to face means having two appointments for the same issue. A waste of their time and mine."

"I would like to see a GP in person more, so a choice of the type of appointment would be good."

"More consideration given by the appointment system regarding times or days that are more suitable. My child is disabled so we need more consideration when offered an appointment bit we don't get that."

Significantly, a large number of respondents felt that the process of making an appointment with their GP practice could be improved if reception staff and/or healthcare professionals were more understanding, empathetic and did not dismiss their health concerns. These attitudes from staff has made some respondents fell undervalued and in some cases, reluctant to make contact in fear of being poorly treated.

"Less gatekeeping, less dismissive attitudes. The attitude currently seems to be that a person is lying and should not get any appointments. Being believed and for staff to realise that calling a doctor is a final option is needed."

"It has been very challenging for everyone, as a 71 year old I am reluctant to try and make an appointment now, feeling less valued as a patient because the GPs are so busy."

"Staff are rude and unhelpful. In the end I gave up and went to Harlow hospital, the staff there were friendly, lovely and helpful."

"It would also help if members of staff on reception duty were less rude to patients. We go to the GP if we are unwell and need help and advice. I don't attend the GP practice to be treated and spoken to in a rude and off-handed manner."

Respondents also recognised that GP services need long-term, systemic change if improvements are to be made, including the recruitment and retention of more healthcare professionals and reception staff.

"More people manning the phone lines if this is now the only way of accessing your GP."

"More GPs and staff available to get an appointment earlier and easier."

"More staff to answer the phones. More doctors."

However, some respondents had a positive experience when making an appointment with their GP practice. These respondents shared that they received a timely response from their GP practice, were listened to and treated with respect, and given the support they needed.

"No problems at all. I had an emergency situation and was seen within an hour of phoning."

"I needed advice about a mark on my skin, I sent photos to the GP and she has put me on the waiting list for minor operations at the surgery."

"It can take awhile to get through but we have always been given appointment when it is necessary."

"The receptionists at my surgery have always been very polite and helpful."

Avoiding GP Services

64% of respondents have avoided contacting their GP practice in the last 12 months. For the majority of respondents, this is because they have found it too difficult to get through to their GP practice.

"It's proving far too time-consuming to contact the surgery, so unless it is an emergency, I tend to resign myself to muddling through."

"I knew it would be a chore trying to get through to the GP practice."

"It's just too much hassle trying to get an appointment."

"I have been trying to go to the doctors for months but knowing that I could never get through has put me off."

One respondent shared that their father was very unwell and they both needed the support of their GP practice during this time. Despite their father being elderly and severely unwell, the respondent struggled to get any care from their GP practice and their father has now sadly died.

"When my father was alive he needed assistance quite a bit and I found that the GP practice was not interested in what was happening to him (he was 97 years of age). It was very difficult trying to get an appointment for someone who had issues and needed to see them urgently. It puts a lot of strain on the carers of that person as well. My father has since passed but before he died the last 10 months were very difficult with the surgery. I've avoided them since."

Specifically, a large number of respondents said that they have been reluctant to contact their GP practice because it is too difficult to access via telephone. Respondents were frustrated with phone lines either being engaged, or having to wait in the telephone queue or on hold to speak to a receptionist.

"I work 9-5 and cannot be on hold for an hour from 8:00am as I need to travel to work. Not everyone who needs to see the GP is sitting at home."

"I've stopped trying after previous ringing and getting a recorded message telling me I was number 48 in the queue to get through."

"I don't contact anymore as I can never get through to the surgery even when I call at 8:00am."

One respondent shared that they are hesitant to contact their GP practice after struggling to get through by telephone. The respondent would now rather cope with the pain they are in than try and contact the GP practice for appointment, even though they know they need to seek support.

"It was too difficult to make contact with them. They were always busy when calling or you were number 20 something in the queue. When you are very unwell and struggling the last thing you are able to do is hang on the phone for that length of time to be told that all appointments have gone. It's been a case of grin and bare it at times when I have been bed bound in severe pain that I cannot move."

Other respondents have avoided accessing their GP practice because they assume no appointments will be available, largely because this is what tends to happen each time they make contact.

"I knew that I wouldn't get an appointment. I tried when I got a hernia. I had a doctor call me around 7 hours after who said it's not something we deal with anymore and to call back if it gets worse."

"I knew I wouldn't get an appointment and would be told to call the next day."

"I knew I would be unsuccessful in getting an appointment."

Similarly, other respondents have not accessed their GP practice because they assume that they will not be offered any choice even if they are given an appointment. As emphasised previously, being able to choose the type of appointment was a priority for our respondents in particular, with some not accepting an appointment unless it is face to face.

"You're often not offered a face to face appointment so what's the point?"

"It's difficult getting an appointment at a suitable date or time."

"Seems pointless to contact – they only offer telephone consultations even if your symptoms obviously need to be looked at in person."

Having a choice if time or date, or receiving an appointment within a short timeframe, was also important to respondents. One respondent shared how despite the hospital advising that they need an urgent appointment with the GP, the earliest appointment they could get was in three weeks time.

"I had to wait three weeks for an appointment and was denied an emergency appointment when needed. I had been discharged from hospital with instructions to see my GP immediately. I was told despite the hospital instructions and taking painkillers around the clock that I did not qualify for an emergency appointment. I therefore had to wait three weeks for an appointment and continued being in pain, taking painkillers throughout the day. As a result I have chosen not to contact the surgery at times despite feeling that it would be in my best interest."

In contrast, some respondents said they are reluctant to access their GP practice because they are concerned about the current burden on the NHS, and feared that by making contact with their GP practice, they would only be exacerbating the pressures facing GP services. This was despite some respondents needing support for their condition and/or symptoms.

"The NHS is so busy and I wasn't sure my complaint was important enough."

"I'm very aware of the pressure on the NHS especially on GP surgeries."

"GPs were under so much pressure I didn't feel able to put upon them at this time."

"I have some minor problems, not life threatening but uncomfortable that I can manage most of the time but need advice and information if there are better alternatives. The media claims doctors are overworked and I think that others probably have more urgent needs than me."

Other respondents shared how they have been hesitant to contact their GP practice after receiving poor treatment from reception staff and/or healthcare professionals.

"They are belittling and rude. You are made to feel awful for being a problem and frankly it is terrifying to have to make an appointment. They have ageist and ableist attitudes that treat anyone needing healthcare as inadequate."

"I was so annoyed with the surgery's attitude. I can't be bothered anymore. I'm scared to get told off!"

"The staff are unhelpful and rude which I find upsetting when you are not well."

"It is hard work and a negative experience speaking to the receptionists."

"The doctor didn't care about my symptoms or conditions when I spoke to them on the phone. I was clearly distressed and they just didn't care."

As a result, 55% of respondents looked for information and advice from elsewhere instead of contacting their GP practice. The most common examples including contacting NHS 111, visiting an Urgent Care Centre or A&E to get the care and support they felt they needed. Respondents also felt that making contact via these routes and services would be more accessible than getting through to their GP practice.

"I have to call 111 because there are never any appointments."

"I felt I was more likely to get practical support by calling 111."

"If needs be I'll go to A&E it will take hours but at least I will be seen."

"Visited Urgent Care Centre in fear of not getting an appointment the next day or not getting through."

Encouraging Access to GP Services

When respondents were asked what would encourage them to contact their GP practice, some said they would be more inclined to access their GP practice if they could use online services to make an appointment, or if telephone systems were improved.

"Booking online for a routine appointment. Some people have jobs and cannot leave work on a whim."

"If I could book appointments online, that would be a lot easier."

"The phone not being constantly engaged would be a start."

Similarly, other respondents said they would be more likely to contact their GP practice if there were more appointments available, and if appointments could be booked in advance, especially if they are for routine checks and non-urgent issues.

"More easily available appointments! Before Covid-19 there were far more appointments. Now there aren't any!"

"Knowing that you could get an appointment to see a doctor or nurse within a week if non-urgent."

"Knowing I would get through and that I would be able to book an appointment for an appropriate time, be this on the day itself or some time in the future."

As emphasised previously, respondents would also be more inclined to access their GP practice if they could have more choice when making an appointment. Respondents shared that they need more choice not only in the type of appointment offered, but also in the time or date, and which healthcare professional they can see.

"If I could choose to see my usual doctor who knows about my conditions and health matters."

"I'd contact if I could have a bit more flexibility when picking the time or date. I have work, caring commitments, a lot going on. Some consideration would be nice."

"To have some degree of certainty that you could see a doctor or other healthcare professional."

"Knowing that I could see someone in person when needed and required, rather than a video call or sending pictures."

However, other respondents said they would access their GP practice if they knew reception staff and healthcare professionals would treat them with greater empathy and respect. Being able to approach and speak to receptionists in particular was important to respondents, as their attitudes and lack of consideration is often what makes individuals reluctant to get in contact.

"Staff that are more approachable. It seems to me that the reception staff diagnose you without any training whatsoever and I have a number of underlying health conditions which get ignored."

"If the receptionists were more understanding and less hostile!"

"It would help if receptionists were all friendly and had empathy as it is very rare to get one that has. There are a couple of them at the surgery and you just keep your fingers crossed that it is one of them answering the phone as otherwise its even more stressful."

"I'd contact if I felt I wasn't wasting their time by calling."

Using Online Services

29% of respondents are not registered with online services. For the majority, this is because they either did not know their GP practice offered online services, or because they had never been offered the opportunity to register. For a small number of respondents, this is because they either do not have access to online technology or do not feel confident using it. Despite these barriers, 53% of respondents said they would register with online services if given the opportunity and/or support to do so.

In comparison, 66% of respondents are registered with online services. In the last 12 months, most respondents have used online services to order repeat prescriptions, while a small number have used online services to either book an appointment, access their medical records, or to have a remote consultation.

Benefits of using Online Services

When respondents were asked what the benefits are of using online services, some noted that online services are more accessible and easier to use than contacting via telephone or visiting the GP practice in person. Respondents also felt that they often received a quicker, more timely response from their GP practice when using online services.

"Prevents having to spend a lot of time waiting for a telephone call to be answered."

"I have a hearing problem so going online is easier than phoning."

"I get a quicker service and a quicker response when I go online."

"I have used the email service to ask questions. They were listed as non-emergency appointments but I had a reply the same day."

A large number of respondents said the greatest benefit of online services was the ability to access their medical records, order repeat prescriptions, and look at or submit test results. Respondents find these functions useful, primarily because it means they do not have to call their GP practice to request any of the following.

"You don't have to wait a million years and hold the line trying to get through to someone to order medication."

"I like being able to order my medications every month online which is really nice and simple."

Other respondents felt that online services were beneficial in not only saving their own time, but the time and capacity of healthcare professionals as well.

"Online services saves their time and mine."

"I can look at test results any time and I can submit blood pressure readings every 6 months which is quick and efficient."

"I can access my medical records and order medication any time without having to sit on the phone for 20-30 minutes."

"It allows the staff to respond to requests in their own time and in theory should reduce the burden of telephone enquiries."

"Less stress for both patients and staff as their system will store messages like requests for repeat prescriptions."

Improving Online Services

When asked how online services could be improved, a large number of respondents said that they should be able to use online services to book appointments. Some noted that this function was previously available, but since the Covid-19 pandemic, it has been disabled.

"Let us be able to book our own appointments online again."

"Reinstate the full service so that appointments can actually be booked."

"It would be good if we could actually book appointments."

Similarly, a number of respondents felt that all of the functions in online services should be enabled to patients, including access to test results, medical records and prescriptions.

"Please allow more services. Used to be able to make appointments, view appointments, but this has stopped working. I would like to see my record too but I'm told this is not possible."

"Allow me to view my medical records and test results as I've been informed this is not possible."

"Provide access to medical records, increase provision of online appointment bookings, keep current prescription online records up to do so that repeat prescriptions can be ordered online rather than necessitating a trip to the surgery to hand in a paper request."

"I am not able to access my medical records (but would do if allowed) and most of the time there are no doctors appointments available to book online. My records also fail to show my current medication so I can't order repeat prescriptions online either."

Other respondents said that online forms, such as eConsult, are not comprehensive and are too prescriptive. As a result, the forms do not allow patients to provide enough information about

their symptoms and/or condition, either preventing patients from getting the support they need, or incorrectly signposting patients to A&E when this is not necessary.

"I've tried to book an appointment and every time I was directed to attend A&E which was not necessary. The only way I could actually get an appointment was if I reduced the intensity of my symptoms in the form to prevent it from automatically advising me to go to A&E which meant that I was not actually able to provide accurate information about my issue."

"Allow a 'ask a general question to your GP' as an option. Add a 'not sure' option to the list of symptoms – none of those matched the condition I wanted help with and in the end I had to pick one just in order to complete the request."

"Try and make forms more simple to understand, easier to navigate and less prescriptive in what it allows you to do."

Although some respondents felt that they received a quick response when using online services, others said that when they use online services, they do not tend to hear from back their GP practice until a few days later.

"We have consistently enjoyed first class treatment at our surgery. It is a shining example to all."

"No benefit if you do succeed in being able to complete a lengthy form as you have to wait at least 24 hours for a call back."

"No one gets back to you for 48-72 hours so if it is something that needs dealing with that day, it's no help at all."

"Two days for a reply is not good enough."

Summary

Our engagement resonates with local and national evidence, highlighting that residents registered with a GP practice in the Borough of Broxbourne tend to find it very difficult to access their GP practice – whether this be for an appointment, general support or other requests such as prescriptions and test results. The majority of respondents noted having a negative experience when trying to access their GP and in turn, this has impacted their confidence in their GP practice to give them the support they need.

This is supported by how almost two thirds of respondents have avoided accessing their GP practice in the last 12 months, even if they are in significant pain or discomfort. Again, this is primarily because respondents find it too difficult to get in contact with their GP practice and assume that no appointments or support will be made available to them, despite their condition or the severity of their symptoms.

In terms of what would improve their experience, the most common answer was to enable additional access routes for getting through to their GP practice, including the use of online services and visiting the GP practice in person. Other examples included improving telephone systems, providing more appointments, offering more choice, and better quality of care from both reception staff and healthcare professionals.

Respondents tended to use online services, however many noted that the functions are limited or inaccessible, preventing respondents from using online services to either book an appointment, access medical records and test results or make simple requests such as a repeat prescription.

Despite the concerning findings raised in this report, it is almost important to note that some respondents have had very positive experiences and praised the continued support their GP practice has provided. Best practice and learning from these particular GP practices should be shared with others not only in this district, but across the county.

Recommendations

Based on the findings outlined in this report, it is recommended that the Hertfordshire and West Essex ICB Primary Care Workstream should encourage GP practices to take forward the following recommendations. The ICB is providing significant support to enable GP practices to improve access and further investment of this will help address some of the challenges.

Improving access to GP services would instil greater confidence in patients. This could achieved through:

1. Enabling a variety of access routes, including the use of online services and visiting the GP practice in person, to accompany all needs and preferences.

2. Continuing to improve telephone systems to reduce delays and waiting times for patients.

3. Greater flexibility in contact hours and opening times to account for school hours, work, and caring responsibilities.

Making appointments more readily available is important, particularly for children and young people and vulnerable groups. This could include:

4. Appointments that are bookable in advance, especially if the concern is either routine or non-urgent.

5. Reviewing and addressing waiting times for appointments, with particular consideration given to:
    - Children and young people
    - Those with a disability, complex needs, or a long-term condition
    - Those with ill mental health

Providing greater choice when offering appointments would improve the quality of care received. This could include:

6. Being mindful of work and caring responsibilities, as well as school hours, when offering appointments.

7. Providing more choice when offering appointments to patients, with a particular focus on offering more face to face appointments where possible. Specific consideration and greater choice should be given to:
    - Children and young people
    - Those with a disability, complex needs, or a long-term condition
    - Those with ill mental health

8. The ICB working with Primary Care Networks and GP practices to identify ways of ensuring there is greater choice for patients.

Providing high quality of care would ensure all patients feel respected and heard. This could include:

9. Listening to and respecting the concerns of all patients, particularly parents and carers, to prevent misdiagnosis and/or mistreatment.

10. Providing thorough assessments and high quality care to all patients, at all times.

11. Healthcare professionals and reception staff treating all patients with respect. This should be monitored to ensure staff are not dismissing concerns, or judging patients for making contact. Reminders and refresher training should also be considered.

12. Delivering Customer Care training for GP receptionists to improve their customer service and communication skills.

GP practices should offer greater information and support, particularly in regards to the use of online services

13. Continuing to encourage patients, particularly parents and carers and vulnerable groups, to contact their GP practice if they have concerns about their health.

14. Enabling online access for patients if this function is not already available.

15. Continuing to increase awareness amongst patients on how they can access online services and encourage or support them to register. The ICB should encourage GP practices to work with other healthcare professionals, Hertfordshire County Council and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector to raise the profile and benefits of using online services.

16. Enabling all patients full access to the functions available via online services, including:
    - Booking appointments
    - Test results
    - Prescriptions
    - Medical records

17. By 1st November 2022 all GP practices should have updated their organisation settings for online services in order to be able to provide record access to patients – whether this be

via the NHS App, TPP or EMIS systems[8]. The ICB should look to review and monitor whether improvements have been made.

[8] GP Online Services clinical system configuration: Immediate action required - NHS Digital

Appendix

Named GP Practices: Residents living in the Borough of Broxbourne Survey[9]

GP Practice	Number of Respondents
Park Lane Surgery	18
Amwell Surgery	17
Warden Lodge Medical Practice	16
The Maples Health Centre	11
Valley View Health Centre	10
Hailey View Surgery	7
Stockwell Lodge Medical Centre	6
The Limes Surgery	6
Cuffley and Goffs Oak Medical Practice	6
Wormley Medical Centre	4
Cromwell Medical Centre	4
Abbey Road Surgery	4
Stanhope Surgery	2
The High Street Surgery	2

[9] Please note that the total does not equal to the total number of respondents due to some respondents choosing not to share the name of the GP practice they are registered with.

healthwatch Hertfordshire

Accessing GP Services: Views from Hertfordshire's Parents and Carers

Engagement: August – October 2022

Published: (xxx)

Contents

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 (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 representations 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 GP services.

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, 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 August to November 2022 the Director of Primary Care Transformation at the ICB has requested Healthwatch Hertfordshire and Healthwatch Essex to explore access to GP services with a specific focus on engaging with:

- Parents, carers and children and young people
- Residents living in the Borough of Broxbourne (and Harlow and Uttlesford for West Essex)

Reasons for exploring access to GP services, as well as parents, carers and children and young people are outlined below.

Please note a separate report has been published which outlines the findings from our engagement with residents living in the Borough of Broxbourne. This report can be found on our website.

Background

National Context

Before the Covid-19 pandemic, GP practices across the county were facing significant and growing strain, with increasing staff shortages and workloads, rising patient demand and struggles recruiting and retaining staff. This started to have a negative impact, with patients finding it increasingly difficult to access their GP practice – whether this be for an appointment, information and advice, or general support. Patients were also seeing a reduction in choice when making an appointment, with many not able to choose the location, time or date of their

appointment, the type of appointment they received, and changes to which healthcare professional they could see or speak to.

The Covid-19 pandemic only worsened these existing pressures and even now as we learn to live with Covid-19, GP practices are still facing increased workloads and higher consultation rates than ever before. As a result, patients are struggling even more to access their GP practice or to get an appointment, and patient choice is further restricted.

The pandemic also necessitated new ways of working, including a rapid uptake of digital technology and services to deliver care, for example through the use of remote consultations and online booking systems. Although this has provided a number of benefits, patients had concerns that face to face appointments in particular would be replaced with online or remote alternatives.

This decline in patient satisfaction with GP services is reflected in the results of the national GP Patient Survey (2022)[4] which highlights a significant decrease in the number of people stating that they had a good experience when accessing GP services, with many noting a lack of choice, availability in appointments, and increased difficulty getting through to their GP practice. Particularly concerning is the rise in the number of people who are avoiding accessing their GP practice despite needing care. This could have a significant impact on people's long-term health and could lead to an increase in demand elsewhere in the NHS, such as in A&E, evidence of which we can already see.

The following is reflected within the recent Fuller Stocktake report published in May 2022, which also outlines the opportunities Integrated Care Systems have for integrating primary care and improving the access, experiences and outcomes for communities[5].

Local Context

Parents, Carers and Children and Young People

Although we are aware of the problems adults tend to face when accessing their GP practice for themselves, we often do not hear about their experiences when trying to get support from the GP practice for their child or the young person they care for.

It is important to hear the lived experience of parents and carers and whether they can access the GP practice with ease and confidence for their child or the young person they care for. This is particularly important as children cannot always communicate their symptoms or health needs. The need of a clinical examination in these cases is particularly important for avoiding and preventing ill health in children and young people.

[4] GP Patient Survey 2022 results - GOV.UK (www.gov.uk)
[5] Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)

Both nationally and locally, stakeholders often do not hear from children and young people about their experiences of accessing their GP practice and whether their experiences differ from those of adults. With many children and young people able to call, visit or use online s GP services without needing consent, it is important to understand what support is needed to ensure this process is as accessible as possible.

Aims

The aims of this engagement project included:

- Identifying the barriers parents, carers and children and young people encounter when accessing GP services
- Understanding the challenges parents, carers and children and young people face when making an appointment with their GP practice
- Exploring the factors preventing parents, carers and children and young people, despite needing care, from accessing GP services
- Understanding how the use of technology is being used by parents, carers and children and young people and whether this is hindering or supporting access to GP services
- Making recommendations to the Hertfordshire and West Essex ICS Primary Care Workstream with the aim of ensuring greater ease and confidence when accessing GP services

Methodology

To explore the above aims, Healthwatch Hertfordshire created two online surveys. One survey was for parents and carers who have a child or care for someone under the age of 18, and the other was at aimed children and young people aged between 13 and 18 years old. Participants had the option to request the survey in an alternative format and/or contact us for support.

Although there was the option to request the surveys in an alternative format, all respondents completed the survey online. This indicates that all of the respondents not only have access to online technology, but also feel competent using it. We would recommend that the ICB looks to engage with those who do not have digital access to ensure their experiences and views are heard.

This age bracket was chosen as children and young people within this age range are more inclined to contact their GP practice independently without needing consent. From the age of 13, children and young people are also able to consent and participate in research without requiring supervision.

The engagement period for both surveys ran from 15th August to 17th October 2022. The surveys were promoted via social media and shared with the NHS and other statutory services and the , voluntary, community, faith and social enterprise sector across Hertfordshire to share and distribute via their networks, contacts and social media channels.

Key findings: Views and Experiences of Parents, Carers and Children and Young People

Demographics and Context

In total 231 parents and carers shared their views and experiences with us[6]. 70% were aged between 25 and 44 years old and 29% were aged between 45 and 64 years old. One respondent was aged over 65. 93% of respondents were female and 5% were male.

Over a quarter (28%) of respondents were from ethnically diverse communities, with 70% of a White British background[7].

33% of respondents identified as a carer, 6% considered themselves to have a disability and 9% considered themselves to have a long-term condition.

Parents and carers shared which GP practice their child or the young person they care for is registered with. The full list of GP practices can be found in the appendix.

It is important to note that we acknowledge the significant challenges faced by GP practices and the findings highlight good practice as well as areas for potential improvement.

Making an Appointment

The majority of parents and carers had a recent experience of trying to get an appointment with the GP practice for their child or the young person they care for, with 79% having tried to do so in the last six months.

Before trying to make an appointment for their child or the young person they care for, 49% looked for information and advice elsewhere. Common routes included searching for information online, the NHS website, NHS 111 and the local pharmacy.

When trying to make an appointment for their child or the young person they care for, 83% called the GP practice, with only 10% using online services and 4% visiting the GP practice in person. Most parents and carers had problems when trying to make an appointment, particularly those who had tried to contact by telephone, with many respondents having to wait in the telephone queue or on hold for over an hour before speaking to a receptionist.

"Took about 2 hours waiting on hold to get through."

"Had to dial 48 times before getting through to the long winded message saying to call back another time because they are experiencing high volumes of calls (this message is always on). Eventually I got through where I had to wait even longer before talking to a receptionist."

[6] Percentages do not always add up to 100% due to some respondents choosing not to share demographic data with us.
[7] Ethnicities included: Indian, Pakistani, Chinese, Bangladeshi, Arab, Asian and White, Black African, Black Caribbean, Black Caribbean and White, White Irish, other White backgrounds, and ethnicities not listed as options.

"I had a one and a half hour wait in the queue on the phone."

"It's crazy you either can't get through at all and when you do wait for anything it's at least 30 minutes. Last time it took 27 calls to get through in the morning."

Some respondents found it difficult to contact the GP practice due to their own work or caring responsibilities preventing them from being able to call for an appointment at the typical morning slot. Parents and carers also shared that it can be hard to get an appointment for their child or the young person they care for due to opening times for appointments being during school hours.

"I phoned at exactly 8:30am and was on hold for 45 minutes before being told that all appointments had been allocated for the day and that I would need to call back the following day. I work in a school and had to take 45 minutes off to call without success."

"I have to arrange care for my son so I can be at the surgery for 8:00am to queue for an appointment for him. It's easier than phoning from 8:00am as it usually takes forever to get through and then they have no appointments left for that day."

"Telephone waiting times are ludicrous. As the main carer I haven't got time for this."

"There is no appreciation of the difficulty of phoning at 8:30am when parents are either at work or on the school run."

Other parents and carers tried to contact the GP practice for an appointment but were immediately told that no appointments were available for their child or the young person they care for, even if the parent or carer was looking to book an appointment weeks in advance.

"I can never get through to my surgery and when I do they always say there are no appointments even though I've called first thing in the morning. They always tell me they have 80,000 patients and it's luck."

"No appointments available that day as lack of doctors on site. No way of booking an appointment in advance either."

"Recorded message said there were no appointments that day. I called when the appointment line first opened."

As a result, some parents and carers felt they had no choice but to contact NHS 111 or to take their child or the young person they care for to A&E to receive medical attention.

"It's almost impossible to get a GP appointment. I have repeatedly had to take my son to A&E as there is no viable option. It's appalling."

"On one occasion I couldn't get an appointment so we ended up at A&E."

"Couldn't get through. Tried for 3-4 days and ended up going through 111."

However, other parents and carers had a positive experience when trying to make an appointment for their child or the young person they care for. This was often because they had used an online booking system such as eConsult and received a timely response. A few respondents noted that the GP practice had improved its telephone system meaning it was now much easier to get through to a receptionist.

"There was always a long queue on hold but this has now changed with the installation of a new phone system."

"The new call back service is helpful as you don't have to wait on hold in the queue."

"For my 2 year old I am able to use their online consult system and that works very well."

Choice in Appointments

For the parents and carers who were given an appointment for their child or the young person they care for by the GP practice, 51% were not offered any choice when making the appointment.

Type of Appointment

Only 16% of parents and carers could choose the type of appointment their child or the young person they care for was given – whether this be a phone call, video call or face to face. A large number of parents and carers felt their child or the young person they care for needed a face to face appointment because of their age and/or the symptoms they were displaying. Despite raising their concerns, their request was denied and a telephone appointment was given instead which parents and carers felt was inappropriate and unacceptable.

"My daughter had a rash. We were asked to upload images and a phone appointment was made in which the doctor said it's hard to tell from a photo. Waste of everyone's time and this is a 4 year old!"

"The issue was one with his stomach and we were offered a telephone appointment which meant no one could actually feel or see his stomach and ascertain why he was in pain."

"I had to do a phone call first even though they couldn't listen to his lungs over the phone!"

"I wasn't given a choice. Just told a doctor would call me back for an assessment. As I was calling about a rash and temperature on my child I didn't feel a telephone appointment would be helpful."

One parent shared that they contacted their GP practice because their baby was having breathing difficulties. However, they were only given a telephone appointment in which the GP simply advised them to keep their baby in the same room. The parent was very upset with this response and felt unsupported by their GP practice.

"My son was denied face to face when he presented with breathing issues, despite having history of breathing issues due to being premature which was mentioned to the GP. The GP would only discuss over the phone and prescribed an inhaler and advised that I put him in a pram and in the room with me whilst I had a shower."

Having the option to choose a face to face appointment rather than a remote or online consultation was particularly important to parents and carers caring for a child or young person with complex needs.

One parent was not offered a home visit by the GP practice even though their child is on a ventilator and was showing clear signs of deterioration.

"He is currently on a ventilator fighting for his life and no doctor felt it was serious enough to be seen."

Another parent whose child has complex needs was also not given a face to face appointment, despite explaining that their child is non-verbal and cannot communicate their symptoms or health needs.

"My son is autistic, non-verbal and has cerebral palsy. Despite me giving this information to the receptionist and the doctor I was only given a video call. This isn't acceptable for a child who cannot communicate what he is feeling or what is wrong. Absolutely disgusting service from my GP. It's not the first time this has happened with my son either."

In some cases, not receiving a face to face appointment led to the child or the young person being misdiagnosed and/or receiving inappropriate treatment for their condition or symptoms. A few parents even had to take their child or the young person they care for to A&E in order to get the care and support they needed. Parents and carers noted that this could have been avoided if their concerns were listened to and if a face to face appointment was initially offered.

"My child needed a face to face meeting but weekend telephone appointments with locums were the only option and this delayed diagnosis by several months."

"We were only offered a telephone appointment despite my request for a face to face. My child was therefore not examined thoroughly and ultimately ended up requiring emergency treatment in A&E due to lack of intervention by the GP."

"I was given a phone call where I was simply told he had a 'virus' and he'd be fine. Gut instinct and previous experience told me he definitely has a chest infection. I had to fight to convince the GP to see my child face to face. Shock horror he has a severe chest infection and needed antibiotics. It seems phone appointments are the default option at the surgery now and only after that can you possibly get a face to face."

"Last 3 appointments were via call to get antibiotics for his chest infection. Although I am experienced I am not qualified to make a diagnosis. We ended up in A&E which could have been avoided."

Choice of Healthcare Professional

Just 5% of parents and carers were able to choose which healthcare professional their child or the young person they care for could see. For some, seeing the same healthcare professional and receiving continuity of care was vital for ensuring their child or the young person they care for felt comfortable and did not have to repeat their story. This was particularly important to parents and carers caring for a child or young person with a learning disability or complex needs.

"My daughter has a learning disability so it is really important that she sees the same doctor who she trusts."

"I could not have a face to face and not given the opportunity to see her own GP who knows her complexities."

"My child has complex needs so we needed to see his allocated GP."

Choice of Time and Date

23% of parents and carers could choose the time or date of the appointment offered to their child or the young person they care for. For some parents and carers, having this choice was essential due to their own work or caring responsibilities, or for meeting the needs of their child or the young person they care for.

"You pretty much have to accept the appointment you're offered. Despite telling them I'm a carer and he's disabled it never seems to be taken into account. It's what appointment they have or nothing."

"Telephone appointments at any time in the morning or afternoon are not helpful for people trying to work, especially when it immediately needs a face to face appointment which was obvious from the beginning."

Similarly, some parents and carers were told that their child or the young person they care for would have to wait up to five weeks for an appointment. Parents and carers were frustrated with this delay and felt their child or the young person they care for needed an appointment much sooner than what was offered.

"Three weeks waiting time for an appointment for a child is too long."

"I could only get a phone call or wait five weeks for a face to face appointment for her."

One parent even made the decision to access a private GP to get an appointment for their child after struggling to get an appointment with their own GP practice within a reasonable timeframe.

"I was extremely dissatisfied. I had to wait a day to be triaged and then waited for at least another week to get an appointment. This was one of a few examples where my children did not get a proper NHS service. We had to go private as a result."

Lack of Appointments

13% of parents and carers were not offered an appointment for their child or the young person they care for when they contacted the GP practice. For most respondents, they were not given an appointment simply because there were none available, even if they were looking to book in advance.

"My daughter needed a routine check up for her condition. I was looking for a couple of weeks time and even then I was told there were none."

"Couldn't get an appointment and I was on hold for nearly an hour to then be told there are no appointments available."

However, some respondents were denied an appointment or signposted elsewhere by the GP practice. This was despite the parent or carer telling the GP practice that their child or the young person they care for was displaying symptoms which they felt required medical attention.

"No appointments available and no way to talk to anyone."

"They told me to take him out of hours as they were busy."

"Even though it is on his medical records from the hospital that he has to be seen by a doctor straight away, they would not see him."

"They refused to see my son when he had an allergic reaction and came up in hives and had diarrhoea."

Timely Response and Support

Unsurprisingly, most parents and carers shared negative experiences and their desire for improved services. However, it is important to acknowledge that some parents and carers praised the support they and their child or the young person they care for received from their GP practice.

"I have never had a problem getting my child an appointment. My doctor is amazing and so helpful. The team of people that work there are so helpful, kind and always there to help. I've never experienced any problems. Best surgery I've ever had."

"I think the GP surgery is great and I never have any issues with them or getting support from them for my child."

"The GP practice is excellent and holistically supportive of our daughter's care – I cannot fault them."

Specific examples included parents and carers receiving a face to face appointment for their child or the young person they care for, in addition to, or instead of, an online or remote consultation. This was important to parents and carers as it meant they felt listened to by healthcare professionals, and that their concerns about their child or the young person they care for were being respected and valued.

"Always an excellent service. We needed a face to face appointment which we got on the same day."

"They took my concerns seriously. Seen face to face and my child was thoroughly assessed."

"My surgery is doing a superb job, always get an appointment and always get through on the phone quickly."

"Had an initial same day consultation and then my child was invited in to be seen by the same doctor an hour later."

Some respondents shared that they often receive a timely response from the GP practice and given support for their child or the young person they care for within a quick timeframe.

"I wasn't offered a choice of time, date location etc but that didn't matter as it was so quick and the appointment given for my child was suitable."

"The surgery has always been easy to get hold of and very responsive. Especially for my young child."

"Sent a photo of my granddaughter's aliment. Then the GP rang back with a diagnosis and prescribed medication."

Improving the Process

Access and Communication Routes

39% of parents and carers said their experience of making an appointment for their child or the young person they care for was either "good" or "very good" while 41% said it was "bad" or "very bad."

When respondents were asked how the process of making an appointment could be improved, many parents and carers felt having access to an online booking system would be beneficial as it would be more accessible and provide another option for making an appointment, rather than having to rely on the telephone.

"I should be able to book online for an in person appointment. We have to call – we cannot go into the practice or book online."

"I would love to have an online booking system where you can choose an appointment."

Likewise, the majority of parents and carers felt it would be easier to make an appointment for their child or the young person they care for if telephone systems were improved and if waiting times on hold or in the telephone queue were significantly reduced.

"The phone system takes quite awhile to get through and becomes a little frustrating when trying to comfort a child with additional needs."

"Do something about the long queues for appointments in the morning – by the time you get through all the appointments are gone."

"Less queue times so you can get through to a receptionist quicker. I have had to ring 111 in the past as I just couldn't get through."

More Choice

A large number of parents and carers emphasised that they should be offered more choice when making an appointment for their child or the young person they care for. Access to face to face appointments was a priority for most parents and carers, especially as children and young people are not always able to communicate their symptoms and health needs. Being able to choose the time and dare of the appointment, as well which healthcare professional they could

see was also particularly important to first time parents, and parents and carers who care for a child or young person with a disability, complex needs or a long-term condition.

"The phone appointments are useless as I personally think it's impossible to diagnose a child who can't tell you what's wrong over the phone without physically seeing them."

"I would have hoped by now for medically complex children like mine or any child that a parent is concerned about should be offered a face to face appointment."

"If a parent wants a face to face appointment they should be able to get one, especially for a child that cannot speak yet. We are first time parents and I am not a healthcare professional. My son is on an inhaler (blue and brown) and we are constantly told it's just a phase!"

"Covid-19 has impacted GPs but I do feel that children who are vulnerable/unable to articulate what is wrong/go downhill fast should have been prioritised for face to face."

"Children with diagnosed physical conditions or who are completely non-verbal should be seen face to face without parents having to fight for it."

Being able to see the same healthcare professional, or receiving an appointment within a short timeframe, was essential for parents and carers whose child or the young person they care for has ill mental health. In some cases, parents and carers had to access private therapy to get the mental health support their child or the young person they care for needed, as they could not get an appointment with their GP practice soon enough.

"I was very unsatisfied. We couldn't get an appointment for up to six weeks. We are fortunate that we could access private medical and psychological care. Most parents are not in this position and would be left to feel unsupported in trying to help their child through a mental health crisis."

"It worked great when my 6 year old had tonsillitis. We were seen the same day and collected the medicine straight away. When my 13 year old had mental health problems I was offered an appointment five weeks away. We have now gone private for the help we need."

"They insisted on a phone appointment even though I explained that it was difficult for a 15 year old to talk about a sensitive issue over the phone. A phone appointment was not suitable for a mental health related complaint and was too far away."

More Appointments and Priority for Children

Parents and carers felt that more appointments need to be made available for children and young people, as well as the ability to book routine and non-urgent appointments in advance and with greater ease. Respondents also noted that GP practices should be more mindful of work and caring responsibilities when speaking to and arranging appointments with parents and carers on behalf of their child or the young person they care for.

"Appointments need to be bookable in advance, not just on the day."

"Telephone times to take account of working parents – if one call is missed you're then unable to get back to the surgery and have to start all over again."

"Offer more book in advance appointments, especially for those with children. Working parents can't always drop everything all of a sudden to bring their child to an appointment in the next 30 minutes."

"Even if you can't get an appointment that day they could offer another instead of saying you will have to call tomorrow or take your chances."

Equally, parents and carers said that children and young people should be given priority when it comes to getting an appointment with the GP practice, especially face to face appointments. Parents and carers shared that they are increasingly concerned with how difficult it can be to get an appointment for their child or the young person they care for, with their age and/or severity of their symptoms or condition not seeming to make a difference.

"There needs to be more appointments available for babies and very young children."

"Children should be seen. People are being misdiagnosed, this is a child!"

"Children should be given priority for face to face as they are often unable to articulate properly what's wrong and can go downhill fast. There needs to be a specific line/triage so children are dealt with without delay."

Avoiding GP Services

Access

49% of parents and carers said they have avoided making contact with the GP practice for their child or the young person they care for in the last 12 months.

Instead of contacting the GP practice, 80% looked for information and advice elsewhere. The most common routes included searching for information online, visiting the local pharmacy, contacting NHS 111 and accessing private GPs.

Most parents and carers have been reluctant to access the GP practice because they have found it too difficult to get through, especially when trying to contact by telephone. Particularly concerning is the number of parents and carers who said they will avoid accessing the GP practice until their child or the young person they care for is too unwell.

"It's too much hassle so I put it off until my child is too poorly to avoid it any longer."

"It's too difficult. You're looking at a 40-50 minute wait on the phone which a) isn't practical and b) means appointments are usually gone."

"I am astounded at how unbelievably hard it has been to access basic medical care for my child. It has taken hours of my time and has been very stressful."

Some parents and carers have not contacted the GP practice because they assume that there will be no appointments available for their child or the young person they care for, or because there will not be an appointment that is either soon enough and/or face to face.

"I knew it would be hard to get an appointment."

"There are never any appointments available."

"I felt there wouldn't be any face to face appointments for him."

In some cases, parents and carers contacted NHS 111 or took their child or the young person they care for to an Urgent Care Centre because they feared that they would not get an appointment with the GP practice soon enough. A few respondents even accessed a private GP in order to get support for their child or the young person they care for.

"You can't get an appointment so we have used NHS 111."

"I visited the Urgent Care Centre for fear of not getting an appointment the next day or not getting through."

"We ended up paying to go private due to it being so difficult."

"We paid for a private GP as we were so frustrated."

Poor Experiences and Mistreatment

Other parents and carers have avoided contacting the GP practice for their child or the young person they care for after receiving a lack of support and mistreatment from the GP practice. Common examples included their child or the young person they care for being misdiagnosed, not listening to the concerns of the parent or carer, and receiving poor quality of care.

"My son was misdiagnosed 3 times and we ended up being referred to the hospital by an optician! Really disappointed by the service we received. My son was not seen once over a 5 week period despite contacting the surgery 4 times regarding the same issue!"

"I was not satisfied with the care my son received previously as they were too busy to help or care for his needs."

"My son has been in and out of hospital since the beginning of the year with a mystery illness but I have little to no help from the GP regarding this. We end up at the hospital every time as I know he will be seen by them and cared for by them. Whereas when I speak to the GP or try to speak to the GP I get nowhere."

One parent shared how healthcare professionals did not listen to their concerns about their child which resulted in a misdiagnosis of pneumonia and sepsis. As a result, the parent has avoided contacting the GP practice for their child after this serious incident.

"I have had such terrible experiences with misdiagnoses, incorrect treatment and lack of care. I have found that in the past GPs at my practice do not listen to me, feeling that they know more about my child than I do. This has resulted in misdiagnosis of pneumonia and sepsis, and multiple occasions where we have been sent away with advice and treatments that do not improve my child's symptoms. Unfortunately this is a known flaw in medical provision for women and their children and something that needs to change."

Similarly, a large number of parents and carers said they have not accessed the GP practice for their child or the young person they care for because of the previous poor treatment they have received from either reception staff and/or healthcare professionals. Parents and carers now feel hesitant to contact the GP practice in fear of being dismissed by staff, seen as a burden on the NHS, or judged for making contact about their child or the young person they care for.

"Fear of being dismissed by the GP as an anxious mother."

"I feel judged, as such we have been made to feel that we should wait until his symptoms become worse/don't get better."

"The receptionists aren't always kind, they make it difficult and I feel anxious before speaking to them."

"Made to feel guilty for asking someone to see my child."

Encouraging Access to GP Services

When respondents were asked what would encourage them to make contact with the GP practice for their child or the young person they care for, as previously emphasised, many parents and carers said they would be more inclined to access the GP practice if telephone systems were improved, or if they could book an appointment using an online system.

"Ability to get through on the phone or book appointments online."

"I'd contact the GP if I knew I wouldn't have to sit for hours redialling."

"Easier to get in touch with and getting an appointment. It's near impossible to get through to anyone right now."

As mentioned earlier in the report, parents and carers would also be more likely to contact the GP practice if they knew an appointment would be available for their child or the young person they care for, and if they were given greater choice when making an appointment.

"Knowing a) I could see her own doctor and b) knowing we could see them face to face within a reasonable timeframe and c) given the choice of face to face or phone call/video call dependent on the urgency."

"Being able to book in advance for your child and if I knew my child would be seen face to face."

However, the majority of parents and carers said they would be far more inclined to contact the GP practice if reception staff and/or healthcare professionals listened and respected their concerns as a parent or carer, provided greater reassurance and understanding, and treated them with more kindness.

"Going to the doctors should not be a battle between patient and doctors to get the child well. Too many times doctors dismiss symptoms and send the child away. This leaves the child unwell or in pain, and in my case, being told they are ok. Doctors should listen to parents and trust what is reported."

"Some of the receptionists could be a little kinder and not so patronising. I understand they have to deal with lots of people but please realise some people genuinely just want to see a doctor and aren't out to cause problems."

"The NHS constantly 'judge' parents for what they have done or not done. There is not enough information about what to do and how we can help the NHS and our children. The last thing I want to do is waste a GP's time or any member of the NHS, however when I do call out for help, a level of understanding would be appreciated. Whilst healthcare professionals see things everyday, it could be a first time for parents!

Using Online Services

Accessing Online Services

49% of parents and carers do not have access to online services for their child or the young person they care for. For most, this is because they did not know they could have access to online services for their child or the young person they care for. Some respondents also shared that they did not know their GP practice offered online services, or what the benefits of using online services are.

A few respondents said they cannot access online services for their child or the young person they care for because this function has not been enabled by their GP practice.

"I have my own access but was told I can't use it for my children."

"Not available for under 18s. Not even via the parent log in."

Other respondents have encountered difficulties when trying to register with or access online services for their child or the young person they care for.

"Problems with access for my child on several occasions and I've now given up!"

"The registration/log in has been ridiculous since the system changed a few years ago. I haven't successfully logged in for my child despite repeatedly registering."

"I have issues accessing for my child due to errors when the account was set up and I've not be able to resolve this with reception staff at the GP practice."

However, it is important to note that despite these barriers, 82% of parents and carers would request access to online services on behalf of their child or the young person they care for if they were given the opportunity and/or support to do so.

Improving Online Services

In comparison, 37% of parents and carers do have access to online services for their child or the young person they care for. When these respondents were asked how online services could be improved, most said that they should be able to use online services to book an appointment for their child or the young person they care for. For the majority, this option is not available.

"My GP practice will not allow us to book appointments for children online, only to view their medical record."

"Please let us book appointments online and be able to send the GP a message! I don't have time or the ability to sit in a phone queue for hours to talk to a receptionist who doesn't understand the medical information I'm trying to explain. It causes so much stress and wastes everyone's time."

"We can no longer make online appointments which stopped during Covid-19 and never resumed."

Some parents and carers noted that although their GP practice does offer the option to book appointments online for their child or the young person they care for, there is never availability, even if they look weeks or months in advance.

"I believe I can book appointments for my child but in reality there are never any available."

"Technically you can book an appointment for children but even if you select in a month's time it says there are no appointments!"

Parents and carers also felt that online services could be improved by enabling access to the medical records of their child or the young person they care for, and if they could share this information with other healthcare professionals to support with continuity of care.

"I can no longer access my child's records through my access which I used to be able to do before Covid-19."

"Need to be able to access my child's medical records to enable more efficient transfer of information across healthcare settings."

"Make sure parents can access their child's full medical records if the parent has set up access."

Significantly, a large number of respondents said there needs to be more information and communication on how parents and carers can access online services for their child or the young person they care for, and the benefits online services can offer, as most parents and carers are not aware. Respondents felt that the use of online services should be promoted more widely and that GP practices should work to build trust with parents and carers to ensure they feel confident accessing and using online services.

"I think communications about online services should be sent out either at the time of birth or upon undertaking the caring responsibility. I could have been provided with this information at one of my son's standard check ups or immunisation appointments. Communication materials could also be provided to childcare/school settings for onward circulation to parents and carers."

"There needs to be more information about online services for parents and carers. I wasn't aware about them."

"I think there needs to be better communication regarding alternative methods of making appointments could be put in place, for example the use of online services. I would also say that trust needs to be built with patients that if they use an online triage process/appointment booking that they will receive a timely response."

Findings from Children and Young People

Unfortunately only 10 children and young people aged between 13 and 18 years old completed our survey. Given this low response, we would recommend that the Hertfordshire and West Essex ICB looks to undertake specific engagement with children and young people about their experiences of accessing GP services.

Across the respondents, 50% said they have never accessed their GP practice before. For all of these respondents, this is because their parent or guardian contacts the GP practice for them.

For the 50% of respondents who had accessed their GP practice, the majority had a positive experience. The greatest barrier was choice, with almost all respondents not offered any choice when making an appointment.

"I was given an appointment but they told me the day and time."

"The appointment was too far away and too long to wait."

When asked how accessing their GP practice could be improved, as emphasised amongst parents and carers, children and young people would also like to be able to book appointments using an online system.

"Let us have online access to book appointments."

"Be better to make an appointment online than call."

Respondents also noted that there should be more information about consent, and when children and young people are able to, or need to, contact their GP practice independently. For example, one respondent shared that they did not know that their parent could not contact their GP practice on their behalf because they are over 16 years old.

"I didn't know you have to ring yourself if you're over 16. My mum rang at first and I had to try again so I missed out on a same day appointment."

As we found with parents and carers, 50% of children and young people said they have avoided contacting their GP practice in the last 12 months. For the majority, this is because they find their GP practice too difficult to access, or because they are concerned about being a burden on the NHS.

When asked about online services, 38% of respondents said they do not have access to online services. For all respondents, this is because they did not know they could have their own account. However, all respondents said they would use online services if they were given the opportunity and/or support to do so.

38% of children and young people do have access to online services, and when asked about the benefits of using online services, all respondents noted that it is much easier and quicker than contacting by telephone.

"You don't have to wait in a queue on the phone."

"It is easier than calling sometimes."

"You get help quicker than waiting on a phone."

When asked how online services could be improved, respondents said that the online forms can be confusing and difficult to complete.

"Takes ages to do the online form. Options are so limited it's hard to explain what's wrong to get an appointment."

"I can't fill in the online forms to get an appointment as they are too long, too complicated and I don't understand lots of the questions. I need to speak to people to understand things."

Respondents also shared that certain appointments, such as for contraception, cannot be booked online. Children and young people said they would like this to be an option, instead of having to contact the GP practice by telephone.

"You can't book contraception appointments online as a child, it's not an option, only for adults."

"Couldn't book my regular contraception injection online even though I am over 16. Have to spend an hour on the phone instead to book."

Summary

Our engagement shows that the majority of parents and carers are struggling to access GP services for their child or the young person they care for. Access is particularly difficult via

telephone, with many parents and carers spending hours trying to get an appointment for their child or the young person they care for, only to be told there are no appointments available, even weeks in advance.

Choice, especially in the type of appointment offered, is a priority for parents and carers. The findings highlight clear cases in which the child or young person should have been given this choice when making the appointment, whether that be due to their age, condition(s) or the severity of their symptoms. Babies and young children, and those with complex needs, disabilities, long-term conditions or mental ill health are at greater risk with reports of misdiagnosis, poor quality of care, or the parent or carer having to take their child or the young person they care for elsewhere to get the medical attention they need. This emphasises the importance of the concerns of the parent or carer being listened to, so the needs of the child or young person can be addressed.

Difficulties in contacting the GP practice and previous poor experiences with reception staff and/or healthcare professionals is encouraging parents and carers to avoid accessing GP services entirely for their child or the young person they care for. Instead, parents and carers are opting to visit an Urgent Care Centre or A&E – often because this route is easier to access rather than being the preferred option– or even paying for a private GP in efforts to get the support their child or the young person they care for requires.

Parents and carers also want online services to be utilised further, with the ability to book appointments online seen as essential for many. Surprisingly, many parents and carers are not aware that they can use online services for their child or the young person they care for, and most would access this if made available to them.

It is important to recognise that the challenges faced by GP practices across the county are significant. However, it is evident that most of the improvements parents and carers want to see are about the process of making an appointment, and easier access to their GP practice, rather than improving the quality of care their child or the young person they care for received. It is clear that some systems currently in place are not designed to meet patient needs and the adoption of improved systems was seen very positively by respondents.

Recommendations

Based on the findings outlined in this report, it is recommended that the Hertfordshire and West Essex ICB Primary Care Workstream should encourage GP practices to take forward the following recommendations. The ICB is providing significant support to enable GP practices to improve access and further investment of this will help address some of the challenges.

Improving access to GP services would instil greater confidence in patients. This could be achieved through:

1. Enabling a variety of access routes, including the use of online services and visiting the GP practice in person, to accompany all needs and preferences.

2. Continuing to improve telephone systems to reduce delays and waiting times for patients.

3. Greater flexibility in contact hours and opening times to account for school hours, work, and caring responsibilities.

Making appointments more readily available is important, particularly for children and young people and vulnerable groups. This includes:

4. Appointments that are bookable in advance, especially if the concern is either routine or non-urgent.

5. Reviewing and addressing waiting times for appointments, with particular consideration given to:
    - Children and young people
    - Those with a disability, complex needs, or a long-term condition
    - Those with ill mental health

Providing greater choice when offering appointments would improve the quality of care received. This includes:

6. Being mindful of work and caring responsibilities, as well as school hours, when offering appointments.

7. Providing more choice when offering appointments to patients, with a particular focus on offering more face to face appointments where possible. Specific consideration and greater choice should be given to:
    - Children and young people
    - Those with a disability, complex needs, or a long-term condition
    - Those with ill mental health

8. The ICB should work with Primary Care Networks and GP practices to identify ways of ensuring there is greater choice for patients.

Providing high quality of care would ensure all patients feel respected and heard. This includes:

9. Listening to and respecting the concerns of all patients, particularly parents and carers, to prevent misdiagnosis and/or mistreatment.

10. Providing thorough assessments and high quality care to all patients, at all times.

11. Healthcare professionals and reception staff to treat all patients with respect. This should be monitored to ensure staff are not dismissing concerns, or judging patients for making contact. Reminders and refresher training should also be considered.

12. Delivering Customer Care training for GP receptionists to improve their customer service and communication skills.

GP practices should offer greater information and support, particularly in regards to the use of online services. This includes:

13. Continuing to encourage patients, particularly parents and carers and vulnerable groups, to contact their GP practice if they have concerns about their health.

14. Enabling parents and carers online access for their child or the young person they care for, if this function is not already available.

15. Continuing to increase awareness amongst parents and carers on how they can access online services for their child or the young person they care for, and encourage or support them to register. The ICB should encourage GP practices to work with other healthcare professionals, Hertfordshire County Council and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector to raise the profile and benefits of using online services.

16. Enabling all patients full access to the functions available via online services, including:
    - Booking appointments
    - Test results
    - Prescriptions
    - Medical records

17. By 1st November 2022 all GP practices should have updated their organisation settings for online services in order to be able to provide record access to patients – whether this be

via the NHS App, TPP or EMIS systems[8]. The ICS should look to review and monitor whether improvements have been made.

[8] GP Online Services clinical system configuration: Immediate action required - NHS Digital

Appendix

Named GP Practices: Parents, Carers and Children and Young People Survey[9]

District	Name of GP Practice	Number of Respondents
Broxbourne	Warden Lodge Medical Centre	5
	The Maples Medical Centre	5
	Park Lane Surgery	4
	Amwell Surgery	4
	Cuffley Village Surgery	2
	Stanhope Surgery	1
Dacorum	Parkwood Surgery	5
	Fernville Surgery	4
	Bennetts End Surgery	3
	Haverfield Surgery	2
	Everest House Surgery	1
	Lincoln House Surgery	1
	Highfield Surgery	1
	Woodhall Farm Medical Centre	1
	Manor Street Surgery	1
	Gossoms End Surgery	1
East Herts	Church Street Surgery	18
	South Street Surgery	11
	Castlegate Surgery	4
	Dolphin House Surgery	3
	Hanscombe House Surgery	3
	Buntingford Medical Surgery	3
	New River Health (Castlegate Surgery and Church Street Surgery)	2
	Watton Place Clinic	2
	Knebworth and Marymead Surgery	2
	Elsenham Surgery	2
	Central Surgery	1
Hertsmere	Manor View Practice	3
	Theobald Medical Practice	1
North Herts	Birchwood Surgery	6
	Nevells Road Surgery	4
	Sollershott Surgery	2
	Bancroft Medical Centre	2
	Orford Lodge Surgery	2
	Royston Health Centre	2

[9] Please note that the total does not equal to the total number of respondents due to some respondents choosing not to share the name of the GP practice their child or the young person they care for is registered with.

	Regal Chambers Surgery	1
St. Albans	The Maltings Surgery	9
	Harvey Group Practice (Harvey House Surgery and Jersey Farm Surgery)	7
	Parkbury House	6
	Summerfield Health Centre	4
	The Lodge Surgery	3
	The Lodge Health Partnership	3
	The Village Surgery	3
	The Elms Medical Practice	2
	Midway Surgery	1
	Hatfield Road Surgery	1
	Davenport Surgery	1
	Redbourn Health Centre	1
	Grange Street Surgery	1
Stevenage	Chells Surgery	3
	Stanmore Medical Group	3
	Shephall Health Centre	3
	The Poplars Surgery	1
	Symonds Green Health Centre	1
	King George Surgery	1
Three Rivers	Vine House Health Centre	5
	New Road Surgery	4
	Gade Surgery	1
Watford	Manor View Practice	5
	Bridgewater Surgery	3
	Watford Health Centre	2
	Sheepcot Medical Centre	1
	Garston Medical Centre	1
	Coach House Surgery	1
	Suthergrey House Medical Centre	1
Welwyn Hatfield	The Garden City Practice	8
	Bridge Cottage Surgery	4
	Hall Grove Group Practice	3
	Spring House Medical Centre	2
	Peartree Lane Surgery	2
	Burvill House Surgery	1
	Moors Walk Surgery	1
	Parkway Surgery	1
	Potterells Medical Centre	1

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Primary Care Board				**Meeting Date:**	**24/10/2022**	
Report Title:	**East of England (EoE) Partnership Strategy for Community Pharmacy**				**Agenda Item:**	**10**	
Report Author(s):	Renate Scheffer, Community Pharmacy Integration Lead, HWE						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation HWE						
Purpose:	**Approval**	☒	**Decision**	☐	**Discussion**	☒	**Information** ☐
Report History:	▪ The Community Pharmacy Transformation Group in meetings held on 27 September and 25 October 2022. ▪ The NHSE Community Pharmacy Strategy Board and will be approved at the Primary Care and Public Health Oversight Group on 28 November '22.						
Executive Summary:	Central to delivering the vision and principles of the NHS Long Term Plan, is the creation of a fully integrated community-based health care system. This includes community pharmacy playing an important and integrated role as recognised in the Next Steps for Integrating Primary Care as outlined in the Fuller Stocktake report. The EoE Partnership Strategy for Community Pharmacy outlines strategic vision, focus, direction, goals to support and enable community pharmacy to realise its full potential over the next five years. The strategy aims to facilitate collaboration across health, social, primary and, community care teams in designing and delivering transformation programmes, reconfiguring services, and redesigning pathways to deliver integrated community pharmacy services. Community Pharmacies play a part in prevention of diseases, reducing health inequalities, helping to tackle obesity and high blood pressure, and providing enhanced public health care as part of a whole system approach. The Strategy represents the collaborative efforts of partners across the EoE, whose contributions have been incorporated. It also makes recommendations for Integrated Care Boards (ICB) to move from vision; to prioritisation; to action, whereby systems need to							

	develop local strategies, working pan regionally where it makes sense to “do once” or collaboration around a regional issue is needed.			
Recommendations:	Primary Care Board is asked to discuss and adopt the strategy and embed this as part of the development of the ICB wider primary care strategy and implementation plan.			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	No conflicts of interest have been identified for the approval of this strategy.			

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	☒

1. Executive summary

The NHS Long Term Plan (NHS LTP) – a blueprint for the future of the NHS which provides the right care at the right time and in the right place – recognises that good health is about more than treating people when they fall ill. It presents a vision of health and care that is driven by prevention and tackling health inequalities. Central to delivering this is the creation of fully integrated community-based health care system. This includes community pharmacy playing an important and integrated role as recognised in the *Next Steps for Integrating Primary Care: Fuller Stocktake report.*

Community pharmacy is and continues to demonstrate resilience, engagement and innovation in the services it provides to patients, communities and populations. This is evident in their ongoing contribution or the Covid-19 vaccination programme for example.

To ensure that community pharmacy continue to build on this, health and care systems in the East of England (EoE) collectively support a vision where community pharmacy is:

1. An integral and integrated part of primary care, leading to improved outcomes for patients and facilitating better access
2. Part of integrated care pathways for primary care and urgent care
3. The first point of contact for many patients
4. Integral to the delivery of self-care and avoiding ill health
5. Integral to addressing health inequalities
6. Are valued and respected as clinicians in their own right

2. Background

This strategy is aligned with national and local policies and plans which aim to strengthen the role of community pharmacies as anchor institutions in local communities.

The NHS LTP commits to developing more joined-up and coordinated care across primary and community health services and a more proactive approach in the services provided. It supports expanded community multidisciplinary teams (MDT) aligned with primary care networks (PCNs). It determines to make greater use of community pharmacists' skills and opportunities to engage patients; and identifies community pharmacies as being able to support urgent care and promote patient self-care and self-management as a key part of developing a fully integrated community-based health care system.

The Fuller Stocktake Report (May 2022) describes a vision of integrating primary care, improving the access, experience and outcomes for communities, which centres around three essential offers:

- Streamlining access to care and advice for people who get ill but only use health services infrequently. This provides them with much more choice about how they access care and ensuring care is always available in their community when needed
- Providing a more proactive, personalised care with support from a MDT of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention

Community pharmacies are contracted and commissioned in England under the national Community Pharmacy Contractual Framework (CPCF). The CPCF is an agreement between the Department of Health and Social Care (DHSC), the Pharmaceutical Services Negotiating Committee (PSNC) and NHS England (NHSE). This describes the joint vision for pharmacies to be more integrated in the NHS, provide more clinical services, be the first port of call for healthy living support as well as minor illnesses and to support managing demand in general practice and urgent care settings.

We are currently in year four of the five-year framework under the CPCF.

Years 4 and 5 of the service development plan will introduce services that build on existing services, including:

- Expanding the Community Pharmacist Consultation Service to enable urgent and emergency care settings to refer patients to a community pharmacist for a consultation for minor illness or urgent medicine supply
- Expanding the New Medicines Service to include antidepressants to enable patients who are newly prescribed an antidepressant to receive extra support from their community pharmacist
- Introducing Tier 2 of the Pharmacy Contraception Service, enabling community pharmacists to also initiate oral contraception, via a Patient Group Direction, and provide ongoing clinical checks and annual reviews
- The service specifications for the Blood Pressure Check Service and Smoking Cessation Service will be amended to allow delivery by pharmacy technicians, helping pharmacies to make best use of their skill-mix

The responsibility for community pharmacy commissioning is being delegated from NHSE to ICBs in April 2023 across the East of England. The CPCF will continue to be negotiated and set nationally, systems will have delegated responsibility for the commissioning and contracting locally. Giving ICBs responsibility for direct commissioning is a key enabler for integrating care and improving population health.

Developing the strategy:

Surveys

In the Spring of 2022 NHSE launched a patient and public survey throughout the EoE region to support the development of this strategy. The survey 'Have your say in the future of community pharmacy' sought to identify views in areas of need and priority from a patient / public perspective.

- Clear themes emerged in the analysis of the survey data. The role of community pharmacies has been especially valued during the pandemic, when the perception accessing a GP was seen to be challenge. Some concerns around understaffing, and areas identified for improvement. Service users expressed that they see an ideal pharmacy as a perfect combination of Staff (including quality customer service), Service/s (including accessibility) and Space to give privacy.

Further surveys and events in the Spring 2022, sought the views of community pharmacy teams and other stakeholders involved in community pharmacy.

The survey data have been summarised in four key areas being

- workforce
- clinical services
- digital and IT
- pharmacy integration.

Vision

Six vision statements were developed using the wider policy context and the views of the patients, public, and community pharmacy teams, as well as each system. Each system within the EoE has identified priorities, potential actions and enablers to support the delivery of each vision statement which form the basis of this strategy. The six vision statements are listed under the executive summary above.

Pillars of Work

The six vision statements and the actions to deliver these have been grouped into four key pillars of work.

Pillar 1: Increase health system integration and partnership

Pillar 2: Optimise services and outcomes

Pillar 3. Improve population health and address health inequalities

Pillar 4. Develop the workforce for delivery

Enablers

The successful delivery of these four key pillars of work requires a number of enablers to be in place and challenges to overcome, these include:

- Improved interoperability of IT systems and appropriate access to patient records

- Shared data, insights and intelligence
- Improved communication, engagement platforms and services
- Appropriate funding and contractual arrangements – nationally and within systems

In addition to the above workforce development priorities were identified by the EoE task and finish group.

International horizon scanning indicated that throughout the world there are similar intentions to modernise the way pharmacy is delivered with a greater emphasis on clinical service delivery within integrated systems. There has been progress where the health economies are well integrated and have a unified approach to care, so the recent formations of ICSs bode well for UK pharmacy development.

The Health Education England's (HEE) initial training and education of pharmacists' reform programme culminates in 2026 with all newly registered pharmacists being able to independently prescribe medicines.

A number of proof-of-concept pilots are already underway to trial new ways of working to deliver improved services and outcomes for patients and service users.

The Fuller Report (2022) identified a consistent thread throughout the successful case studies that change was locally led and nationally enabled. Therefore, systems working together, and with NHSE, DHSC and PSNC, will be the most effective route to integration.

3. Next Steps

Looking into the future, advances in medicine could radically change the way illness is managed. For example, drug treatment will be personalised to each individual ensuring the most effective treatment with the minimum risk of adverse effects.

At the same time the delivery of healthcare will need to evolve. The reasons for this are multifactorial and include the changing needs and expectations of the population and the ability of the public purse to fund services to meet those expectations.

Community pharmacy will have a key role in making patient care personalised, enabling patients to be involved in choices about their medicine treatment, deprescribing if appropriate and having direct referral to a range of other services.

The report by the Kings Fund - *A professional Vision for pharmacy practice in 2032,* sets out the possibilities for community pharmacy in the next 10 years envisioning an integrated multidisciplinary system enabled by IT and automation, supported by artificial intelligence. This technology supports safer medicines supply and releases clinical time within community pharmacy for one-to-one interaction, virtual or in-person, with patients.

Community pharmacy is already the easy access health hub within a community, but additional clinical input can be used to enhance population health, for instance through early detection of illness and prevention of ill health.

Next steps for ICBs

ICSs to develop Community Pharmacy in a way that takes account of the critical issues that have arisen post pandemic, the shift in commissioning to ICSs, NHS LTP priorities and emergent and innovative technologies that are set to radically change the delivery of health care and population health management.

4. Recommendations

Recognising that systems have differing priorities and timescales; it is recommended that systems

- Work to understand the needs and priorities of the local population. How and which of these priorities and actions identified in this strategy can be implemented to support local needs

  This will be supported by reference to the area Pharmacy Needs Assessment (PNA), Joint Strategic Need Assessment (JSNA) products and the Joint Health and Wellbeing Strategy (JHWS)

- Make evidence-based decisions on service priorities focused on key issues and priorities

- Assess current status of digital infrastructure and system interoperability, and improvements required to support integration of community pharmacy

- Identify challenges for development and opportunities to address these challenges

- Develop detailed operational and implementation plans for short- and medium-term actions in line with the strategic priorities on the pathway to longer-term strategic changes

    - This will include revising commissioning arrangements, moving away from isolated commissioning to joint commissioning by local authorities and health organisations

    - Implementation of new services, or of new models of delivery for existing services, will need to be done within capacity and capability constraints

Primary Care Board is asked to discuss and adopt the strategy and embed this as part of the development of the ICB wider primary care strategy and implementation plan.

East of England Partnership Strategy for Community Pharmacy

Rolling 5 years from December 2022

Contents

Our strategy on a page

High level summary/visualisation of the strategy to be added after the final version has been agreed

Foreword

The NHS Long Term Plan – a blueprint for the future of the NHS which provides the right care at the right time and in the right place – recognises that good health is about more than treating people when they fall ill. It presents a vision of health and care that is driven by prevention and tackling health inequalities. Central to delivering this is the creation of fully integrated community-based health care system. This includes community pharmacy playing an important and integrated role as recognised in the *Next steps for integrating primary care: Fuller Stocktake report.*

The East of England Partnership Strategy for Community Pharmacy outlines our strategic visions and goals to support and enable community pharmacy in the East of England realise its full potential. Supporting integration and transformation, building on the strong foundations in place and to deliver on the vision of the NHS Long Term Plan. Playing a part in prevention of diseases, reducing health inequalities, helping to tackle obesity and high blood pressure, and providing enhanced public health care as part of a whole system approach. The Strategy represents the collaborative efforts of partners across the East of England, whose contributions have been incorporated and without whom this would not have been possible.

Community pharmacy is and continues to be demonstrate resilience, engagement and innovation in the services it provides to patients, communities and populations. This is evident in their ongoing contribution or the Covid-19 vaccination programme for example. To ensure that community pharmacy continue to build on this health and care systems in the East of England collectively support a vision where:

1. Community pharmacy is an integral and integrated part of primary care, leading to improved outcomes for patients and facilitating better access
2. Community Pharmacy is part of integrated care pathways for primary care and urgent care
3. Community Pharmacy is the first point of contact for many patients
4. Community Pharmacy is integral to the delivery of self-care and avoiding ill health
5. Community Pharmacy is integral to addressing health inequalities
6. Community pharmacists are valued and respected as clinicians in their own right

Through the identified priorities, actions and enablers that underpin these six vision statements, our overall goal is to increase health system integration and partnership, optimise services, improve population health and improve health inequalities, address workforce issues; all for the benefit of the patients, communities and population we are here to serve.

By realising the potential of community pharmacy and the expertise of the pharmacy teams within them, with the collaboration of partners across the East of England, we can be confident that community pharmacy will cement its position as a valued and essential component for healthcare delivery in primary care.

William Rial, Regional Chief Pharmacist

Introduction

This strategy has been developed to help give focus and direction for community pharmacy in the East of England over the next five years.

The strategy aims to facilitate collaboration across health, social, primary and, community care teams in designing and delivering transformation programmes, reconfiguring services and redesigning pathways to deliver integrated community pharmacy services.

The creation of Integrated Care Boards (ICBs) in July 2022 and the delegation of the commissioning of community pharmacy to them in April 2023 now affords more opportunities. This strategy identifies a range of priorities and actions, which will be implemented at differing levels, such as neighbourhood, Integrated Care System (ICS) or region. By having an agreed regional strategy it will:

- Ensure a level of consistency in the implementation of national programmes and avoid unwarranted variation
- Identify and prioritise regional resources
- Maintain a focus on prevention and reducing health inequalities
- Enable regional and national support in areas such as workforce and infrastructure development, to avoid duplication of effort and maximise economies of scale
- Drive quality and oversight

This is a rolling strategy written at a point in time where structure, governance and commissioning responsibilities are still being defined and agreed for the ICBs and local partnerships. The intention is to regularly review and update to ensure it is delivers improvements for patients, community pharmacy teams and wider stakeholders alike.

NHS England established 42 statutory ICBs on 1 July 2022 in line with its duty in the Health and Care Act 2022. This was as part of the Act's provisions for creating ICSs. ICSs are partnerships that bring together NHS organisations, local authorities and others to lead the delivery of NHS care and improvements for patients set out in the NHS Long Term Plan. See https://www.england.nhs.uk/integratedcare/integrated-care-in-your-area/ for more information.

For the purpose of this strategy the term "system" has been used to reflect both the ICS and the ICB where the implications are across the ICS.

Vision

This strategy supports a vision where community pharmacy is a core part of health and care services, integrated into systems, and providing an essential contribution to system-wide health protection and improvement.

Community pharmacy is an integral part of primary and community care, leading to improved outcomes for patients and facilitating better access

Community pharmacy is embedded in pathways across the wider health and care system

Community pharmacy is a patient centred service that is the first point of contact for many patients

Community pharmacy is integral to the delivery of self-care, avoiding ill health and improving population health

Community pharmacy is integral to addressing health inequalities

Community pharmacy professionals and wider teams are valued and respected

Community pharmacy will support and strengthen wider health and care services by undertaking key roles in improving the use of medicines, treating common clinical conditions, managing long term conditions, and addressing health inequalities, population health and wellbeing.

To realise the potential of community pharmacy, development of the role and services needs to be underpinned by:

- Collaboration with partnership organisations to integrate strategies and services
- Increased public and health professional awareness of community pharmacy capabilities and services
- Sustainable workforce models which maximise the skill mix of community pharmacists, technicians and wider pharmacy teams
- Improved system and digital infrastructure with shared patient records
- Better use of data to inform decisions, monitor outcomes and improve services
- Good access to community pharmacies
- Investment and practical support in community pharmacy to realise full potential

Strategic context

This strategy is aligned with national and local policies and plans which aim to strengthen the role of community pharmacies as anchor institutions in local communities.

The **NHS Long Term Plan** (LTP) (Jan 2019) states that the NHS will focus on its aim to make the population fit for the future by:

- Enabling everyone to get the best start in life
- Helping communities to live well
- Helping people to age well

The plan commits to developing more joined-up and coordinated care across primary and community health services and a more proactive approach in the services provided. It supports expanded community multidisciplinary teams aligned with primary care networks (PCNs). It determines to make greater use of community pharmacists' skills and opportunities to engage patients; and identifies community pharmacies as being able to support urgent care and promote patient self-care and self-management as a key part of developing a fully integrated community-based health care system.

The LTP sets out a new service model offering patients more options, better support and joined-up care at the right time in the optimal care setting. It strengthens the focus on prevention and reducing health inequalities, and on improving care quality and outcomes. It also looks to address current workforce issues, support staff and to upgrade technology for digitally enabled care.

ICSs and ICBs are central to the delivery of the LTP through enabling service integration to meet local needs, bringing together providers and commissioners of NHS services with local authorities and other local partners, to make shared decisions on population health, service redesign and implementation.

The **Fuller Stocktake Report** (May 2022) describes a vision of integrating primary care, improving the access, experience and outcomes for communities, which centres around three essential offers:

- Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- Providing a more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention

Community pharmacies are contracted and commissioned in England under the national **Community Pharmacy Contractual Framework** (CPCF) (Jul 2019, updated September 2022). The CPCF is an agreement between the Department of Health and Social Care (DHSC), the Pharmaceutical Services Negotiating Committee (PSNC) and NHS England (NHSE) and describes the joint vision for pharmacy to be more integrated in the NHS, provide more clinical services, be the first port of call for healthy living support as well as minor illnesses and to support managing demand in general practice and urgent care settings.

The CPCF supports:

- Better utilisation of the clinical skills of the teams that work in pharmacies
- Doing more to protect public health
- Taking on an expanded role in urgent care
- Continuing to prioritise quality in community pharmacy and promoting medicines safety and optimisation

2022/23 is year four of the five-year framework. The agreement for the two remaining years (Community Pharmacy Contractual Framework 5-year deal: year 4 (2022 to 2023) and year 5 (2023 to 2024) continues to support measured and incremental expansion in clinical service provision from community pharmacies, in line with the sector's ambitions, but recognising current capacity pressures.

Years 4 and 5 of the service development plan will introduce services that build on existing services, including:

- Expanding the Community Pharmacist Consultation Service to enable urgent and emergency care settings to refer patients to a community pharmacist for a consultation for minor illness or urgent medicine supply
- Expanding the New Medicines Service to include antidepressants to enable patients who are newly prescribed an antidepressant to receive extra support from their community pharmacist
- Introducing Tier 2 of the Pharmacy Contraception Service, enabling community pharmacists to also initiate oral contraception, via a Patient Group Direction, and provide ongoing clinical checks and annual reviews
- The service specifications for the Blood Pressure Check Service and Smoking Cessation Service will be amended to allow delivery by pharmacy technicians, helping pharmacies to make best use of their skill-mix

The **Pharmacy Quality Scheme** (Sep 2021, updated Oct 2022) forms part of the CPCF. It rewards community pharmacies for delivering quality criteria in all three of the quality dimensions: clinical effectiveness, patient safety and patient experience.

Integrated Care Systems

ICSs have four key aims:

- Improving outcomes in population health and health care
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

The responsibility for community pharmacy commissioning is being delegated from NHSE to ICBs in April 2023 in the East of England. The CPCF will continue to be negotiated and set nationally, systems will have delegated responsibility for the commissioning and contracting locally.

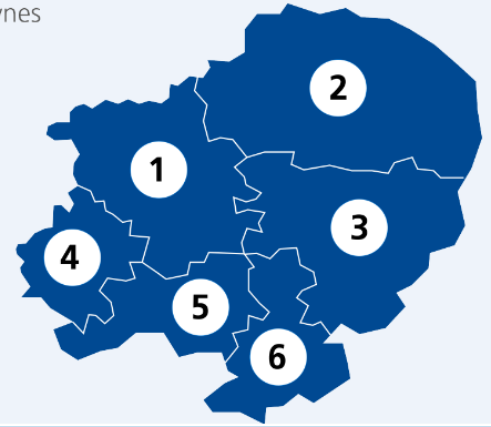
Giving ICBs responsibility for direct commissioning is a key enabler for integrating care and improving population health. It allows the flexibility to join up key pathways of care, leading to better outcomes and experiences for patients, and less bureaucracy and duplication for clinicians and other staff.

Systems vary in size and have differing priorities according to local needs, underpinned by developing structures and strategies. Each system has produced a summary (see Appendix A) of their current position and approach to community pharmacy. These reflect the differing approaches and need to ensure that this strategy is as flexible as possible to support system implementation.

The East of England has an estimated population of 7.1 million and as of April 2022 there were 1,144 community pharmacies (figures from NHSE – East of England).

There are six systems in the East of England.

1. Cambridgeshire and Peterborough
2. Norfolk and Waveney
3. Suffolk and North East Essex
4. Bedfordshire, Luton and Milton Keynes
5. Hertfordshire and West Essex
6. Mid and South Essex



ICS	Registered pharmacies
Cambridge and Peterborough	145
Norfolk and Waveney	178
Suffolk and North East Essex	170
Bedfordshire, Luton and Milton Keynes	158
Hertfordshire and West Essex	281
Mid and South Essex	212
East of England Total	**1144**

Views from service users

In Spring 2022 NHSE and a patient and public survey throughout the East of England region to support development of this strategy. The survey 'Have your say in the future of community pharmacy' sought to identify views of need and priority areas from a patient / public perspective.

> *"Pharmacies are vital to communities and a very valuable [community] asset"*

Clear themes emerged in the analysis of the survey results (ref/hyperlink to the final report to be provided by NHSE).

The role of community pharmacies has been especially valued during the pandemic, when the perception of reaching a GP was that it could present a challenge. However, there is a key theme indicating that pharmacies cannot and should not replace GPs. Rather, people wished for better communication and improved systems between the two.

There was strong agreement and support for :

- The pharmacy having good links with the doctor's surgery and working together to look after patients and their community
- Pharmacies taking a bigger role in patient healthcare by providing services to help their health and/or health conditions
- Pharmacies supporting vaccinations, pain management, routine blood tests and hypertension monitoring

The patients and public that responded to the survey expressed some concerns around understaffing, and areas identified for improvement included:

- queues, long wait times and insufficient opening hours
- Communication and advertising of available services

It should be noted that the survey took place shortly following COVID-19 restrictions and social distancing had been in place.

Service users expressed that they see an ideal pharmacy as a perfect combination of **three S's** - **Staff** (including quality customer service), **Service/s** (including accessibility) and **Space** to give privacy.

- **Staff:** Many mentioned that on top of being friendly and helpful, pharmacy staff are providing or should provide excellent customer service and a personal touch taking the time to get to know their customers and community and often go above and beyond.
- **Service:** Responders identified extended hours, specifically evenings and weekends, and an efficient, well-organised and well-staffed pharmacy as ideal.
- **Space:** as commented on to a lesser degree than staff and service/s, but confidentiality and privacy is highly important when mentioned.

An additional 'S', not always directly stated but implied, is **Safety** – safe practice must underpin all community pharmacy services.

Views from pharmacy teams and healthcare professionals

In Spring 2022 a series of surveys and events sought the views of community pharmacy teams and other stakeholders involved in community pharmacy.

There were high levels of support for better integration of community pharmacy, primary, urgent and acute care, and for improving joint working across services to:

- Provide easier access to healthcare services for patients
- Ensure community pharmacy becomes the first point of call for minor ailments
- Manage long-term conditions with routine tests and enhanced monitoring
- Enable improved patient outcomes

The survey results have been summarised in four key areas – workforce, clinical services, digital and IT and pharmacy integration.

Workforce: community pharmacy teams feel there is a need for joined-up workforce planning that:

- Increases recognition of community pharmacy and community pharmacists to be valued and respected as clinicians
- Raises awareness about different roles in provision of healthcare services and the expertise of community pharmacy teams
- Increases workforce numbers, particularly accredited checking technician and pharmacist roles
- Enables workforce training and development time to be protected and funded
- Provides more opportunities to support flexible, portfolio working

Clinical services: community pharmacy teams identified that development and integration of services requires:

- Improved communication between services and ensuring close collaboration
- Ensuring adequate funding for community pharmacies
- Formal referral routes between community pharmacies and other healthcare services
- Improved referral processes, including potential for self-referral, into services

Digital and IT: community pharmacy teams agreed that a digitally enabled and improved system architecture is required to support:

- Integrated IT systems and/or single system use across pharmacies and GPs and wider services eg hospitals for discharge
- Shared healthcare records
- Improved referral tools and standardised data templates and data entry
- Increased application of digital solutions for example remote consultation capabilities, and electronic prescribing

Pharmacy integration: survey respondents highlighted that to be successful pharmacy integration will need to:

- Improve communication between services
- Have a clear roadmap and a shared vision
- Consider sustainability of programmes with adequate funding and incentivisation.

Vision, priorities and actions

The six vision statements below were developed using the wider policy context and the views of the patients, public, and community pharmacy teams, as well as each system. Each system has identified priorities, potential actions and enablers to support the delivery of each vision statement. Below are the combined summaries and which form the basis of this strategy.

The vision	Strategic priorities	Potential Actions	Enabled by
1. Community pharmacy is an integral part of primary and community care, leading to improved outcomes for patients and facilitating better access	Align community pharmacy strategy with primary and community care strategy and system strategic priorities Embed community pharmacy into PCNs and integrated neighbourhood teams Raise the profile of community pharmacy across the system and gain insight and visibility of capacity, pressures and opportunities, gaps and variation	Include community pharmacy leads in all levels of system leadership, strategic planning and pathway design Develop the designated PCN Community Pharmacy Lead role Map current services for improved understanding of community pharmacy provision and incorporate into wider system resilience and capacity planning Develop integrated service delivery models Collaborate on optimised use of agreed pathways Monitor service delivery data to improve health outcomes and identify gaps in care	Funding for the PCN Community Pharmacy Lead role and community pharmacy participation in integration design and implementation activities Better communications platforms/services Improved interoperability of IT systems (including appropriate access to patient records) Shared data, insights and intelligence on current and planned provision, demand and capacity

The vision	Strategic priorities	Potential Actions	Enabled by
2. Community pharmacy is embedded in pathways across the wider health and care system	Establish community pharmacy as a core service element of the primary care system enabling patients to access care at the right time in the optimal setting Provide better access to assessment, advice and medicines for patients requiring treatment for low acuity conditions Increase reach of community pharmacy to promote self-care and preventative strategies for ill health	Promote the expertise and knowledge of community pharmacy, including services offered to the public to encourage uptake and to other healthcare professionals to support referral Further implementation and optimisation of currently commissioned services Local commissioning of Patient Group Directives and independent prescriber-led services for the treatment of low acuity conditions in all community pharmacies Review the range of services currently offered by community pharmacies and support extension of services to cover gaps	Community pharmacy involvement in health awareness campaigns Peer network to share best practice, review learning and determine potential for local implementation Better communications platforms/services Improved interoperability of IT systems (including appropriate access to patient records) Data sharing Sufficiently funded pharmacy workforce (pharmacists and other staff)

The vision	Strategic priorities	Potential Actions	Enabled by
3. Community pharmacy is a patient centred service that is the first point of contact for many patients	Improve public and patient awareness of community pharmacy expertise and services Enable onward referral or signposting between community pharmacy and other healthcare teams such as general practice, NHS 111 or A&E Improve service accessibility Optimise the Community Pharmacist Consultation Service	Promote community pharmacy as a clinical provider Ensure services are consistently delivered, visible and actively advertised to patients/other healthcare providers Review demand against current provision to identify accessibility issues and options to address inaccessibility Consider innovative approaches to service provision to increase accessibility	Better communication platforms/services Improved interoperability of IT systems (including appropriate access to patient records) Funding for piloting and implementation of new service technologies and approaches Sufficiently funded pharmacy workforce (pharmacists and other staff) Contractual support for alternative service provision approaches

The vision	Strategic priorities	Potential Actions	Enabled by
4. Community pharmacy is integral to the delivery of self-care, avoiding ill health and improving population health	Give people more control over their health and wellbeing Provide wider support for prevention and detection of ill health, to help people stay healthy and moderate demand on the NHS	Promote community pharmacies as 'health living' centres providing prevention support, advice and services Work with Local Authority public health teams and PCNs to develop greater understanding of the characteristics and needs of local populations Maximise delivery of existing clinical services including hypertension case finding, weight management and smoking cessation Consider extending currently commissioned services or implementing new services to address unmet needs	Better communications platforms/services Improved interoperability of IT systems (including appropriate access to patient records) Funding for piloting and implementation of new service technologies and approaches Sufficiently funded pharmacy workforce (pharmacists and other staff)

The vision	Strategic priorities	Potential Actions	Enabled by
5. Community pharmacy is integral to addressing health inequalities	Develop services to tackle local population health inequalities and address unwarranted variation Maximise community pharmacy contribution to Core20PLUS5[1]	Work in partnership with GP practices, PCNs, Local Authorities and other healthcare providers to develop whole system approaches to inequalities Assess and understand local population health inequalities and unmet need.	Availability and accessibility of population health data

[1] Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort - the most deprived 20% of the population as identified by the Index of Multiple Deprivation – plus ICS-chosen population groups experiencing poorer-than-average health access and focuses on 5 clinical areas for accelerated improvement

The vision	Strategic priorities	Potential Actions	Enabled by
6. Community pharmacy professionals and wider teams are valued and respected	Maximise the skills of community pharmacists, pharmacy technicians, wider pharmacy teams and associated healthcare professionals Address workforce shortages Create a structure that offers workforce development and opportunities	Review commissioning arrangements to actively encourage and optimise appropriate use of workforce/skill mix within services Develop a community pharmacy workforce strategy which is integrated into wider system workforce planning and resourcing Focus on recruitment, retention and wellbeing of the community pharmacy workforce Consider flexible, cross-sector workforce models including shared posts with GP practices and hospitals Reinforce positive image through public messaging, communications and engagement Embed the Quality Improvement approach to learn and expand best practice	Collaborative working with Health Education England (HEE), professional leads (including Local Pharmaceutical Committee) and higher education institutes Promotion of careers in Community Pharmacy Changes to pharmacy training and qualifications Increased community pharmacy placements for trainees Protected learning time Multidisciplinary training opportunities Pharmacy Integration Fund[2] investment Facilitation of independent prescriber training

[2] NHS England » Pharmacy Integration Programme

Delivery of actions

The vision statements and the actions to deliver these have been grouped into four key pillars of work.

Pillar 1 Increase health system integration and partnership

Pillar 2 Optimise services and outcomes

Pillar 3 Improve population health and address health inequalities

Pillar 4 Develop the workforce for delivery

The successful delivery of these four key pillars of work requires a number of enablers to be in place and challenges overcome, these include:

- Improved interoperability of IT systems and appropriate access to patient records
- Shared data, insights and intelligence
- Improved communication and engagement platforms and services
- Appropriate funding and contractual arrangements – nationally and within systems

Pillar 1 Increase health system integration and partnership

Why is this important?

Partnership and shared ownership for improving local population health is at the core of the new way of working.

Whilst ICBs have been legislated as legal entities, it is important to recognise the limitations of what this legislation can realistically achieve. It is not possible to legislate for collaboration and co-ordination of local services; this requires changes to behaviours, attitudes and relationships among staff and leaders right across the system.

As ICBs take on commissioning of pharmacy they will need to take an integrated approach to working and co-ordinating with stakeholders including NHSE, LAs, Healthwatch, acute and community providers, professional representative groups, and contractor representatives.

What needs to change?

Community pharmacy integration must be embedded into system and primary care strategies going forwards. Support is needed for the development of strategic and operational community pharmacy leadership and this leadership must be formally recognised in the governance structure and process.

ICBs and ICSs are responsible for providing system leadership and bringing commissioners and providers together in new collaborative ways of working. Building a culture of collaboration and alignment of community pharmacy with PCNs, GPs and other primary care teams requires protected time and space in which to plan and problem solve together. **Cross service referrals and multi-disciplinary teams will need to be developed to provide agile service delivery teams and treatment pathways**. This will need to be supported with the sharing of expertise and insights, and the pooling of data and information. Multi-disciplinary teams will combine learning, best practice and case studies in determining what 'good' may look like.

Central to enabling collaboration will be the recruitment of pharmacy roles to the ICB, funded by the Pharmacy Integration Fund for the first two years. These roles will work with system partners and key stakeholders to develop and support integration and transformation and are a dedicated resource to champion community pharmacy integration.

Another key enabler for the ICB is the appointment of a Community Pharmacist to the ICB Board, this person is also a member of the Primary Care Commissioning and Assurance Committee providing oversight, leadership and a different perspective on the opportunities for integration and collaboration.

Actions to be delivered under this pillar

- Include community pharmacy leads in all levels of system leadership, strategic planning and pathway design
- Develop the designated PCN Community Pharmacy Lead role
- Map current services for improved understanding of community pharmacy provision and incorporate into wider system resilience and capacity planning
- Develop integrated service delivery models
- Work in partnership with GP practices, PCNs, Local Authorities and other healthcare providers to develop whole system approaches to inequalities

Pillar 2 Optimise services and outcomes

Why is this important?

Over recent years, community pharmacies have already developed and implemented a wide range of clinical and public health services which, support integration and collaboration with other parts of the NHS.

Current community pharmacy services are largely a mix of Essential and Advanced services delivered as part of the CPCF. Please refer to Appendix B for more details

What needs to Change?

Community pharmacy will continue and, where necessary augment, existing services to ensure resilience and to deliver equitable access to services. Alongside this is the need to capture service outcomes to ensure continuous improvements in the quality of care, disease prevention and health inequalities.

Priority clinical areas in the LTP include:

Prevention
Smoking
Obesity
Alcohol
Antimicrobial resistance
Action on health inequalities
Hypertension

Better care for major health conditions
Cancer
Cardiovascular disease
Stroke care
Diabetes
Respiratory disease
Adult mental health services

In addition to the services within the pharmacy contract there are provisions for:

- Nationally services commissioned by NHSE to a national specification
- Locally commissioned services contracted via a number of different routes and by different commissioners, including Local Authorities, ICBs and NHSE local teams

ICBs may want to consider in their primary care strategies the opportunity to develop and commission innovative local services directly, either as a locally commissioned service or by development of the Local Pharmaceutical Services regulations. There are good opportunities for collaboration and for reducing fragmentation of commissioning, for example in the wider rollout of oral contraception supply.

Local health partnerships, including PCNs and Integrated Neighbourhood Teams (INTs), will need to determine how community pharmacy teams best contribute to preventing ill health, early detection of disease and population health management and improvement.

Taking a holistic view will be important, for example, embedding the principles of ‘making every contact count’ into more services with

community pharmacies being able to refer directly to other neighbourhood services.

Actions to delivered under this pillar

- Promote community pharmacy as a clinical provider
- Collaborate on optimised use of agreed pathways
- Monitor service delivery data to improve health outcomes and identify gaps in care
- Further implementation and optimisation of currently commissioned services
    - Maximise delivery of existing clinical services including hypertension case finding, weight management and smoking cessation
- Local commissioning of Patient Group Directives and independent prescriber-led services for the treatment of low acuity conditions in all community pharmacies
- Review the range of services currently offered by community pharmacies and support extension of services to cover gaps
- Consider extending currently commissioned services or implementing new services to address unmet needs

Pillar 3 Improve population health and address health inequalities

Why is this important?

Local health and care organisations and partnerships are increasingly focused on population health. It is not just about putting in standard services to a generic specification but combining local insights and data to ensure that service delivery is appropriate to local population needs.

The CPCF underlines the key role of community pharmacy as an agent of improved public health and prevention, embedded in local communities. For example, community pharmacy will play an increasingly important role in prevention, detection and screening, and case-management in primary care. Support can be targeted at communities with social and economic inequalities and poorer health outcomes and services designed to achieve improvements in population health.

Creating healthy communities

The Fuller report identifies the opportunity that integration of primary care presents to re-balance focus from treating people who have already become sick to helping people to stay well for longer. This aligns with the Core20PLUS5 programme addressing health inequalities with five clinical areas of focus requiring accelerated improvement:

- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case-finding
- Maternity
- Severe mental illness.

This will not only have the greatest impact on the future sustainability of health and care services overall but can genuinely help to transform lives.

What needs to Change?

When planning on how to address identified inequalities and developing preventative health and healthy lifestyle programmes, systems and PCNs need to consider the opportunities presented by community pharmacy. Community pharmacy services that target areas such as prevention of unplanned pregnancies and reduction from drug use harm (needle exchange, supervised consumption, provision of naloxone) can help provide appropriate provision in the right setting. Community pharmacies also offer unique geographical reach for addressing accessibility issues, as was seen in the successful approach to the COVID-19 vaccination programme which made the service more accessible and convenient for patients and therefore improved outcomes.

Actions to delivered under this pillar

- Promote the expertise and knowledge of community pharmacy, including services offered to the public to encourage uptake and to other healthcare professionals to support referral
- Ensure services are consistently delivered, visible and actively advertised to patients/other healthcare providers
- Review demand against current provision to identify accessibility issues and options to address inaccessibility

- Consider innovative approaches to service provision to increase accessibility
- Promote community pharmacies as ‘health living’ centres providing prevention support, advice and services
- Work with Local Authority public health teams and PCNs to develop greater understanding of the characteristics and needs of local populations
    - Assess and understand local population health inequalities and unmet need

Pillar 4 Develop the workforce for delivery

Why is this important?

It is recognised that a resilient and sustainable workforce plays a fundamental role in delivering the aims and goals of the strategy.

The LTP describes the ongoing training and development of multidisciplinary teams in primary and community hubs and making greater use of community pharmacists' skills and opportunities to engage patients.

NHSE and ICBs are working with Health Education England to further clinical education and development for pharmacists and pharmacy technicians. This collaboration is important to deliver the vision and actions and to avoid duplication of effort.

What needs to change?

Pharmacy workforce recruitment, retention and development will need to be a clear and ongoing focus. Each system is aiming to attract, retain, develop and equip a flexible and responsive workforce. Service models will be increasingly based on collaborative working across the primary healthcare system, bringing opportunities for new roles and new ways of working. A region-wide working group is providing the focus on workforce issues, and actions needed to support the required workforce transformation. The working group aims are to:

- Identify capacity and skills gaps and support staff in moving beyond traditional roles to meet changing needs
- Identify new workforce models that consider the roles of different pharmacy team members including pharmacy technicians, prescribing pharmacists, multi-sector foundation pharmacists and opportunities for portfolio working across service teams
- Consider how development of digital and IT infrastructure will change the composition and skill requirement of the future workforce
- Identify how to reposition community pharmacy and it's developing workforce models as a compelling service to work in
- Ensure commitment to supporting the emotional, mental and physical health and wellbeing of staff working in community pharmacy.

A summary of development priorities is given at Appendix C.

Actions to be delivered under this pillar

- Review commissioning arrangements to actively encourage and optimise appropriate use of workforce/skill mix within services
- Develop a community pharmacy workforce strategy which is integrated into wider system workforce planning and resourcing
- Focus on recruitment, retention and wellbeing of the community pharmacy workforce
- Consider flexible, cross-sector workforce models including shared posts with GP practices and hospitals
- Reinforce positive image through public messaging, communications and engagement
- Embed the Quality Improvement approach to learn and expand best practice

Enablers

The Fuller Report (2022) identified a consistent thread throughout the successful case studies was that change was locally led, nationally enabled. Therefore, systems working together, and with NHSE, DHSC and PSNC, will be the most effective route to integration.

IT and digital infrastructure and data services

Key to enabling integrated care is the development of an information management and technology (IM&T) infrastructure that will:

- Increase system interoperability to provide shared care records and e-referral across service boundaries
- Enable community pharmacists and GPs to access the same system
- Support pharmacies to become digitally enabled
- Enable enhanced data and analytic capabilities around population health, service availability, capacity, demand and outcomes
- Improve access to services for patients and transform pharmacy processes including:
    - on-line appointment booking
    - remote access to health advice and guidance
    - video consultations
    - wearable technology to collect monitoring data (such as medicine use, lifestyle, blood pressure)
    - electronic prescribing and dispensing
    - automated stock control
- Transform communication and integration through remote, collaborative working and virtual networking between healthcare teams.

During the COVID-19 pandemic digital technologies transformed the delivery of care in various services. There is opportunity now to build on this and use the potential of digital technologies to help address both long-term challenges and immediate pressures.

Care must be taken however, to ensure that health inequalities are not increased due to inability of population segments to access digital services.

The current picture in terms of community pharmacy digital capacity and effective use of data is complex. An understanding of the current baseline along with national priorities being embedded into the local digital strategy will be key to establishing next steps.

It may be more efficient for certain activities in this area to be coordinated at regional and national level for example:

- Standardisation of data items/definitions
- Production of data sharing agreements to overcome the problem of data-sharing liability
- Engagement with Information and Communications Technology (ICT) suppliers for value for money delivery

Communication and engagement

There is a need for greater patient and public awareness raising on what community pharmacy services offer in order to increase understanding and improve uptake.

At all levels, national, regional, system and place, more needs to be done to inform patients and empower them to seek the most appropriate care for their needs. Joint communication strategies to align approaches to patient communications, maximise effectiveness of available resources and make every contact count will be key. National campaigns should be underpinned by clear local signposting.

Financial and contractual arrangements

Delivering required service changes within the current funding envelope is a recognised challenge. For example the CPCF sets out the direction for community pharmacy services, there is flat funding until 2024 which does not reflect increasing costs and inflationary pressures.

More responsive funding mechanisms may enable clinical interventions are made within community pharmacies. This could include

- Demonstration of the return on investment of locally commissioned pharmacy services
- Development of robust business cases to support appropriate and sustainable funding streams
- Moving away from non-recurrent short-term funding

It is recognised that some level of IT capital investment may be needed to achieve the level of infrastructure required. And also workforce development will also benefit from additional funding.

This investment will be needed to be provided at a national or system level through a combination of reprioritisation and efficiencies.

Future opportunities for community pharmacy

To inform this strategy a rapid scan of published literature was undertaken to identify key developments relating to community pharmacy. Please refer to Appendix D for list of references.

Looking into the future, advances in medicine could radically change the way illness is managed. For example, drug treatment will be personalised to each individual ensuring the most effective treatment with the minimum risk of adverse effects.

At the same time the delivery of healthcare will need to evolve. The reasons for this are multifactorial and include the changing needs and expectations of the population and the ability of the public purse to fund services to meet those expectations.

Community pharmacy will have a key role in making patient care personalised, enabling patients to be involved in choices about their medicine treatment, deprescribing if appropriate and having direct referral to a range of other services.

The report by the Kings Fund - *A professional Vision for pharmacy practice in 2032,* sets out the possibilities for community pharmacy in the next 10 years envisioning an integrated multidisciplinary system enabled by IT and automation, supported by artificial intelligence. This technology supports safer medicines supply and releases clinical time within community pharmacy for one-to-one interaction, virtual or in-person, with patients.

Community pharmacy is already the easy access health hub within a community but additional clinical input can be used to enhance population health, for instance through early detection of illness and prevention of ill health.

The key themes identified in this strategy document: workforce; digital enablement; system integration; and development of clinical services; provide the steps to achieving the long term (5-year plus) vision.

The international horizon scanning indicated that throughout the world there are similar intentions to modernise the way pharmacy is delivered with a greater emphasis on clinical service delivery within integrated systems. With a few notable exceptions, such as Canada getting pharmacists to deliver long-term condition management and Estonia's digital integration of pharmacy, no country has made significant progress at scale. Most examples are small scale pilots or professional group's strategic intentions that require wider buy-in.

There has been progress where the health economies are well integrated and have a unified approach to care, so the recent formations of ICSs bode well for UK pharmacy development.

The Health Education England's initial training and education of pharmacists' reform programme culminates in 2026 with all newly registered pharmacists being able to independently prescribe medicines. This initiative will require all systems to have a strategic plan for how these new pharmacists, and already practising independent prescribers (IPs), will support the systems prescribing priorities in a fully integrated way. Due to community pharmacies access to the most deprived parts of the community there are opportunities to utilise pharmacists' independent prescribing qualifications to address health inequalities. Development of the existing workforce, to become independent prescribers, will require sufficient designated prescribing practitioners (DPPs) and designated medical practitioners (DMPs) to support the training programmes. Community pharmacy Scotland have funded community pharmacy DPPs to work with two pharmacists undergoing independent prescribing training.

There is now a contractual obligation for all community pharmacies to complete the annual pharmacy workforce survey and this will provide an opportunity for each ICB to fully understand the complete local pharmacy workforce priorities and opportunities.

The successful scheme “walk in my shoes” has demonstrated the power of job shadowing to improve collaboration and integration between different practitioner groups. This model could be applied to improve patient care and reduce duplication of effort.

A number of proof of concept pilots are already underway to trial new ways of working to deliver improved services and outcomes for patients and service users. For NHSE East of England are piloting a scheme across the region to provide community pharmacies read and write access to consenting patients’ primary care records. The Community Pharmacy IT Integration Pilot (TPP Pilot) aims to:

- Enable community pharmacies and GP practices to send each other tasks via the system, and where permission is given, book appointments for patients in each other’s settings
- Improve integrated working between GP practice teams and community pharmacies by providing an audit trail of activity where patients have been referred from one setting to another
- Enable healthcare professionals to follow-up on tasks as required, and thereby create potential to improve patient care. Previously referrals would be sent via phone, e-mail or by asking patients to make appointments directly – with no way of primary care professionals following up on activity post-referral

The pilot will be implemented using SystmOne with up to 40 pharmacies being involved. The pilot is expected to commence in November 2022.

Next steps

To move from vision; to prioritisation; to action, systems need to develop local strategies, working pan regionally where is makes sense to “do once” or collaboration around a regional issue is needed.

Recognising that systems have differing priorities and timescales; it is recommended that systems

- Work to understand the needs and priorities of the local population; and which and how the priorities and actions identified in this strategy can implemented to support local needs

  This will be supported by reference to the area Pharmacy Needs Assessment (PNA), Joint Strategic Need Assessment (JSNA) products and the Joint Health and Wellbeing Strategy (JHWS)

- Make evidence-based decisions on service priorities focused on key issues and priorities
- Assess current status of digital infrastructure and system interoperability, and improvements required to support integration of community pharmacy
- Identify challenges for development and opportunities to address these challenges
- Develop detailed operational and implementation plans for short- and medium-term actions in line with the strategic priorities on the pathway to longer-term strategic changes
    - This will include revising commissioning arrangements, moving away from isolated commissioning to joint commissioning by local authorities and health organisations
    - Implementation of new services, or of new models of delivery for existing services, will need to be done within capacity and capability constraints

A Regional Community Pharmacy Strategy Board, comprising of the six systems, NHSE and wider stakeholders, will remain in place to help coordinate actions delivered across the East of England, provide networking of good practice and support systems. The Board will also **agree within six months** of the publication of this strategy the measurable outcomes for each of the following vision statements

1. Community pharmacy is an integral part of primary and community care, leading to improved outcomes for patients and facilitating better access
2. Community pharmacy is embedded in pathways across the wider health and care system
3. Community pharmacy is a patient centred service that is the first point of contact for many patients
4. Community pharmacy is integral to the delivery of self-care, avoiding ill health and improving population health
5. Community pharmacy is integral to addressing health inequalities
6. Community pharmacy professionals and wider teams are valued and respected

This strategy will be refreshed and updated on a regular basis to align with national development and system plans.

Appendix A – East of England integrated care systems

Note: the information in the summaries below is exactly as provided by the systems. No re-formatting/re-structuring has yet been attempted

Our integrated care system is committed to working together to improve the health and care of our local people throughout their lives. Our services will be designed to fit together around people and as such we recognise that community pharmacies represent the healthcare services that our people choose to use more frequently than any other.

As pharmacies are embedded in the heart of our communities, perfectly placed to address inequalities, we will jointly develop pharmaceutical services to help improve the lives of people in our communities.

Our heathy living pharmacies will help create an environment that is easily accessible giving our people the opportunities to be as healthy as they can be.

We will listen to our patients and develop local pharmacy services to meet the needs of both our population and the system through the commissioning of clinical services. We will enhance our programme of early intervention and detection of long-term conditions to help support improved outcomes.

Recognising that whilst prescribing is the most common intervention made in healthcare and yet can also cause significant harm, we will prioritise medicines safety through utilising the community pharmacy workforce expertise in medicines optimisation.

We will ensure that the full range of care professional and clinical leaders from diverse backgrounds are integrated into system decision making at all levels. As such community pharmacy leaders will be involved and invested in planning and delivery at system, place and neighbourhood level.

Our Plans for Community Pharmacy

- Increase the use of the Discharge Medicines Service
- Improve digital connectivity between providers through the local and national SystmOne pilot
- Maximise the use of community pharmacy PGDs e.g. the insect bite service
- Increase referrals via the Community Pharmacy Consultation Service
- Supporting pharmacies to deliver self-care & self-management for both minor ailments & long-term conditions
- Make best use of prevention services – vaccination services, hypertension case finding, smoking cessation, weight management etc.
- Increase the number of prescriptions ordered via the electronic repeat dispensing service.
- Expand the current oral contraceptive pilot
- Support workforce to minimise unexpected closures

Norfolk & Waveney ICB benefits from long-standing and extremely positive relationships between system leadership and staff and the community pharmacies in our area and their representatives at the LPCs. This has led to the long-standing commissioning of pioneering services such as our local direct-access Urgent Medication Supply Service, the Medicines Support Service, and Palliative Care service.

This collaboration continues to develop as we moved to devolved commissioning. Alongside early integrated pharmacy and medicines optimisation (IPMO) work, which highlighted accelerating the uptake of community pharmacy services, our N&W Community Pharmacy Integration Group has been meeting bi-weekly for over 12 months. With a membership including our Deputy Head of Medicines Optimisation, GP Clinical Lead, LMC and LPC representatives and additional resource drawn from digital etc., this group has effectively led on developing pharmacy service integration to date.

A good example of the benefits of this group's work is the support they have provided to pharmacies and surgeries alike in terms of guidance on dealing with pressures, including how these partners can help each other. These N&W resources have now been incorporated into national guidance.

https://norfolk.communitypharmacy.org.uk/pharmacy-contract-it/regulatory-matters/unauthorised-closure-of-pharmacies/pharmacy-surgery-pressures-guidance-and-resources-for-pharmacy-display/

Recognising that our community pharmacies are, sadly, at a national epicentre of workforce shortages, we have been developing a pharmacy workforce plan, which is now well-advanced and is currently being integrated into our wider workforce planning. It is unfortunately true, though, that the pharmacy workforce crisis has and is affecting the sector's ability to consistently engage with some developments, and has had an impact on service delivery, and perhaps confidence in some pharmacy services. Supporting pharmacies through this challenging time and seeking to maintain and improve working relationships between our pharmacies and surgeries/PCNs are fundamental to securing the foundations for future integration and development.

Building on the national picture, we recognise that integrating community pharmacy is and will increasingly be integral to the delivery of seamless high-quality patient care as set out in the Long Term Plan. It is therefore vital that across all levels of the ICS for Norfolk and Waveney that we include senior sector representatives in emerging structures, such as membership of the new Primary & Community Care Programme Board. As our network develops, we will seek to support further engagement and integration and Place and PCN level as appropriate.

It is recognised that plans for working with and developing community pharmacy services cannot and should not "stand alone", and so such plans will be intrinsically linked to our wider system strategies and planning.

Our Norfolk and Waveney landscape

Community Pharmacy in Norfolk and Waveney comprises 182 contractors, all of whom work largely independently of each other. We also have 105 GP practices and 17 Primary Care Networks (PCNs), all at different stages of maturity and development. Community Pharmacy are involved in PCNs to varying degrees across the patch and the newly formed ICS offers opportunities to developing relationships across system, place and PCNs.

Norfolk and Waveney has a unique geography potentially impacting on recruitment and specifically attracting new workforce to the area. As depicted by the map below, Norfolk and Waveney is the furthest easterly point in the East of England region, with vast coast line and a mix of rural and urban landscape.

Pharmacy sectors have always collaborated well across the Suffolk and Northeast Essex (SNEE) ICS footprint, but this has been strengthened over recent years as the ICS structures continued to form. This will be key as the system prepares for the devolved commissioning of the community pharmacy contract and is being supported with increased capacity through the appointment of a Community Pharmacy Clinical Integration lead.

Recent initiatives include work on developing an Integrated Pharmacy and Medicines Optimisation (IPMO) Strategy and laying the foundations for the integration of nationally commissioned community pharmacy services into patient pathways. This has led to growing support for the use of community pharmacies as the experts in the management of minor ailments, as an accessible entry point for prevention and public health services and as a fundamental part of the primary care team.

The pandemic has demonstrated without doubt, the benefits that further development and integration of the community pharmacy network would deliver for our local population. The sector showed itself to be resilient, engaged, and innovative in the way that it rose to the challenge and the ICS has continued to work with the sector to build on this. This has led to involvement in innovative NHSEI service pilots such as the Oral Contraceptive Management Service, which is providing important insights as to how such a service could be commissioned nationally. A further pilot on IT integration through SystmOne is also being supported and community pharmacy continues to play an important role in the Covid Autumn Booster Campaign.

System partners are also clear that integration needs to happen, not only in terms of service development but also the enablers that underpin true integration. SNEE has supported an initiative around the integration of community pharmacies with Primary Care Networks across the ICS and this will be developed further over coming years. Community pharmacy has been included in the Digital Strategy for the system so that the unique challenges the sector has around digital interoperability and data sharing can be addressed. The ICS is also developing a comprehensive pharmacy workforce strategy across all pharmacy sectors to ensure we have a sound foundation for optimising the role that pharmacists can play in all sectors in improving the health and wellbeing of our population. We are also starting to see the commissioning of locally funded community pharmacy services targeted to the support of patient need such as the Palliative Care Service.

There is also a recognition that community pharmacy should be involved at a strategic level and the ICB has welcomed community pharmacy representation as part of the ICP. As ICS strategies continue to develop, the contribution that community pharmacy can make to primary care can be fully recognised and this strategy will be used to feed into that wider strategic planning.

Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System is committed to embedding integrated working and sees the transition of community pharmacies services to the ICB as a key enabler to support this.

In preparation for the transition a community pharmacist has been appointed to the ICB Board and the Primary Care Commissioning and Assurance Committee. The ICB has long standing, collaborative relationships with community pharmacies and has been able to build on this through funding and supporting community pharmacy representation at each of our four place-based boards representing our commitment to ensure the voice of the community pharmacy is at every level of the system.

BLMK will work with patients, voluntary sector, clinical networks, local authorities and community pharmacists to review and redesign clinical and social care pathways to address local health inequalities. We will do this by planning a targeted approach on the community pharmacy enhanced service programme to ensure the services offered will have the most impact and beneficial outcomes that supports our initiatives to "start well", "live well" "age well" and "growth".

BLMK was a national early implementer utilising our community pharmacists to successfully deliver the covid vaccination programme and this was and continues to be a catalyst for change and has enhanced relationships with our GP practices and Primary Care Networks which we will develop further.

Community pharmacies are at the centre of our communities and are one of the only primary care providers where a patient can directly access advice and support from a clinician. In BLMK we believe that access to health services is a system approach and we will commit to increasing the number of referrals to the Community Pharmacy Consultation Scheme. This is an opportunity to support GP contractors and Community Pharmacies. We will do this by aiming to transition 6% of all appointments from General Practice to our community pharmacies over forthcoming years.

Fundamental to our strategy is digital programme to enable community pharmacists to have access to patients' clinical records held on GP practice systems. This is an ambition that the ICB would like to pursue. It is in a strong position as all BLMK practices use SystmOne. To support this ambition the ICB has agreed to pilot this option and the learning from this will be further developed to see what is potentially feasible whilst ensuring that robust information governance is in place and patient consent.

The ICB is currently rolling out "Shiny Mind" app to our GP contractors this is a new national programme that provides training to clinical staff though a train the trainer model. The app is a wellbeing resource to promote self-management and self-efficacy utilising virtual prescribing at scale to chosen conditions, specific patient cohorts via a portal which uses content management system (CMS). This includes behaviour change nudges tailored by the clinician through communications with patients, supported by a messaging service. Evidence has shown that 'positive behaviour nudges' results in improved clinical outcomes e.g. population health. Research found that patients with diabetes sent personalised text messages had a positive outcome and saw HBA1C levels fall. Behavioural nudges have the potential to expand into wider public health programmes and the ICB is keen to explore the opportunities and aim to offer to our community pharmacies over the next 1-3 years.

Underpinning this work the ICB will work in collaboration with Bedfordshire and Buckinghamshire Local Pharmaceutical Committees whose role is to advise pharmacy contractors on all matters to improve pharmaceutical services to our local population. This will include discussions on how we can support contractors, take forward our system plans ensuring the intended outcome is beneficial for contractors and the local community.

Successes

- Community pharmacies across Hertfordshire and west Essex (HWE) have been pivotal in embracing the COVID vaccination programme. An increased number of patients have been able to be vaccinated due to the longer opening hours of community pharmacies. In some cases, extra clinics have been set up on a Sunday to accommodate for patient demand. A number of pharmacies providing the vaccination service, are also situated in areas of inequality. This has vastly helped to meet the needs of the local population and in turn has helped increase accessibility to the vaccination service.
- Community pharmacies are central to their communities. They are recognised locally by the public and the wider system for their continued efforts and invaluable contributions, supporting throughout the pandemic in what has been a continuously changing and challenging environment.
- Pharmacists worked closely with voluntary organisations to ensure all patients including those most vulnerable had access to their medicines. Many pharmacies set up a home delivery service with the help of volunteers delivering medicines. Some pharmacists also tapped in to the support of St John's Ambulance volunteers and community nursing teams to help vaccinate patients. This brought about a more joined up working approach and helped alleviate pressures that pharmacists were faced with in their day to day job.
- Existing established pharmacy networks in west Essex have brought pharmacists together from all sectors. Cell network set ups across HWE by pharmacy leaders have enabled pharmacists to feel supported when faced with challenges. Conversations have focussed on providing solutions and the sharing of best practice.
- Some community pharmacies played an important role in supporting local GPs by vaccinating care home residents and ensuring the supply of medicines to care homes was still maintained during the pandemic.
- HWE ICB works closely with the Local Pharmaceutical Committee (LPC) for Hertfordshire and West Essex. Both LPCs are active members of various committees and provide input and community pharmacy leadership on numerous work streams. Working with the LPCs has made a tangible difference to the involvement of Community Pharmacists in existing and new enhanced services such as GP CPCS. All practices within HWE were trained on GP CPCS by the LPC. GP practices were also provided with a number of reference resources to guide them. The LPC continue to support pharmacies with this service. GP CPCS has been successful across HWE and the vast majority of GP practices are referring to pharmacies.
- Some Pharmacists will also be involved in the NMS anti-depressant pilot and the SystmOne pilot. These NHSE pilots are providing a great opportunity for pharmacists to work more closely and collaboratively with primary care.
- HWE ICB had funding approved by Health Education England (HEE) to pilot a lead Community Pharmacist in each PCN locally. Other PCNs within the East of England, will also have the opportunity to be involved in this pilot.

- HWE ICB is proactively considering the part community pharmacy plays or could play in all pathways through its nationally commissioned services such as hypertension.
- HWE as part of the East of England prioritised the transfer of hospital discharge medicines information to community pharmacies. Acute Trusts have been involved since 2018 and this is now embedded as the Discharge Medicines Service.

Quotes from Community Pharmacists across HWE

Quadrant Pharmacy has been privileged to be part of the Covid-19 vaccination programme since January 2022, and our whole team is looking forward to supporting the Autumn booster programme for our local community.

The whole community pharmacy network has pulled together throughout the Covid pandemic, and the vaccination programme is one example of where we have worked with each other, and our local CCGs/ICB, to give integrated care to our population. We welcome the support we have had from the local NHS teams, and look forward to continuing collaborative working with our GPs and PCNs. Hopefully by expanding the community pharmacy network of vaccination hubs, we will be able to give a wider spread of local sites for vaccinations on all of our patients' doorsteps.

-Rachel Solanki

Superintendent Pharmacist, Quadrant Pharmacy & Chair, Community Pharmacy Hertfordshire.

Easter pharmacy has been working closely with the local PCN enabling the housebound patients to receive their Covid and Flu vaccinations promptly. We are starting to also work closely with local surgeries regarding monitoring of blood pressure. We provide advice and assistance to local patients via GP CPCS with regards minor ailments ultimately saving GP appointments.

-Babatunde Sokoya

Easter Pharmacy, west Essex.

Challenges

Challenges outlined in the strategic priorities document include, digital interoperability, workforce and funding. Conflicting commissioning arrangements can inhibit collaboration. The key aim is to build trust across primary care providers. HWE ICB, has developed a number of actions and enablers to address these challenges as part of the Community Pharmacy East of England five-year strategy.

- CPCS has been successful in some areas but there is further progress to be made in other areas
- For both CPCS and hypertension service addressing the requirement for formal referral to be able to action, if that can be removed or amended then pharmacies will be able to provide a wider service.

The Mid and South Essex (MSE) Primary Care Strategy -will be updated for 2022/23 following receipt of the NHSE response to the Fuller Report and will drive integration of community pharmacy building on local successes to date.

Nationally commissioned Services

- **NHS 111-CPCS-** The majority of community pharmacies across MSE are signed up to provide this advanced service.
- **GP-CPCS-** In the first 6 months of 22/23 approximately 2,500 CPCS referrals were processed by community pharmacies across MSE, only 5% of which required urgent redirection to a GP. The local focus is on promoting the adoption and spread of CPCS referrals across a larger number of GP practices to more fully utilise the benefits this pharmacy service offers.
- **Discharge Medicines Service-** The ICB is working closely with MSE hospitals to overcome local implementation challenges in order to increase DMS referrals above current relatively low levels due to workforce and IT issues. Local community and mental health providers are also able to refer, including from Virtual Frailty wards. There remains significant scope to increase the local benefits.
- **Smoking Cessation Advanced Service-** 75 pharmacies across MSE are signed up to provide this service and will be linked with the Hospital Health Managers currently being recruited.

Locally commissioned services-

- **Sexual Health Services**- commissioner-local authorities
- **Smoking Cessation Services** -commissioner- local authorities-
- **Substance Misuse Service** -commissioner- local authorities
- **Warfarin Independent Prescribing/PGDs** - commissioner ICB

Integration of Community Pharmacy and GP practices through framework and PCN DES contract: e.g.: CPCS; hypertension case finding; vaccinations; NMS, IIF- carbon inhalers and DOACs.

Innovation within MSE

- **Community Pharmacist PCN Leads -** during 2021/22 MSE funded protected time for 27 PCN leads to link with PCN clinical directors and develop local working relationships; and will be continued in 2022/23.
- **SystmOne pilots:** Chelmsford West PCN and one community pharmacist linked with a practice in Southeast Essex are taking part which provides read/write access to patient records, includes the pilot oral contractive service and is due to go live in September 2022.
- **New Medicines Service Pilot for antidepressants** - pharmacies in Aveley, South Ockendon and Purfleet (ASOP) PCN in Thurrock will be completing training in Sept and going live late Sept/Oct. This has been achieved through joint working with mental health, local authority and health taking a multiagency approach.
- **HPV-MSM and Monkeypox vaccination pilots -** 6 pharmacies are providing the HPV vaccinations, of which 2 are also providing Monkeypox vaccination.
- **Community Ear Health service- part of Audiology Pathway-** shortly to be piloted in three community pharmacies spread across MSE to support initial assessment for hearing loss which will include wax removal if necessary, using commercial technology.
- **Community Pharmacist Independent Prescribing**-there are a small number of IP community pharmacists currently providing private services, providing an opportunity to commission services to utilise this workforce in the NHS.
- Additional **Pharmacy First** initiatives are under consideration.

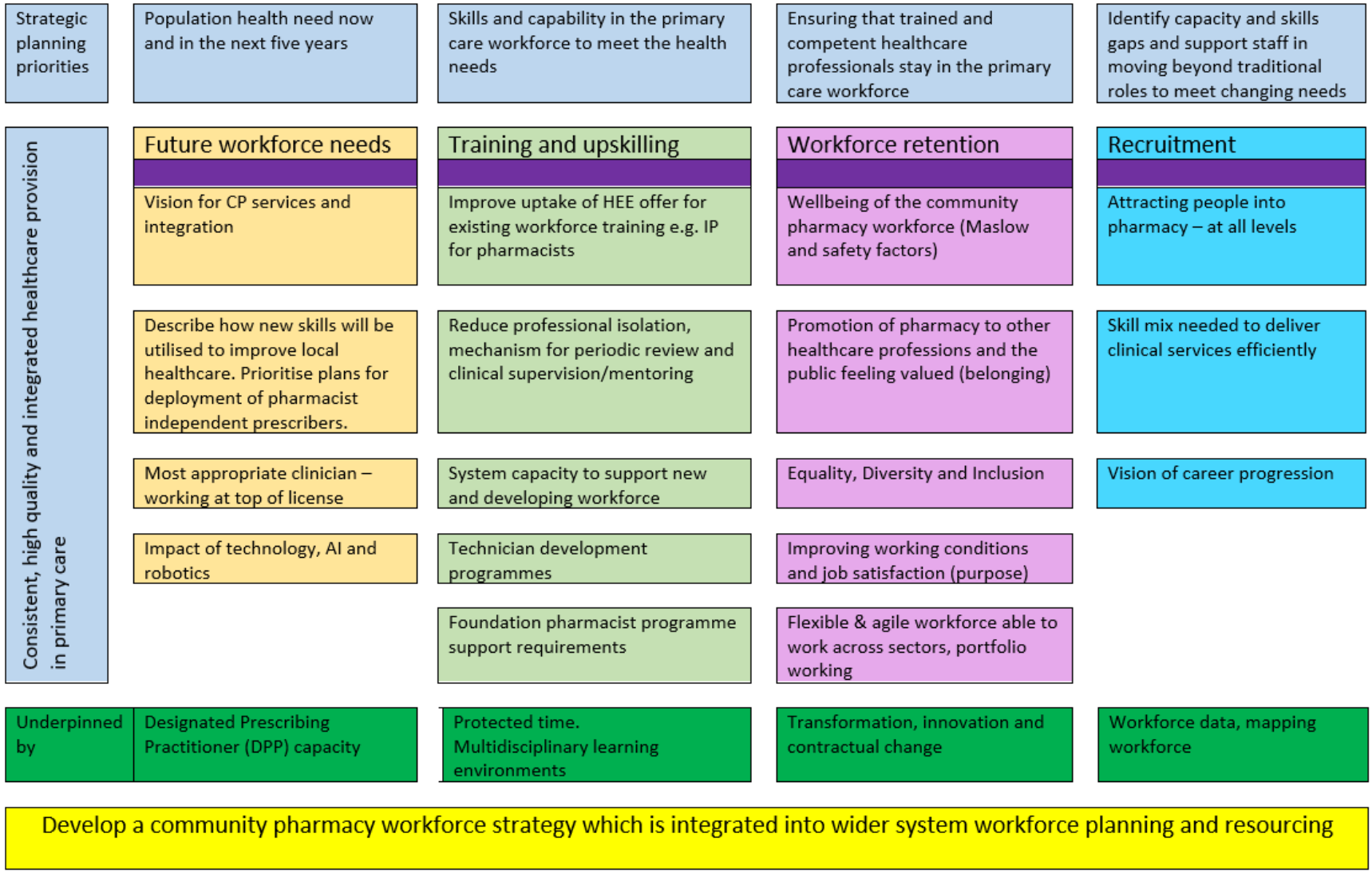
Appendix B – CPCF services as of 2022/23

Essential services - offered by all pharmacy contractors as part of the pharmacy contract
Discharge Medicines Service Provide extra guidance around prescribed medicines to patients referred by NHS Trusts
Dispensing Appliances
Dispensing Medicines and Electronic Prescription Service
Disposal of unwanted medicines Accept back unwanted medicines from patients
Healthy Living Pharmacies Provision of a broad range of health promotion interventions. All pharmacies were required to become Level 1 HLP by April 2020
Public Health (Promotion of Healthy Lifestyles) Participate in up to six health campaigns at the request of NHS England and prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation
Repeat Dispensing and electronic Repeat Dispensing Dispense repeat dispensing prescriptions issued by a general practice; ensure that each repeat supply is required; and seek to ascertain that there is no reason why the patient should be referred back to their general practice
Signposting Help people who ask for assistance by directing them to the most appropriate source of care and support
Support for Self Care Help to manage minor ailments and common conditions, by the provision of advice and where appropriate, the sale of medicines, including dealing with referrals from NHS 111

Advanced services – community pharmacies choose whether or not to provide these services
Appliance Use Review
Community Pharmacist Consultation Service
Flu Vaccination Service
Hepatitis C Testing Service
Hypertension case-finding Service (NHS Blood Pressure Check Service)
New Medicine Service
Pharmacy Contraception Services
Smoking Cessation Service
Stoma Appliance Customisation

Locally commissioned services and Patient Group Direction (PGD) based services – community pharmacies choose whether or not to provide these services
Interventions to reduce alcohol use
Substance misuse support, supervised consumption and needle/syringe exchange service
Support services for self-management of long-term conditions e.g. diabetes
Weight management
Pain management
Early cancer detection
Mental health support
Women's health services and sexual health including, chlamydia screening and treatment, menstrual health and menopause
Infected insect bites
NHS health checks
Emergency supply
Palliative care
Collection and delivery services (non-funded - temporarily funded as a pandemic service)

Appendix C Workforce development priorities identified by the East of England task and finish group



Appendix D - Horizon Scan Review

The ambitions for community pharmacy within this strategy align with the recently published *A vision for pharmacy practice in England* (rpharms.com), Jun 2022) commissioned to support the Royal Pharmaceutical Society working with The King's Fund, which aims to capture the key changes in the landscape from 2016 to inform the development of the vision of the future for pharmacy. References are made to key areas of development in the devolved nations and further afield within community pharmacy, and these include increasing focus on professional clinical services, including prescribing; increasing adoption of technology, particularly electronic health records and e-prescribing but also prescription dispensing machines and remote dispensing robots; contract reform in community pharmacy, and increasing the proportion of capitated and service-related payments as opposed to dispensing.

A review of the community pharmacy workforce 2021 and beyond (cpwdg-report-a-review-of-the-community-pharmacy-workforce-final.pdf (wordpress.com), June 2021) looks at the future direction of community pharmacy, how it can support the NHS and assesses how, with the requisite investment, the pharmacy workforce can meet these demands. Recommendations include a collaborative approach to ensure that community pharmacy is an attractive career choice for future pharmacists; development of frameworks and infrastructure, including services, to allow pharmacists and pharmacy technicians to use their clinical skills, a collaborative approach to ensure the updated Initial Education and Training standards Standards for pharmacy education | General Pharmaceutical Council (pharmacyregulation.org) are implemented in a way that meets the needs of colleagues, employers, the NHS and most importantly, patients.

As part of the HEE three-year programme of education and training for post-registration community pharmacy professionals and in preparation for 2026, when all pharmacists will be able to independently prescribe at registration, almost 3,000 funded training offers will be available from Autumn 2022 for current pharmacists eligible to undertake independent prescribing training Independent Prescribing | Health Education England (hee.nhs.uk) In addition to this, new 'pathfinder' sites will be launched across England from the beginning of 2023 which will include NHS-funded pharmacist prescribing services based in community pharmacies. The sites will be based in integrated care organisations and will become a "test bed" for a potential wider rollout of independent prescribing services through the community pharmacy contract in England Pharmacist independent prescribing pilots will begin across England from 2023 - The Pharmaceutical Journal (pharmaceutical-journal.com).

Community pharmacists in England will also be offered funded clinical skills training, expected to start in December 2022.

Key learnings, principles and priorities for transformation of the pharmacy profession are outlined in *The Future of Pharmacy in a Sustainable NHS: Key Principles for Transformation and Growth* (Future of Pharmacy Policy Asks.pdf (rpharms.com), Jul 2020) developed in response to the COVID-19 pandemic. It describes the need for Community pharmacy to be fully integrated into, and supported to deliver, NHS services as a valued and recognised NHS provider. Pharmacy teams must be fully integrated and utilised across primary and secondary care to support a seamless patient journey through mobilisation of the whole of the pharmacy workforce, ensuring clinical expertise is used across the system.

Pharmacy in Place. The Future for Community Pharmacy in Integrated Care Systems (SME v1 (bbi.uk.com), June 2021 provides a blueprint for

ICSs to develop Community Pharmacy in a way that takes account of the critical issues that have arisen for post pandemic, the shift in commissioning to ICSs, NHS LTP priorities and emergent and innovative technologies that are set to radically change the delivery of health care and population health management. The spheres of activity relevant to Community Pharmacy include:

- Restoring service delivery in primary care and community services
- Maximising diagnostic capacity
- Enhanced discharge arrangements
- Reducing pressure on A&E through the national NHS111 programme
- Increased capital to support urgent care
- Addressing health inequalities

The key areas for an ICS in the deployment of community pharmacy services will include:

- Extending the Community Pharmacist Consultation Service
- Personalised medicine and improving diagnostic pathways
- Developing pharmacogenomic services

Better integration and interoperability across healthcare settings requires digital health care solutions to enable community pharmacy to manage demand and meet patient needs.

A new pharmacy in Letchworth, Hertfordshire, has considerably invested in new technologies to improve efficiency and their dispensing robot frees up pharmacists' time. *Automation and services: 'Pharmacy of the 21st century' opens in Letchworth* (Automation and services: 'Pharmacy of the 21st century' opens in Letchworth|Chemist+Druggist :: C+D (chemistanddruggist.co.uk), February 2022). After a patient requests their prescriptions electronically, the pharmacy dispenses it and sends the patient a text once it's ready. Patients can then collect their prescription from collection points which operate 24 hours a day.

A next generation patient medication record system that works with a centralised Hub and Spoke model and supports the pharmacists to manage their workload has unlocked potential for new services, providing a more service-led community pharmacy offering for patients. *How one team rolled out a bespoke dispensing model to 700 pharmacies* (How one team rolled out a bespoke dispensing model to 700 pharmacies :: C+D (chemistanddruggist.co.uk), June 2021). New handheld devices help staff in branches track and locate medicines and patients are updated via an SMS system.

Read and write access to a full and integrated electronic patient record will enable pharmacists to provide better advice to patients, the ability to improve medicines optimisation, make more informed clinical decisions and improve medication safety. A pharmacy explains how read-write medical record access and the ability to instant message doctors in surgery has derived huge benefits. (The award-winning pharmacy with full read-write patient record access :: C+D (chemistanddruggist.co.uk), January 2020)

Patients and other health professionals will increasingly rely on the clinical knowledge and skills of community pharmacists who will deliver a wider range of clinical services as part of cross-sector, multi-professional teams, working to deliver joined-up, integrated patient care pathways.

A good example of this is provided by the team at Fferyllwyr Llyn Cyf explain how their innovative acute conditions service has demonstrated

that community pharmacies are ideally placed to offer high quality, timely healthcare to patients thereby reducing pressure on GP practices. Under the scheme, patients can walk in, phone for an appointment or be referred by their GP. They can be seen in a matter of minutes for a range of minor ailments including skin conditions, migraines or headaches, and urinary tract infections. *How one pharmacy team rolled out an acute conditions service.* (How one pharmacy team rolled out an acute conditions service and bagged two C+D Awards in the process :: C+D (chemistanddruggist.co.uk), September 2021)

There also needs to be an increasing awareness of climate impact and delivering sustainable, greener services for example:

- Reduction of plastic packaging
- Re-usable devices
- Referral of patients to green initiatives such as walking and cycling outdoor activities
- Electric service vehicles

Glossary and abbreviations

Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐
	HWE ICB Primary Care Board		Meeting Date:	24/11/2022
Report Title:	HWE ICS Digital Strategy		Agenda Item:	09
Report Author(s):	Adam Lavington, Director of Digital Transformation, HWE ICB			
Report Signed off by:	Frances Shattock – Director of Performance and Delivery, HWE ICB			
Purpose:	Approval ☐	Decision ☐	Discussion ☒	Information ☒
Report History:	■ ICS Strategic Digital Board – 20/09/2022 ■ ICS Wider Executive Team Meeting – 26/09/2022			
Executive Summary:	The NHS Long Term Plan includes national requirements for digital that are expected to be delivered at ICS level from July 2022. NHS England therefore requested initial Digital Investment Plans at ICS level by July 2022. The HWE ICS Digital Strategy and costed 10 year plan was produced to meet this requirement and ensure our collective ambition and direction is clearly articulated. The national What Good Looks Like (WGLL) digital maturity framework supports a system approach to driving up digital maturity, it outlines seven success measures and sets out the expectations for a mature, well developed, digitally enabled organisations. The ICS Digital Strategy focusses on enabling our professionals to transform the services to meet the needs of our residents. The strategy has been developed collaboratively with system leadership, transformation teams, clinicians, digital leaders and supporting roles in various discussions, forums and workshops involving in excess of over 100 key stakeholders across social care, the third sector and our health care partners. The strategy and the associated investment plan is built around five key areas of focus that came from those discussions, and which are building on work already in progress across the ICS. The five themes are: 1. Digital Collaboration – System Wide Collaboration 2. Digital Platforms – Essential Strategic Digital Platforms 3. Digital Direct Care – Proven Digital Care Enablers 4. Digital Innovation – Local Digital Care Innovation			

	5. Digital Skills – Digital Inclusion and Workforce Capability Clear strategic digital investment and delivery principles, aligned to current health and care sector best practice, underpin the ICS Digital Strategy. Hertfordshire and West Essex ICS Digital Strategy 2022 – 2032 Video link: Hertfordshire and West Essex ICS Digital Strategy 2022 - 2032 - YouTube
Recommendations:	The ICB Primary Care Board are asked to note the ICS Digital Strategy and high level 10 year delivery plan.

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
Digital Strategy 2022 – 2032

LOADING

Working together
for a healthier future

Contents

Foreword

Dr Jane Halpin – Chief Executive Officer

SRO For Digital Transformation
Hertfordshire and West Essex ICB

Our Integrated Care Board (ICB) aims to improve health, wellbeing and care for the population of Hertfordshire and West Essex (HWE). Formal documents, such as the NHS Long Term Plan, set out national ambitions for improvement over the next decade and underpin the important role of technology in future health and care services. These documents set out key priorities for digital services which will radically change the way we can support and care for local people.

In today's world, we are living longer so keeping healthy and connected is more important than it has ever been. We want to make sure local communities are thriving and vibrant places, where there is choice in every aspect of our daily lives including health and care. We increasingly accept and expect digital technologies to make our lives easier – online shopping and banking, booking of holidays or days out, or communicating and socialising with friends and family. It is right and timely that these expectations extend to wellbeing through health and social care services.

The pandemic enabled us to achieve levels of digital change that might otherwise have taken many years. So it is critical we build on that progress and ensure that all of our health and care providers across Hertfordshire and West Essex have strong foundations for a digital future. The national 'What Good Looks Like' framework has seven success measures that helps us check we understand our own position and progress in terms of having the right ICS-wide digital and data strategy.

It supports us to identify digital and data solutions for improving health and care outcomes, by working with local residents, partners and front line staff. Better and faster sharing of information between residents, patients and care staff gives residents a better experience and also helps us make services more efficient. Digital tools that capture information or carry out analytical tasks will help increase safety and quality. New approaches to providing care can depend on our digital capabilities – whether that is 'virtual ward' approaches that support people in their own homes, or the ability to send scans and pictures for expert diagnosis without needing patients to travel long distances.

Our digital strategy is ambitious and forward looking – and we don't expect the journey to be easy to deliver. It will give us the base to build better pathways for residents now and in the future. I am grateful to all those who have already helped get us to this point and looking forward to working and collaborating more closely with colleagues to turn this into reality, to better support the people we serve in Hertfordshire and West Essex

Adam Lavington – Director of Digital Transformation

Hertfordshire and West Essex ICB

Digital technology is such a vital part of our daily lives and why should health and social care be any different. In Hertfordshire and West Essex, we have a unique opportunity to embed digital technology as an enabler for the delivery of our wider ICS strategy. The right technology can give people choice, improve patient safety, drive better commissioning decisions whilst also targeting health inequalities and service pressures thereby ultimately improving resident outcomes at a population level.

The NHS is on a digital transformation journey unknown before in health and social care and the Hertfordshire and West Essex ICS ambition is to be a leader in this space in the next five years and beyond. Our system is under great pressure and our clinicians and residents have the right to be able to have access to the right technology that will enable a partnership between our residents, our clinicians and our social care services. We believe that after extensive stakeholder engagement, our strategy, digital vision and the themes identified, give us a strong foundation and the ambition to transform.

We plan to remove paper from our system through new electronic records and enable access to those records where and when needed. We will use technology to give our residents the tools to stay healthy in their homes and stay connected to a healthcare professional where needed. We will ensure that we are innovative and invest in technology in robotics, Artificial Intelligence and precision medicine so that we can not only speed up diagnosis but remove duplication and provide care that is focussed on an individual's needs.

We will also ensure that no one is left behind by our decisions and that our residents and colleagues are able to co-produce with us so our technology solutions help realise their maximum potential. Plus all of our decisions will be in line with our commitment to the green agenda. We are passionate about digital inclusion which includes addressing barriers such as having the right digital skills and support, connectivity, awareness, confidence and access, ensuring all technology meets our userbase needs, including those dependent on assistive technology to access digital health and care services.

NHS England set out the 'What Good Looks like' framework which gives us a baseline of where we are now. This coupled with the Hertfordshire and West Essex ICS digital strategy gives us the direction to deliver a digitally enabled health and social care system. The only limiting factor in driving digital maturity ambitions is our ability to believe in what is possible; however by adopting our blueprint and having confidence in our vision, we can make it a reality.

Context

Why we need an ICS digital strategy

Hertfordshire and West Essex are great places to live and work.

Our area is home to some of the healthiest, diverse and vibrant communities in the country, but there remain unacceptable differences in the health, wellbeing and life expectancy of some of our residents.

We want everyone who lives or works here to enjoy the best that our area has to offer. Our ICS wants to support our thriving communities where everyone has the right to a fulfilled and happy life, we know good physical and mental health is essential to achieve that goal. That's why it's important that we address health and care inequalities within our population.

Too often, those people that need the most support experience the greatest difficulties in using our services and for those who work directly with residents, service users and patients, trying to get people the right help at the right time can be frustrating too.

The trends are worrying, with avoidable diseases like type 2 diabetes on the rise. In both adults and children, conditions linked to inactivity and poor mental health mean that we risk worsening, rather than improving, health.

These challenges are not ones the NHS can fix alone. Residents have told us that they want their services to "focus on my wellness, rather than my illness". Making this shift requires a shared ambition between the NHS, local government, our community and voluntary sector and the people who live and work here.

Our digital strategy and programme plan focusses on creating the conditions for everyone to fulfil their potential, but to ensure a healthier future we need to act decisively and work together as one system with a collective ambition. To achieve these aims we know that having the right digital capabilities, including the technology and infrastructure, is a fundamental requirement.

It is these capabilities that will enable those that provide care to work together to create the best outcome for our residents. Residents, patients and service users will be able to access information about themselves and interact digitally with their clinical and care professionals when it is appropriate and convenient to do so, using the tools that reflect society's current technology expectations.

Those that can't, or don't wish to, access services using digital capabilities will still benefit as those that support them will be more aware of their needs and will be able to provide that support as part of a collaborative team who can collectively meet their needs in a more seamless way than they can today.

Care professionals should have the tools to better understand the health and care trends within our population and be able to focus their collective expertise on those that are most vulnerable and those that have the greatest need or have the greatest challenges in accessing services.

By ensuring that all our partners have the right technology, systems and skills in place we will be able to provide a better working environment where we can deliver safer care. With better access to information and best practice advice and guidance, we will be able to focus more on supporting people in their homes when that is more convenient and safer to do so.

This ambition is supported by national guidance including the 'What Good Looks Like' (WGLL) digital maturity framework, which has seven success measures and sets out the expectations for a mature, well developed, digitally enabled organisation as well as a focus on levelling up these digital capabilities across England. This digital strategy focusses on enabling our professionals to transform the services to meet the needs of our residents.

This digital strategy sets out the approach we want to take as an ICS for the next 10 years with the immediate focus on the coming three years with regards to our investment decisions.

The NHS Long Term Plan includes national requirements for digital that are expected to be delivered at ICS level from July 2022. These include targets for virtual wards, resident access channels, digital inclusion and several other key areas set out in the 22/23 national priorities and operational planning guidance.

NHS England had therefore requested initial Digital Investment Plans at ICS level by July 2022, to help us focus the Hertfordshire and West Essex investment plan.

The digital strategy has been developed collaboratively with system leadership, transformation teams, clinicians, digital leaders and supporting roles in various discussions, forums and workshops involving in excess of over 100 key stakeholders across social care, the third sector and our health care partners. The strategy and the associated three-year investment plan is built around five key areas of focus that came from those discussions, and which are building on work already in progress across the ICS.

The key enablers in achieving success in digital maturity as an ICS are far broader than just technology and our ICS digital strategy therefore focusses on not only technology but applying a digital culture with commitment from all in supporting its delivery.

Through ICB digital leadership and governance, we will ensure the right practices and processes are in place to respond to our residents' raised expectations of digital healthcare. This will include alignment and collaboration with the overarching Hertfordshire and West Essex ICB strategy and enabling strategies such as the clinical, estates, finance, procurement, green strategy, HR and people plan etc.

Having a cohesive digital strategy will put our ICS in a position to deliver our overarching HWE ICS strategy.

We will be equipped to:

1. **Prevent people's health and social care needs from escalating**
2. **Personalise health and social care and reduce health disparities**
3. **Improve the experience and impact of people providing services**
4. **Transform performance**

The health and care landscape in Hertfordshire and West Essex

Hertfordshire and West Essex is a complex landscape in terms of the provision of health and care, involving the organisations illustrated below, alongside care homes, pharmacists, optometrists, dentists, third sector organisations and other support services in the community. Our care pathways and health and care services cross boundaries between places within our Integrated Care System (ICS) and to colleagues in other areas, within other ICS's, such as London and Cambridge amongst others. These cross-border services are provided by organisations such as Essex County Council, Essex Partnership University NHS Foundation Trust and Central London Community Healthcare NHS Trust.

The Hertfordshire and West Essex ICS is starting from a low technological base, resulting from a historical lack of resource and investment. This is reflected in the current baseline position against the new "What Good Looks Like" (WGLL) digital maturity framework which averages three out of five overall. However, there are several significant digital investment programmes underway. Good progress has also been made on some large system-wide projects – notably the Hertfordshire and West Essex Shared Care Record (ShCR) has been described by senior clinicians as "transformational" in the delivery of care.

11x NHS and other Health Service Providers

Over 1,500,000 Residents

Over 130 GP Practices & 300 Community Pharmacies

- East and North Hertfordshire
- South and West Hertfordshire
- West Essex

Community / Mental Health Trusts

- Hertfordshire Community NHS Trust
- Essex Partnership University NHS Foundation Trust
- Hertfordshire Partnership University NHS Foundation Trust
- Central London Community Healthcare NHS Trust

East of England Ambulance Service

2x County Councils and 13x District Councils

- Essex County Council
- Hertfordshire County Council

Hertfordshire Urgent Care

Acute Trusts

- East and North Hertfordshire NHS Trust
- The Princess Alexandra Hospital NHS Trust
- West Hertfordshire Teaching Hospitals NHS Trust

Various other Professional Bodies, Voluntary Sector, Community, Faith And Social Enterprise Organisations

National digital NHS context

Digital technology is now a core part of our lives and has been demonstrated to be hugely valuable in how we now undertake many routine tasks, such as banking and travel arrangements. In UK public sector health and social care delivery, digital is typically less mature than the other sectors. The NHS Long Term Plan seeks to address this and includes national requirements for digital that are expected to be delivered at ICS level from July 2022. These include targets for virtual wards, resident access channels, digital inclusion, and other key areas set out in the 2022/23 national priorities and operational planning guidance.

With funding limited across the wider NHS and Social Care sectors, there is also a focus on digital convergence and standardisation initiatives, including, but not limited to, convergence of electronic patient care record systems, shared care plans, and improving digitisation of social care, mental health and community health services as well as within outpatient settings. It is expected that funding for these initiatives will be coordinated and distributed at ICS level from July 2022 via Integrated Care Boards, and that ICB's will play a central role in digital investment decisions.

The "What Good Looks Like" framework is also moving towards a mandatory national digital maturity framework, core to the national guidance and is already being actively used to focus strategic investment and effort. Our current assessment is one of relatively low digital maturity as an ICS. Our early work in Hertfordshire and West Essex has taken advantage of national support through the ICS Population Health and Place Development Programme. This has supported ICS's in assessing how to build our digital maturity through a series of centrally provided Action Learning Sets based on the WGLL framework. NHS England had requested initial 3-year Digital Investment Plans be developed at ICS level. To help focus the Hertfordshire and West Essex investment plan, this strategy sets out the approach for our digital maturity growth in Hertfordshire and West Essex.

This digital strategy provides a framework in which our collective digital investment decisions can start to be made. It does this by providing:

- **Our Vision, Goals and Strategic Principles** – to focus our efforts and help us make the key digital investment decisions and establish strategic programmes of delivery.
- **Our Digital Mission** – describing how the ICS will focus its system-wide efforts to improve our digital maturity as a health and social care system to support the improved health and care of our residents.
- **Our Digital Roadmap** - that sets out our journey over the next decade and provides the backdrop to our 3-year investments, conditioned by available funding provided from within the ICS budgets, and from national sources when these become available.

Our Hertfordshire and West Essex ICS digital strategy provides examples of our achievements to date but also supporting example future digital visionary stories to help visualise the benefits and impact our strategy and plans will have on our residents and care professionals.

https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/

What our digital strategy covers

The Hertfordshire and West Essex ICS digital strategy provides a framework of principles and goals in which ICS-wide digital priority programmes will support the ICS transformation initiatives and support how investment decision making is made. It recognises the need for organisations to deliver their own specialist digital needs within their dedicated budgets but also where the need is consistent with the collective system needs and national standards. The strategy is therefore additive to local efforts and requirements.

The ICS digital strategy focusses on:

- Supporting the ICS transformation initiatives as needed with ICS wide solutions, that are also consistent with the needs of the PLACES within Hertfordshire and West Essex.
- Making a measurable difference to the collective health and care provision across Hertfordshire and West Essex and its borders through common approaches to the use of digital technology.
- Improving the commonality of digital solutions and their ability to talk to each other (interoperate) so that the needs of the population are better catered for.
- Driving up digital maturity in line with the WGLL digital maturity framework.
- Securing the best value for the Hertfordshire and West Essex ICS from digital investments.

It does not:

- Replace organisations' or PLACE digital strategies; rather it informs, provides a reference point and context for those.
- Address Business as Usual (BAU) digital and information technology plans funded out of local budget allocations to maintain day to day services.
- Cover initiatives that don't meet the strategic transformation, investment or delivery principles.
- Address digital solutions specific to one organisation's specialist needs.

Vision, Goals and Principles

Digital Vision

Working together for a healthier future

↑

'Our teams come together to deliver an effortless, integrated digital experience without boundaries to improve health and care outcomes for all people'

Our Digital Goals

- We will work together to maximise the opportunities to coordinate system wide digital solutions, and provide the right care at the right time, through multi-disciplinary health and social care teams.
- We will bring together the essential connectivity, information, intelligence and data for all care settings as needed by service users, residents and care professionals to improve the overall health and well being of our population.
- We will use digital technology to help keep people well in their homes and improve their overall life chances, at the same time addressing the twin challenges of demand and capacity across the system.
- We will encourage targeted investment and digital innovation at the front line that has potential scaleable benefits to improving health and care outcomes. We will involve Academic Health Science Networks (AHSNs), universities, and the private sector where it makes sense, and we can afford it.
- We will improve the inclusion of our population in accessing their health and care needs digitally where appropriate and will build a digitally confident and skilled workforce.

Strategic digital Investment principles*

We will apply a clear set of principles to the way we target our investments in digital, aligned to current health and care sector best practice.

Prioritise the things that residents and staff need

- Projects at ICS level will focus on resident and staff benefit, and competing projects evaluated against these.
- Competing benefits profiles must explicitly demonstrate direct or indirect benefit (e.g. better access - direct, or better security - more indirect).

Practical implications - All benefit cases/calls for funding must be explicit and address categories agreed by the ICS.

Get the best out of digital suppliers

- Develop and maintain strategic supply relationships at ICS level where this makes sense.
- Aim to use the same solution where procurement rules allow, it makes strategic sense, is cost effective and appropriate contractual vehicles exist.

Practical implications - Use an established proven supply route where we can to get economies of scale and replicate solutions and relationships.

Set clear, realistic goals

- Ensure that the primary aim of digital investment is realistically achievable and has evidenced benefits for residents and staff with "optimism bias" challenged.

Practical Implications - Rigorous testing process for cases as assurance for the ICB.

Invest in a dedicated, cross functional ICS team

- Create a right sized, coordinated cross functional, cross care setting, cross place virtual digital team to maintain focus on the vision and ensure that learning and approaches are coordinated rather than reinvented.

Practical Implications - A new digital operating model across Hertfordshire and West Essex.

* Based on guidance published by NHS Providers as latest (May 2022) in a series of guidance for Boards of NHS organisations on digital agenda , commissioned by HEE and supported by NHS England. The guidance is focussed at NHS Trust but applicable to all digital transformation in health and care settings. They align with HWE senior leadership wider ways of working.

Strategic digital delivery principles*

We will maintain our delivery focus and maximise our returns on investment through our high-level delivery principles.

Think long term, deliver in the short term

- Rigorous assurance to ensure we remain in line with ICS strategic goals with ICS strategic goals.
- Maintain focus on the vision and mission for digital at ICS and PLACE levels expressed in benefits terms, and support for the overall ICS Vision.

Practical implications - Delivery milestone and benefits realisation tracking at ICS level through the agreed governance processes for ICS funded projects.

Test, measure and learn

- Innovate locally, test at PLACE level, scale at system (either bigger scope or replicated instance).
- Blueprint models and technology approaches for the same problems (don't solve the same problem 3 times).

Practical implications - Review all projects and pool resources around front runner (e.g. care coordination, portals etc.).

Don't stick to the wrong plan

- Rigorous delivery assurance against business cases and outcomes coupled with an ability to change plans and objectives as the environment or circumstances dictate.

Practical implications - Leadership and Governance for digital within the ICS. Gated process with go/no-go decisions being made through clearly defined governance routes. Some projects may be stopped if not delivering, to make better use of resources.

Build trust in digital

- Address digital inclusion and exclusion explicitly through the strategy.
- Adopt a benefits realisation framework in a clear, structured and useful way.
- Digital capability development for residents and staff. Working towards upskilling to a digitally mature workforce, investment in education, training etc.

Practical implications - Cases evaluated on 'time to benefits' and 'strategy for change management'. Don't assume digital answers everything the ICS needs.

* Based on guidance published by NHS Providers as latest (May 2022) in a series of guidance for Boards of NHS organisations on digital agenda , commissioned by HEE and supported by NHS England. The guidance is focussed at NHS Trust but applicable to all digital transformation in health and care settings. They align with HWE senior leadership wider ways of working.

Our Digital Strategy Mission

What we will deliver and how we will do it

Digital Collaboration
System Wide Digital Collaboration

Our goal is to work together to maximise the opportunities to coordinate system wide digital solutions, and provide the right care at the right time, through multi-disciplinary health and social care teams.

To achieve this, we will work together to adopt a coordinated health and care needs led approach to digital that focusses on local demands, but which is coordinated through place-based digital and care professional networks, including care representatives closer to the resident such as GPs, social workers, pharmacists, optometrists, dentists, third sector organisations and others in the community. This will enable a broader and more holistic approach to digital being adopted in line with our approach to care (e.g. through our Primary Care Strategy).

Digital Platforms
Essential Strategic Digital Platforms

Our goal is to bring together the essential connectivity, information, intelligence and data for all care settings as needed by service users, residents and care professionals to improve the overall health and well-being of our population.

To achieve this, we will build and then enhance and optimise the key strategic digital platforms we need once for the ICS, or we will develop a fully joined up, interoperable, landscape of local platforms. We will optimise existing digital platforms wherever possible rather than building new replacements.

Digital Direct Care
Proven Digital Care Enablers

Our goal is to use digital technology to help keep people well in their homes, offer choice and improve their overall life chances through healthcare at the residents' fingertips, at the same time addressing the twin challenges of demand and capacity across the system.

To achieve this, we will use digital technology at scale to bring care closer to our residents in their homes or the places they call home. We will focus on engagement with our users internally and residents in the co-creation of new ways of digital working and make solutions easy to use and with a consistent look and feel.

Digital Innovation
Local Digital Care Innovation

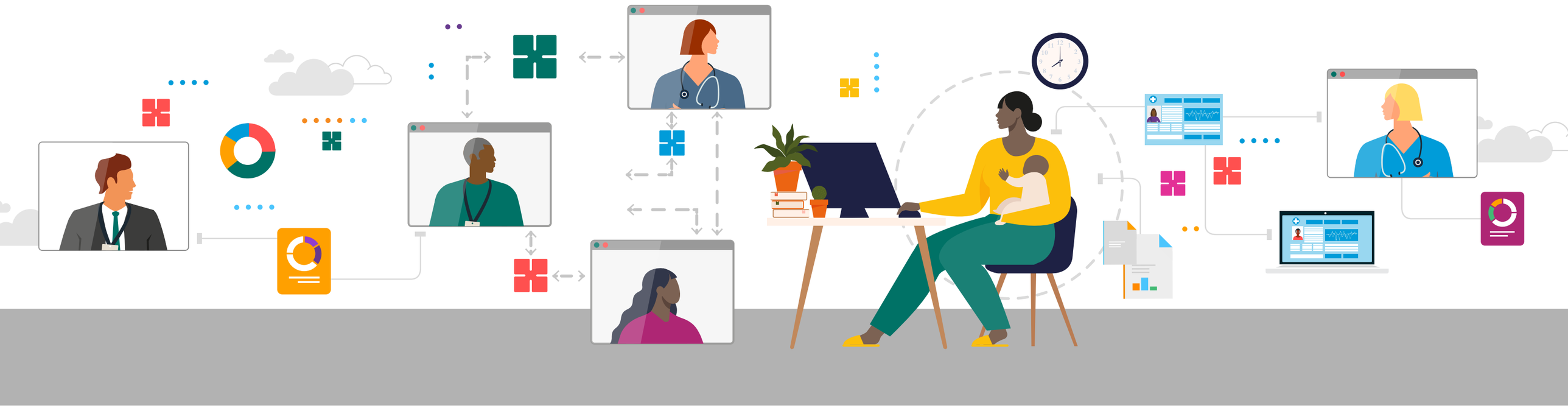
We will strive to lead digital innovation partnering with AHSNs, universities, and the private sector to identify and adopt new technologies that offer scalable benefits to support our ICS challenges and workstream priorities.

To achieve this, we will pilot digital health and care innovation at smaller scale where there is a potential to grow and deploy this more widely, and we will learn from others using innovative technologies such as Artificial Intelligence, Precision Medicines and Robotics.

Digital Skills
Digital Inclusion and Workforce Capability

Our goal is to improve the inclusion of our population in accessing their health and care needs digitally where appropriate and will build a digitally confident and skilled workforce.

To achieve this, we will develop a coordinated approach with third sector partners and others to address barriers to accessing health and care services digitally, providing access to technology, information and navigation to those least able to access digital services. We will support and train our staff in the use of digital technologies to develop their confidence and skills in using digital tools particularly at the front line. We will strive to build trust in digital solutions for health and care and keep our staff and residents safe on-line.



Digital Collaboration
System Wide
Digital Collaboration

"What Good Looks Like"* Success Measures:

1. Well Led
2. Ensure Smart Foundations
3. Safe Practice
4. Support People
5. Empower Citizens
6. Improve Care
7. Healthy Populations

What does this include?

- We will focus on communication, collaboration and leadership of digital change involving care professionals at all levels and across all settings, ensuring engagement and co-creation of solutions with our residents.
- The Governance model will be adjusted to support the new landscape ensuring alignment with the strategy and driving benefits for residents, care professionals and partner organisations.
- By 2025 we will deliver a well led, well governed, accessible digital ecosystem in terms of collaboration for residents and care professionals meeting relevant technical and safety standards.
- We will aim to deliver digital solutions once for the common good converging existing solutions in line with our investment principles and national ambition for convergence of health and care digital technologies.
- We will develop a coordinated, professionally led approach to digitally enabled safe care, collectively making recommendations for investment and focus on support of our ICS priorities.
- We will aim to "level up" our capability on data quality, removal of paper processes, and digital maturity.
- We will promote the use of shared funding, resources and acquisition of digital solutions across the ICS where this is in line with our investment and delivery principles.
- We will ensure ICS to ICS collaboration to make sure that our residents are cared for across ICS borders or between places within our ICS, and that we build our digital solutions in a seamless way that supports this.
- We will ensure that our local ICB clinical priorities are supported where needed through digital enablement such as reducing substance misuse, smoking and alcohol consumption, children and providing a good start in life, good nutrition, healthy weight, physical activity and the lifelong education agenda.

What are we already doing?

- Empowering Clinical leaders to drive transformation and benefits such as clinical fellows.
- Investing in time for national Digital Academy training for our clinicians and Chief Information Officers (CIO).
- Established an ICS clinical reference and practitioner group with ICS wide representation.
- We have an ICS Programme Management Office (PMO) to oversee clinical workstream programmes and provide assurance of delivery.

"By 2023 we will have established a Chief Clinical Information Officer (CCIO) approach to leading our digital landscape in support of safe care. We will identify digital and data solutions to improve care by regularly engaging with frontline users and residents and have digitally capable Boards."

What digital capability will we deliver?	When could we have it?	What benefits will it give us?	What will care professionals say?	What will our residents say?
Invest in a sustainable multidisciplinary digital care professional "office of the CCIO" at ICS level.	Q1 2023-24	A coordinated approach to making the right priority calls on digital investment from a professional perspective and maximising the use of digital in support of our residents and safe care.	"We are confident that our digital solutions for the ICS are led by care professionals, and that they will work at the front line"	"Gone are the days where as residents, we feel we didn't have a voice in their digital decision making"
Invest in Digital Board education as part of the programme of developing digital awareness and capability.	Q1 2023-24	Confident Board level sponsorship, assurance, challenge and decision making on digital initiatives.	"Our ICB board and the Boards of our organisations are making joined up calls on digital investment that seems to be making a real difference at the front line"	"Digital seems to be everywhere for our health and care needs these days, whether that's at home, at the GP or in hospital. It used to be more of an add on, but today it's as important as our household utilities"
Invest for the long term in digital clinical fellows at ICS levels and care professional digital leads for all ICS organisations.	Q4 2023-24	Sustained investment in a core set of senior care professionals able to support digital initiatives and targeting technology where it enhances the provision of care.	"We have peers who are genuine digital experts who we can turn to who can guide us in making the best use of digital technology."	"I was talking to my consultant, and he said that the technology he was using had been designed by another consultant in Watford and he was really pleased with it"
Introduce a quality improvement / benefits realisation method at ICS level in support of the identification of digital initiatives.	Q4 2023-24	A sustainable approach to improving care using digital solution integrated with quality improvement / benefits realisation approaches.	"Digital is just something we now always consider when we are trying to improve the care we provide"	"I can see people using modern technology on the front line these days in preference to pen and paper"

* "What Good Looks Like" is the overall digital maturity framework for ICS digital maturity introduced by NHS England in 2022 to measure progress towards an overall national level of digital capability.

Digital Collaboration
System Wide
Digital Collaboration

Existing Case Studies

Community Pharmacist support for patients leaving hospital (Transfers of care around medicines -TCAM)

The Eastern AHSN worked with Hertfordshire Partnership University Foundation NHS Trust (HPFT) and all the acute Trusts in the Hertfordshire and West Essex ICS and the local pharmaceutical committee to help set up a secure electronic interface between the hospital IT systems and PharmOutcomes, the community pharmacy system. This enhanced TCAM by providing patient data quickly and seamlessly to their community pharmacist.

The benefits for the patients in implementing TCAM is that it provides the on-going support around their medication and what and when it should be taken, post discharge out of hospital, as the community pharmacy will have access to the prescription information prescribed on discharge. The additional benefit, to both the patient and to the hospitals in having TCAM in place, is that it supports the prevention of re-admission; with medication and discharge support being provided by the community pharmacists.

* SOURCE : Eastern Academic Health Science Network

Digital Innovation Zone (DIZ)

The Essex and Hertfordshire Innovation Zone has created a space for collaboration and engagement, breaking down sectoral and organisational silos and attracting co-ordinated investment. This has been enhanced by regular guest speakers' slots at the DIZ board meetings with a range of digital issues and initiatives with speakers from digital infrastructure providers and EELGA (regional local government) as well as our local partners, Anglia Ruskin University, Essex County Council, Princess Alexandra Hospital. Joint programmes of work include LFFN ultrafast GP practice connectivity and the living smart homes project, working with residents on-line supporting the digital inclusion agenda, holding seminars funded by charity funding.

* SOURCE : Digital Innovation Zone (DIZ)

Gut Reaction Programme

The East and North Hertfordshire NHS Trust supported a national Health Data Research UK programme in the creation of a Gut Reaction Data Access model and database which includes over 20,000 patient records (with full consent) in order that inflammatory bowel disease and associated conditions could be analysed under a trusted research environment . The collaboration spanned 15 different organisations, health, private sector innovators and drug companies. Working with leaders in the National Institute for Health and Care Research (NIHR) BioResource, Patient Advisory Committee (PAC) and the patient and public involvement and engagement workstream (PPIE) to create a new mutually agreed approach which will research the data for inflammatory bowel disease (IBD) patients which helps support the model for data driven decisions, reviewing and advising on use cases for research using Gut Reaction Data, providing insight on the use of data in sensitive areas such as polygenic risk scoring and artificial intelligence (AI) and engaging and sharing learnings with other hubs involved in the Health Data Research UK (HDR UK) programme.

* SOURCE : Phillip Smith – Associate Director of Research ENHT

Digital Platforms
Essential Strategic Digital Platforms

"What Good Looks Like"* Success Measures:

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7. Healthy Populations

What is included?

- The digital MUST DOs for strategic platforms in the NHS Long Term Plan.
- Further developed Shared Care Records including ICS to ICS connectivity to bring together the full picture of our residents' health and care needs.
- Create a focus on high quality data to deliver high quality care and meaningful analytics.
- Shared Data Platform and Population Health Management (PHM) technologies to help us better understand the needs of the population we serve using modern approaches such as predictive and prescriptive analytics.
- Resident Access platforms to enable our residents to access their information and engage with and manage their own health and care whilst respecting their preferences (priorities in Maternity/ Outpatients and Cancer pathways).
- Care Coordination Centre(s) to coordinate health and care provision, supported and enabled by technology.
- Electronic Care Record convergence to bring together the clinical platforms used by health and care professionals both within our ICS and beyond it.
- Shared infrastructure where appropriate to provide a standardised and lower cost service to our teams, more effective collaboration and MDT working, resident access and to support the Hertfordshire and West Essex green agenda.

What are we already doing?

- We have developed a Shared Care Record and continue to evolve it.
- We have delivered high speed connectivity for GPs in collaboration with the Digital Innovation Zone.
- West Hertfordshire Teaching Hospitals NHS Trust has implemented a modern Electronic Patient Record (EPR) and is now realising the benefits in terms of improved and safer care.
- We have a plan for a system-wide Data Platform.
- We are developing a Child and Adolescent Mental Health Services (CAMHS) access "front door" for children and young people.
- We are designing the West Essex and East and North Hertfordshire Care Coordination centres.

"By 2027 we will have modern health and care technology that gives us a single version of the truth for our residents as individuals and our population and communities as a whole."

What digital capability will we deliver?	When could we have it?	What benefits will it give us?	What will care professionals say?	What will our residents say?
Shared Care Record	Now 2025-26 for all care pathways	A single joined up view of a resident's care wherever they have received it, both inside and outside our ICS.	"I am confident that I have the full up to date view of those to whom I provide care wherever they have received it so that I can provide them with the best possible care."	"I don't have to repeat my story to anyone"
Electronic Care Record	2022 – 2027	Modern care record systems that talk to each other across all our health and care providers and paperless care records.	"I have the best technology at my fingertips whether I am working in ED, in the community or on an ambulance."	"I am confident that our hospitals, clinics and social work teams have the best possible technology available to manage my care"
Shared Data Platform and Population Health Management (PHM) technologies	2023-24 Levelling up of data access and intelligence and PHM analytics 2028-29 Data and Analytical Maturity	An accurate view of the health and care needs of our communities that enables us to target resources supported by trusted research environments.	"I know that we are able to target our teams on making a difference for the neediest residents in Hertfordshire and West Essex." "We can use advanced analytical tools to better understand the needs of our population"	"I feel our communities are healthier and better looked after than they ever have been"
Resident Access platforms	2023-24	Our residents (Target 75%) will be able to interact with care professionals without letters or paper or manage aspects of their own care as much as possible by the NHS App.	"Those I care for are aware of their care pathway, rarely miss an appointment and feel they get a personalised and responsive service"	"I don't have to wait to contact my care providers and I generally get questions answered the same day"
Care Coordination Centre(s)	2023-24	Ability to make the best use of scarce resources and assemble the right expertise managing transfers of care / shared care across the system.	"I feel I am able to make a real difference working with teams of care professional across all settings."	"The care I got covered all of the things that were worrying me through a "one stop shop".
Shared infrastructure	2023 – 2032	Unified core infrastructure across all of health and care in Hertfordshire and West Essex offering a lower cost and single interface and world class cyber security.	"Our networks and kit "just work" and have the same look and feel wherever I am."	"I never see my care givers having to wait for anything to load up on their screens"

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Digital Platforms
Essential Strategic
Digital Platforms

Existing Case Studies

Shared Care Record - General Practice

An elderly patient from London recently moved into a care home in East & North Hertfordshire. I conducted a telephone consultation as the carers at the home reported that she had confusion but they didn't know if this was an existing condition or a new issue.

Normally the next step would be a dementia screen; the patient would have to provide a urine sample and undergo a CT scan and blood test. However, looking at the Shared Care Record I could see letters and test results from London hospitals and information from her previous GP practice in London. This showed that she had already had the tests she needed and I could refer her directly to a memory clinic.

The Shared Care Record prevented the need to repeat the tests which would have been time-consuming and created a delay to the patient receiving care. It also prevented the need for a GP to visit the home on this occasion.

"The Shared Care Record is a valuable resource of additional information. It helps clinicians to make better decisions and has already helped to speed up referrals and prevent repeat investigations."

* SOURCE: ShCR communications Team

Data, Population Health Management and Analytics

A population health management (PHM) approach was developed to support a reduction in Health Inequalities through using data to identify cohorts of a population. The Primary Care Network (PCN) is identifying interventions which will reduce health inequalities through personalising previous standard offers of care e.g. screening. For the first phase of the Directed Enhanced Service (DES) whereby the requirement is to utilize data to identify a population within a PCN experiencing inequalities in provision or outcome. The PCN with the support of the data and BI team have now defined an approach for identifying and addressing the unmet needs of the population which involved engagement with the selected population to understand the gaps and barriers to care as an output of discussions with the local system partners organisations to agree the engagement approach collaboratively. Cohorts identified include Obesity, Black, Asian and Minority Ethnic (BAME), Deprivation, Pre-Diabetes, Diabetes and Hypertension. Data packs were created in a standardised way in the absence of a developed infrastructure / data platform utilising three separate data sources rather than an ICS wide linked data set. The packs included recommendations.

Primary Care Broadband Connectivity

Having successfully secured £1.7m of funding from Department of Digital, Culture, Media & Sport in 2019/20 a key focal point for the primary care in 2020/21 was working with the Digital Innovation Zone, in partnership with HBL ICT shared service by initiating the physical delivery of infrastructure that has transformed the connectivity of our GP surgeries, both in terms of download and upload speeds and in terms of network resilience. The network enables our ICS health partners to deliver more-effective and efficient services that wrap themselves around the patient. The LFFN network connects up 77 GP surgeries to gigabit capable fibre-to-the-premise broadband networks that will enable even more healthcare provision to be moved away from single-point acute locations such as town-centre hospitals to a more community-based model. The ICS were the first area in the country to follow-through on the national government's pledge to deliver fibre connectivity to every GP surgery.

* SOURCE: Digital Innovation Zone

Digital Direct Care
Proven Digital Care Enablers

"What Good Looks Like"* Success Measures:

1. Well Led
2. Ensure Smart Foundations
3. Safe Practice
4. Support People
5. Empower Citizens
6. Improve Care
7. Healthy Populations

What is included?

- NHS Long Term Plan **must do** objectives that focus on out of hospital care settings co-created with our residents focussing on "connected lives".
- Supporting Elective Recovery ensuring direct care initiatives are aligned with improved pathways where possible.
- Digitally enabled objectives set out in the Primary Care Strategy 2022.
- Virtual Wards and Hospital@Home in line with the national priorities to provide top class care remotely in peoples' homes.
- Remote monitoring to enable us to monitor the health and care needs of our residents and provide direct care when needed.
- Increased use of online/virtual consultations, supporting the Hertfordshire and West Essex green plan and reduced travel and inconvenience for service users.
- Assistive Technology to support residents who need help with their daily living needs.
- Secondary Care to Primary Care specialist advice and support leading to the removal of consultations, where appropriate, and supporting interventions through more proactive care introducing specialists at the right time.
- Cross care setting bed management, demand and capacity, scheduling and case management systems.

What are we already doing?

- We are mobilising a Digital First for Primary Care (DFPC) Programme covering GPs, pharmacy, optometry, dentistry and other services provided in local settings.
- We have successfully piloted virtual Chronic Kidney Disease support for primary care clinicians using digital technology and considering this approach to other conditions.
- We are successfully running a number of Virtual Wards and have widespread use of Online/Virtual consultations.

"By 2027 Virtual Wards will be a proven and successful way of delivering care across the whole of Hertfordshire and West Essex. We will be delivering remote care wherever that makes sense, and we will have exceeded all our Long Term Plan objectives in digital care."

What digital capability will we deliver?	When could we have it?	What benefits will it give us?	What will care professionals say?	What will our residents say?
Adult Social Care (ASC) Falls Prevention to be used to protect 20% of care home residents by 2024.	Q3 2024/25	Significant improvements to care for frail residents. Reductions in harm and hospital admissions. Reduced associated mortality.	"We have been able to prevent significant numbers of falls in many of our service users and work with local services to safeguard them in the homes."	"I feel safe and supported at home and know that the risk of me having a bad fall is a lot lower than it was"
Early Memory Diagnosis and Support Service Remote Monitoring of Severe Mental Illness (SMI) patients	Progressive once agreed to 2024/25	Early assessment and practical support around residents with Severe mental illnesses who may be suffering from dementia.	"We are better able to manage our seriously unwell residents in the community and anticipate the longer-term evolution of their difficulties"	"I have been so worried by the progression of my relatives' difficulties, but remote care has been really helpful to alleviate that"
Wound Care Digital App for Community Nurses	Progressive once agreed to 2024/25	Better diagnosis and support for community nurses. Improved resident outcomes. Reduced harm and hospital admissions.	"I feel I am making much better decisions for those to whom I provide care in the community and provide them with significantly better care"	"I know that when the nurse comes, she is getting really great support from expert advice via her app."
Virtual Ward and Hospital programmes	Progressive once agreed to 2026/27	Improved resident outcomes. Reduced harm and hospital admissions. Reduced pressure on the system.	"We are able to much more closely monitor the health of more residents and keep them well in their homes than ever before"	"I have multiple long-term conditions but know that I am getting care that is 24/7 at home"
Online/Virtual Consultation Expansion	Progressive once agreed to 2026/27	Improved resident outcomes. Reduced harm and hospital admissions.	"I am able to manage those to whom I provide care much more effectively and know that they don't have to travel to see me"	"I find it difficult to get out of my home so speaking to my GP online is brilliant"
Secondary Care physician support and advice to Primary Care clinicians	Progressive once agreed to 2026/27	Building on the successes of the vCKD pilots in the ICS to provide secondary care advice and guidance to primary care clinicians caring for residents with multiple long-term conditions.	"I am now getting real time advice from secondary care consultants for my patients with a range of complex long term conditions reducing referrals significantly and enabling me to provide significantly better care"	"My GP has been able to keep me really well for much longer than used to be the case a few years ago when I was constantly having to go into hospital for tests and medication reviews when things flared up."

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Digital Direct Care
Proven Digital Care Enablers

Existing Case Studies

Virtual Chronic Kidney Disease (vCKD)

East and North Hertfordshire NHS Trust (ENHT) in partnership with the Hertfordshire and West Essex ICS and Digital First Primary care team worked collaboratively to develop a new virtual community kidney service for its patients. Patients with a declining kidney function through blood tests (eGFR) are automatically alerted to their usual GP. The GP is then able to refer on-line into an e-clinic where secondary care consultants have full read/write access to the primary care SystmOne (S1) record for that patient to carry out an assessment and put forward recommendations to the GP. The Renal consultant updates the S1 record through clinical coding, to support the GP with the appropriate level of care or medication required.

In implementing vCKD, this has prevented patients being referred into the acute services, interventions have been put into place earlier and has saved over 200 attendances in clinic since the grant money was received to implement vCKD. vCKD also gives any electronic referrals service (e-RS) rejected renal referral a consultant delivered Virtual review to act as a safety net and support primary care.

Since March 2021, over 700 vCKD reviews have taken place and 92% of those have discharged with advice to GPs, such as providing recommendations for medication adjustments. Only 8% of those vCKD reviews have required a renal clinic attendance. Waiting times for vCKD have shortened to approximately an 8-12 day wait, versus a Nephrology clinic appointment average waiting time being between 80-100 day wait.

The focus of this project has been around supporting primary care management of chronic kidney disease and prevents patients being referred onto an acute pathway. The benefits so far have been that it is providing easier and quicker access for patients requiring renal specialists, GPs can refer on-line into an e-clinic providing the ability for e-clinic kidney consultants to assess and triage patients without any consultation with either the patient or the GP, saving valuable face to face appointment slots to those patients who need it most. The partnership are now looking into extending this virtual service to practices that use the EMIS primary care electronic patient record system and longer term would like to look into supporting other specialties but along with moving vCKD into a business-as-usual environment, which requires more sustainable funding. Overall vCKD has meant that CKD is being jointly and effectively managed across primary and secondary services.

SOURCE : Andrew Findlay – Consultant Nephrologist. ENHT

Digital Innovation
Local Digital Care Innovation

"What Good Looks Like"* Success Measures:

1. Well Led
2. Ensure Smart Foundations
3. Safe Practice
4. **Support People**
5. Empower Citizens
6. **Improve Care**
7. **Healthy Populations**

What is included?

- Innovation where there is capacity to invest in this at ICS level and where it makes sense from the overall perspective of digital maturity of the system.
- New medical devices and approaches.
- We will explore the use of robotic process automation to reduce costs and save time in our back office.
- We will explore "Artificial Intelligence" applications where appropriate including machine learning and data science for Population Health Management.
- We will seek to adopt precision medicine technologies as they become proven.
- We will horizon scan to understand the full potential of digital health and care technologies for our population.
- We will leverage Virtual/Augmented Reality (e.g. remote assistance for community working).
- We will consider providing a safe space for innovation including working with external innovators and research companies.
- We will build on health and care innovation being developed by near neighbours such as Cambridge University Hospitals and in London.

What are we already doing?

- We plan to invest in a digital innovation team that will find new technologies to fit Hertfordshire and West Essex challenges.
- The ENHT supported a national Health Data Research UK Programme in the creation of a Gut Reaction Data Access model using AI and machine learning approaches to enhance drug discovery.
- A new rapid review process for research and innovation has been developed by East and North Hertfordshire Research and Innovation Group within the East and North Hertfordshire PLACE, to ensure research and innovation feeds into service transformation to address population health needs.

"By 2032 we will have moved beyond the essentials and be outstanding from the perspective of our measured digital maturity. We will have an integrated continuous improvement approach to digital innovation that is managed and has links to our universities, AHSNs, the private sector and others."

What digital capability will we deliver?	When could we have it?	What benefits will it give us?	What will care professionals say?	What will our residents say?
Established links with the wider NHS, universities, AHSNs, and others aligned to exploring and testing new technologies for care in line with the NHS Long Term Plan.	2023/24	Wider coordination and insight into approaches to common problems. Additional capacity to help with analytics and HWE-wide initiatives where that is affordable.	"We have a really good insight into what the art of the possible is and the future that enables us to think through the opportunities for care provision five years out"	"I see a lot of awards for care tech in my area which gives me real confidence that my family will get great care here".
Remote monitoring and resident owned devices	2024/25	The ability to support new pathways that support the resident at home whilst enabling specialist support and active interventions when needed	"We are able to safely support complex mothers to be at home whilst reducing their unnecessary trips to the hospital when they are worried."	"This pregnancy was so much lees stressful than my previous one. With my home monitoring device and the connection to my mobile the midwives were able to reassure me when I was worried and even ask me to contact them when they were concerned. I really felt safe and supported"
Robotic Process Automation	Progressive once agreed to 2026/27	Elimination of repetitive, time consuming and error prone manual tasks in front line care and back office.	"The management of waiting lists by automated processes means that I'm seeing the neediest residents earlier"	"I know that if I need to be seen by someone urgently it will be automatically prioritised"
AI in Diagnostics for example MRI & prostate, and support for cancer diagnosis	2026/27	Assistive technology support for clinicians to identify and grade cancers earlier. Improved diagnosis and resident outcomes.	"With AI support we are picking up and treating cancers much earlier and saving lives"	"I had a routine scan. The radiologist couldn't see anything but the system they were using identified something that had to be treated and now I am cancer free"
Genomic treatments to support cancer patients	Progressive once agreed to 2026/27 and beyond	Targeted treatments for individuals improving outcomes and mortality for residents.	"I know that the tools I have available to treat those to whom I provide care are advancing all the time"	"I was able to benefit from "personalised medicines" in my treatment programmes and am now well"

Digital Innovation
Local Digital Care Innovation

Existing Case Studies

EPUT LAB and Oxehealth on mental health in-patient wards

Oxehealth's Oxevision platform was designed to monitor patient safety and wellbeing. It is now in 17 adult and child inpatient mental health assessments wards in EPUT, since Spring 2021.

Oxevision consists of a secure optical sensor which monitors a patient's pulse and breathing rate 24 hours a day and alerts staff if they display activity or behaviour that may present a risk to their safety. The sensor detects changes in skin tone and chest movements, even when patients are under bedding, reducing the need for them to be disturbed or woken for observations when they may be sleeping. The platform was initially in use on 4 of EPUTs wards following a successful trial. It was then implemented into a further 13 wards including psychiatric intensive care units, adult inpatient and assessment wards and child adolescent wards, Oxevision is among ground-breaking technology that has been introduced to the Trust by their EPUT LAB, a digital clinical innovation forum where clinicians share digital solutions to improve health and social care

The platform compliments the vital role our clinical staff play in improving patient safety by continually monitoring their vital signs, safety and wellbeing and providing clinical insights to front line staff.

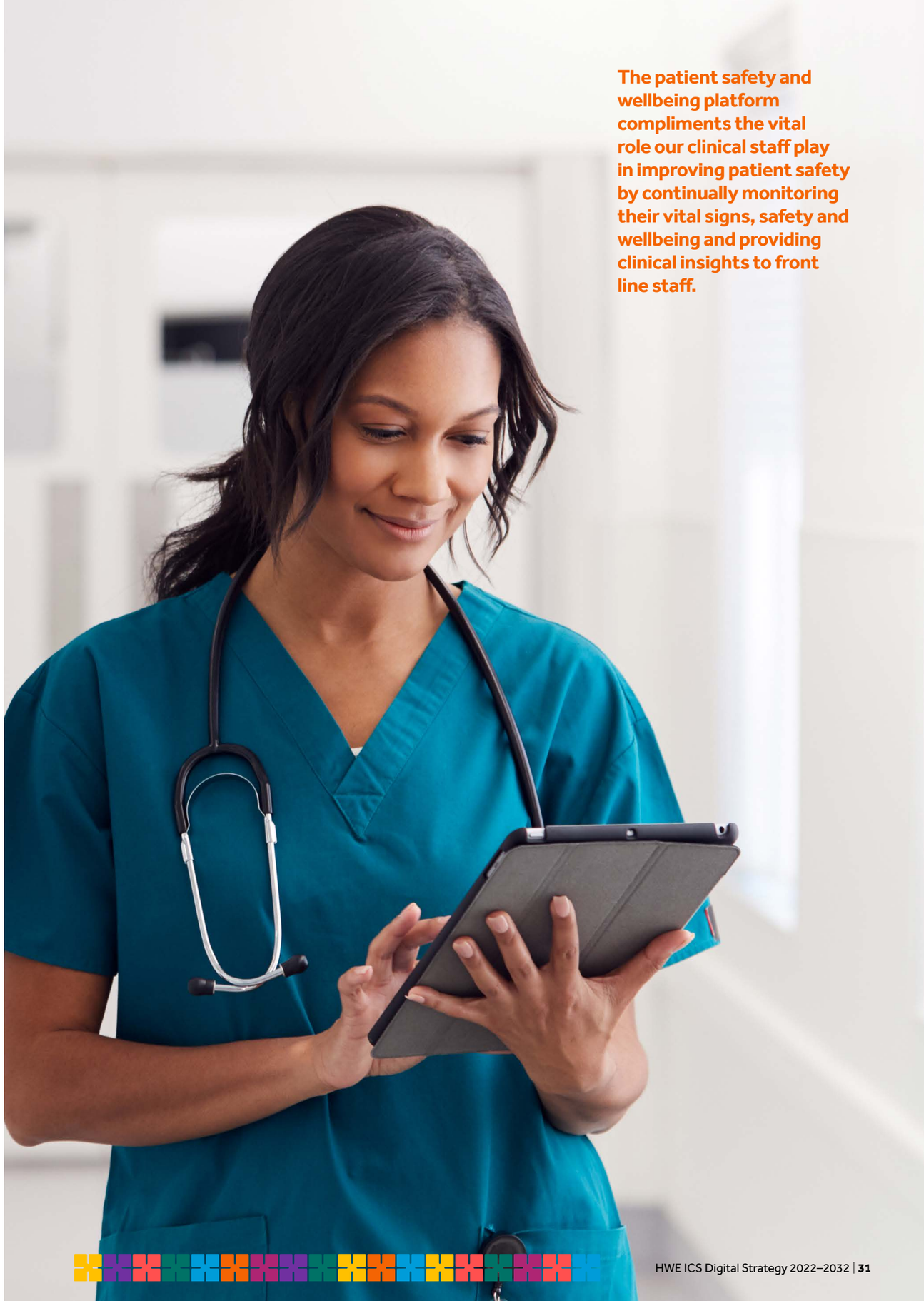
SOURCE: Oxehealth website

Incorporating Research and Innovation in service transformation

A process has been developed by East and North Hertfordshire Research and Innovation Group within the East and North Hertfordshire PLACE, to ensure research and innovation feeds into service transformation to address population health needs. It is a two-way process so the transformation efforts also feed back into research and innovation. In including research and innovation as part of the process, it provides recognition of the current evidence base (published research) awareness of current research already in progress, awareness of national and local innovation schemes, identification of local research and innovation champions and the identification of issues requiring further research.

Examples of shared practice are plentiful and cover the strategic transformation priorities such as waiting well, community diagnostic centres, stroke and neurological conditions, respiratory conditions, heart failure, chronic kidney disease, hospital at home, frailty and mental health. Stakeholders include East and North Hertfordshire NHS Trust, Hertfordshire Community Trust, the University of Hertfordshire, Eastern AHSN. NIHR Clinical Research Network East of England, Healthwatch Hertfordshire, Hertfordshire County Council, Hertfordshire Partnership University NHS Foundation Trust EoE Ambulance, East and North Hertfordshire Primary care networks, Garden House and Isabel Hospice, and Hertfordshire local pharmaceutical committee.

* SOURCE : Phillip Smith – Associate Director of Research ENHT

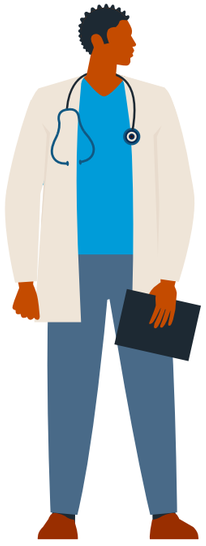


The patient safety and wellbeing platform compliments the vital role our clinical staff play in improving patient safety by continually monitoring their vital signs, safety and wellbeing and providing clinical insights to front line staff.

Digital Skills
Digital Inclusion and Workforce Capability

"What Good Looks Like"* Success Measures:

1. Well Led
2. Ensure Smart Foundations
3. Safe Practice
4. **Support People**
5. **Empower Citizens**
6. Improve Care
7. **Healthy Populations**



What does this include?

- We will build the digital capacity, capability and confidence of our staff at all levels from front line to Board.
- We will always ensure that the digital solutions we build are easy to use, and work towards a unified digital interface across our ICS both for care professionals and residents whilst recognising our resident preferences for accessing services.
- We will understand, monitor and tackle digital exclusion in our communities where we can, but always ensure that no-one is excluded from safe, excellent care, leveraging the excellent work Social Care and the third sector are already delivering.
- We will work to create a culture that is comfortable with the use of digital solutions for staff to deliver care across all care settings.
- We will engage with national initiatives to close the digital divide for health and care including empowering residents via adoption of the NHS App, NHS Apps library, GP online services and free NHS Wi-Fi .
- We will build trust in digital solutions for our residents through co-creation with them and through the skills and confidence of our teams in using them to provide safe care.
- We will encourage the safe and appropriate use of digital technologies that operate to recognised standards and ensure that we safeguard the wellbeing of our staff and residents online.

What are we already doing?

- The "WeAreDigital" primary care digital inclusion assessment which involved surveying residents of the community on access to primary care.
- Supporting digitally excluded service users of health and care services through the third sector providing recycled IT equipment (supporting the green plan) and providing training, support and navigation services.

"By 2027 we will have significantly improved the measured levels of digital inclusion for our population in health and social care provision through uptake of the NHS App, remote technology use and other on-line health and care services. We will aim for our workforce to have digital passports/digital mandatory training across all care settings."

What digital capability will we deliver?	When could we have it?	What benefits will it give us?	What will care professionals say?	What will our residents say?
Supporting people without access to technology to gain access and the skills to interact with their health and care providers digitally when they wish to.	2025/26	More of our population will be more confident in, and able to access health and care services and service information using secure, trusted technology when and where convenient for them. As we provide more services online, we can be confident that our population is able to access these tools and resources if they so wish.	"The people I care for are better informed about the services and can contact me digitally for support and advice without having to wait until my next visit. I feel more confident that they remain safe and well between visits".	"I feel that the online interactions I have with anyone in the social care service are always done to a high standard and in a way that doesn't make the stress of dealing with my circumstances any more difficult. I know that if I am concerned, I can contact them and will receive an answer without having to wait for a visit"
Support services for digital access to health and care commissioned across all of the communities we serve.	2023 - 2027	We will progressively move services to accessible digital platforms for most of our population but ensure that the digitally excluded remain supported. This will result in more efficient and more targeted care, and improved convenience and travel for our service users.	"I am able to offer our service users high standards of care in their home or the place they call home using digital technologies and be confident that they will receive safe, round the clock care."	"I know that I am getting a much higher standard of care at home than I might in hospital because I know my health is being monitored 24/7 even if it's not obvious to me, and that if I suddenly fall ill help will already be on its way"
By March 2025, constituent organisations of an ICS have: established digital, data and technology talent pipelines, and improved digital literacy among leaders and the workforce	2024 - 2026	We will equip our entire workforce with the skills it needs to use digital technologies to provide care and inspire confidence in those technologies for our service users.	"Our entire workforce is digitally confident and getting things done is much more seamless and effective as a direct result".	"I feel confident in using the digital systems. I see my social worker and know that he/she is able to use the technology to provide me and my family with great all-round care."

Digital Skills
Digital Inclusion and Workforce Capability

Existing Case Studies

Staying Connected project : NHS Charities Together in partnership with Hertfordshire and West Essex ICS (IT equipment and digital inclusion)

Working in partnership, we have had a number of companies who have been working with us on the Staying Connected project. For example; Tesco Mobile and Vodafone donating SIMS and dongles; Epson, Hertfordshire LEP, Lumina Technologies for donating unwanted equipment; and Mine of Innovation in Knebworth helping with receiving equipment that we cannot use and using the parts to fix up other items. Example case studies on how this project has helped the residents of Hertfordshire and West Essex are below.

Source: Simon Aulton – Community Action Dacorum and Tim Anfilogoff – Head of Community Resilience, Hertfordshire and West Essex ICB

Frailty and Digital Inclusion (on-line exercise support services)

At first Brenda lacked confidence doing the standing exercises without me there in person, but each week she always manages to try something new and test her confidence further. When we first started she was holding on with two hands to do her side steps and she now does them with her hands by her side. I am incredibly proud of her!

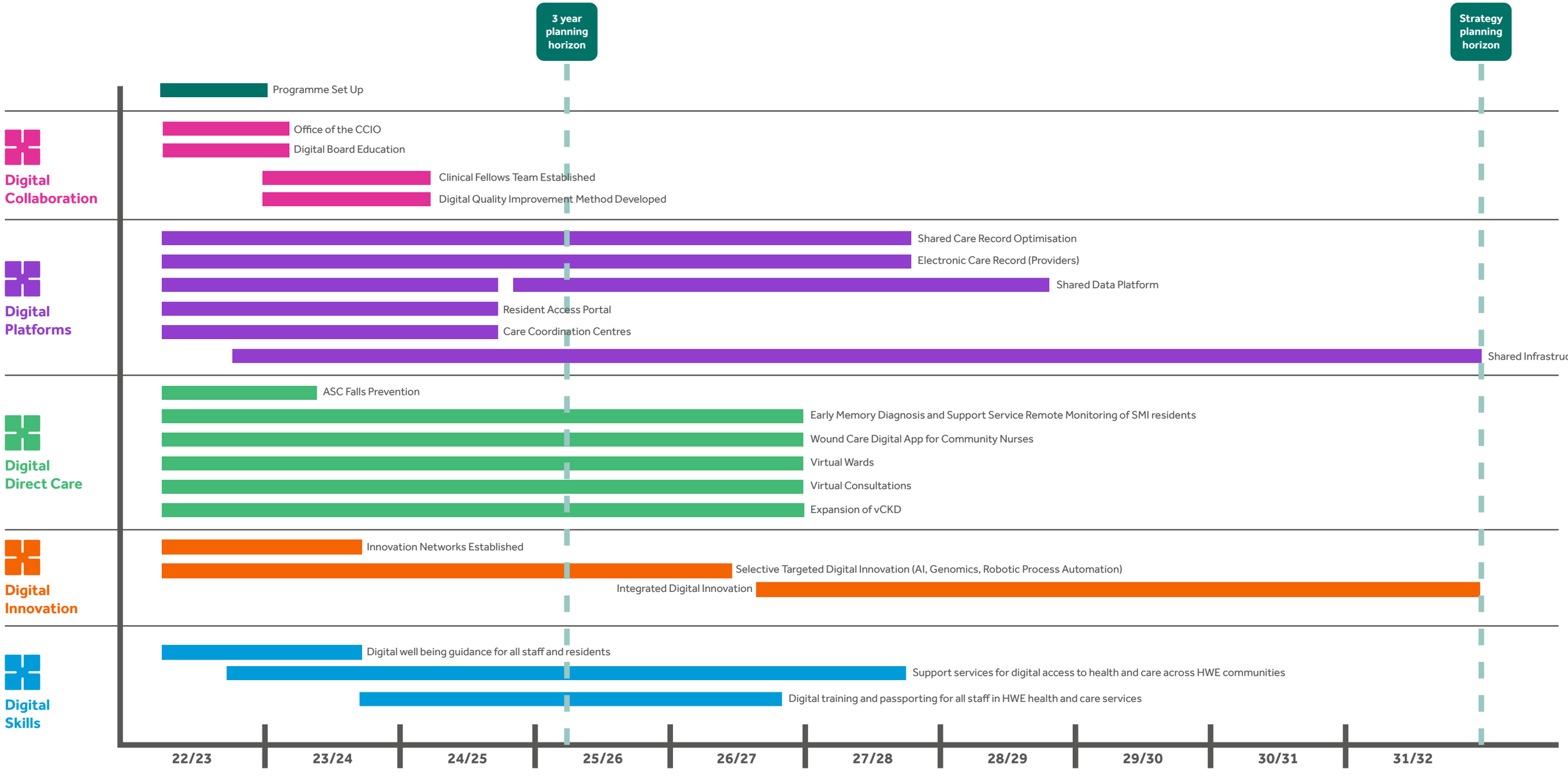
Source: Hertfordshire Independent Living Service (HILS)

Mental Health and Digital Inclusion

Prior to having the device, resident M was low and isolated. Now she is connected with others and can distract negative thoughts. Resident M said the tablet is amazing as she can play games to keep her mind busy and attend Zoom groups to reduce feelings of isolation. She has downloaded the Blue Jeans app to access respiratory physiotherapy sessions. She is also using the tablet and its functions as a motivational tool, with her support worker to de-clutter her house. Since having the tablet resident M has not called in distress and is ever so grateful for the difference it has made to her life.

Roadmap

Our high level 10-year delivery plan



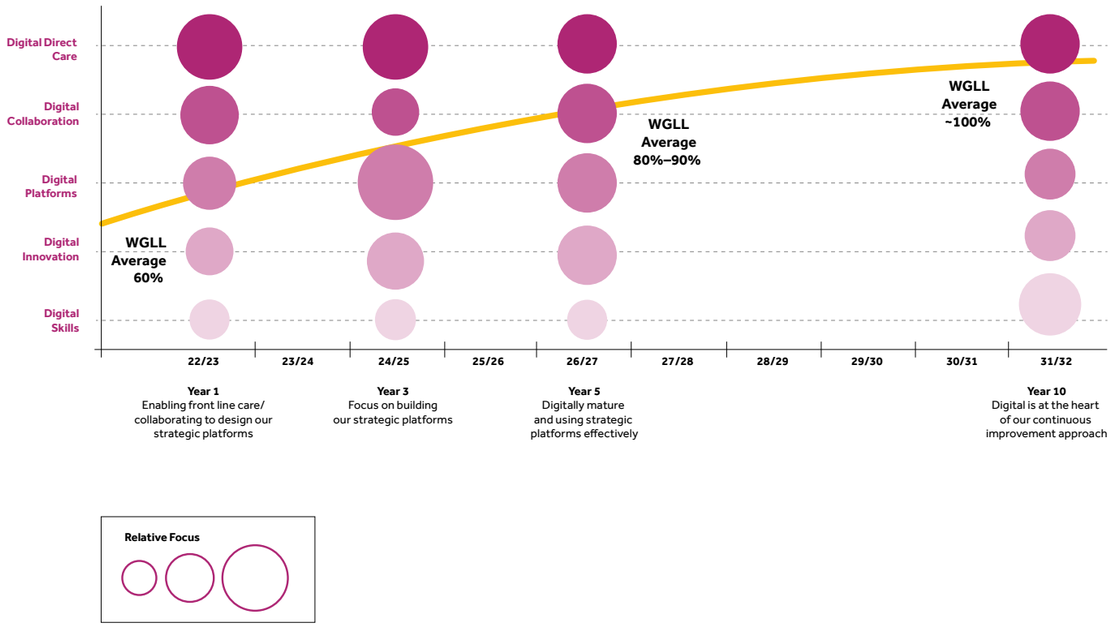
Our 10 year digital maturity journey

As the ICS moves forward on its strategic journey the focus of its efforts will evolve over time. With an initial focus on leveraging digital capabilities that support front line care there will be a progression to focussing on the major platforms that will underpin the true transformational efforts over the longer term.

As progress is achieved across the five themes there will be a corresponding improvement in the WGLL maturity level as indicated in this chart.

Each theme descriptor in this strategy highlights the WGLL measures that will be impacted as the delivery progresses.

(Appendix A shows the current WGLL assessment which is the foundation on which this strategy builds.)



How our digital themes support transformation

Managing the risk and challenges

Our digital risk appetite

We will never invest in digital technology that might compromise the safety or quality of care of our residents.

We may take balanced risk decisions to invest where the technology is proven to be safe and valuable at small scale, but unproven to be fully effective at a larger scale.

We will occasionally actively seek to invest in digital technology innovation and take delivery and financial risks to innovate digitally where there is potential for significant benefits for our residents.

Strategic risks

- **Funding may not match our ambition** – Mitigation via application of our investment principles, robust business cases and assurance processes and readiness to respond to funding opportunities.
- **Resources may not be available to deliver our ambition** – Mitigation via application of our delivery principles.
- **Changes to policy or legislation may impact our strategic approach** – Mitigation via a re-appraisal of the emphasis of our strategy within the overall mission rather than a wholesale change of strategy.
- **Competing approaches to the same problem** – Mitigation via rigorous application of our approach to business cases and investment and a "fund once only" approach at ICB level to common problems.
- **Events in the external environment that impact our strategy** – This includes unforeseen disruption to supply chains and populations such as a pandemic, economic downturn or global conflict. Our flexible approach to the use of our digital principles, will help in mitigating these external risks.

How we will deliver

We will

Build a flexible and agile ICB Digital Maturity Team to plan, coordinate and oversee our major programmes. This will provide a structured approach for all ICS programmes to ensure transparency of progress, good use of the scarce resources at our disposal and provide assurance that programmes will be delivered and benefits realised.

Work collaboratively as partners to both lead and deliver our ICS programmes. Leads for each Programme will be identified from partner organisations and be accountable to the collective governance.

Support each other in delivering programmes, sharing our skills and experiences to ensure successful delivery and joint learning.

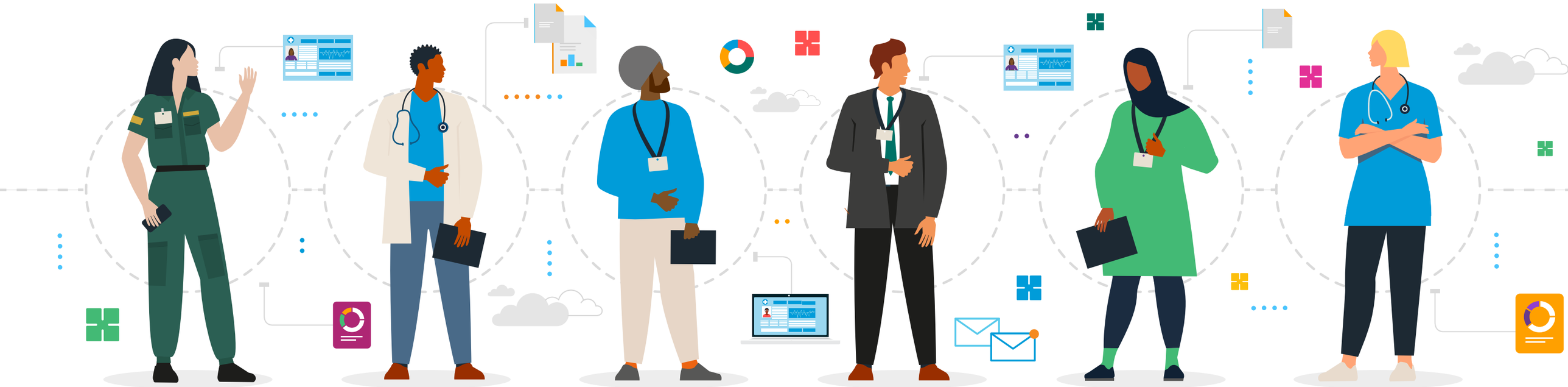
Engage our front line staff, residents and leaders in the design and delivery of our programmes, putting users and care recipients at the centre of our work.

Our governance

Our digital governance will run in line with our digital strategy enable us to work better together as partners and provide the controls and assurance our residents should expect.

This will ensure best value for the taxpayer whilst meeting expectations for the modern digital age and improving the efficiency of the services we provide.

Our health and care professionals will play a key role in our governance, ensuring that we remain focussed on projects that improve the outcomes and long-term life chances for our population as well as improving the working lives for all our staff and carers within our population.



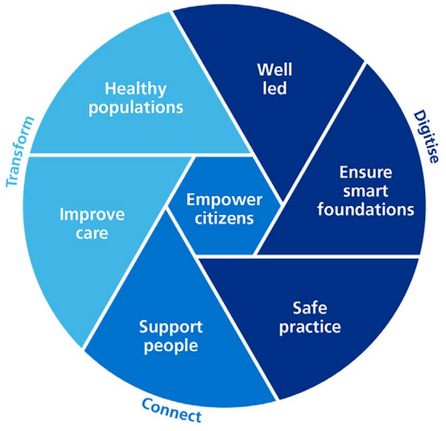
Digital Maturity Assessment Appendix A

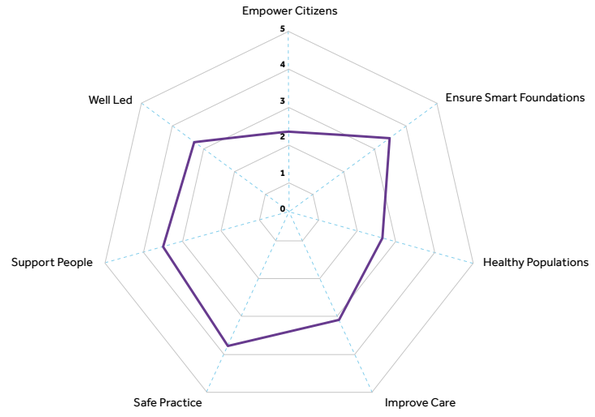
What Good Looks Like (WGLL) - the 7 success measures

The "What Good Looks Like" (WGLL) digital maturity framework published in August 2021, is directed at all ICS leaders, as they work with their system partners. It sets out a target level of digital maturity at both system and organisation levels. It describes how arrangements across a whole ICS, including all its constituent organisations can support success in relation to digitisation, and connecting and transforming services.

The framework sets clear expectations for how NHS England will assess the progress of the digital agenda.

The following pages detail the self assessment for Hertfordshire and West Essex ICS undertaken during quarter 1 of 2022/23, and have been used to inform this digital strategy, and the 3-year digital investment plan for the ICS





1. WGLL Assessment "Well Led" measure

ID-1	ID-2	Success Measure	Standard	Average score for ICS
1	0	Well Led	Boards are equipped to lead digital transformation and collaboration. They own and drive the digitally enabled transformation journey, placing citizens and frontline perspectives at the centre.	**3.29**
1	1	Well Led	Build digital and data leadership expertise and strong board-level accountability for digital transformation - this would include having a CIO or CCIO (or role within this function) as a member or attendee of the board	**2.86**
1	2	Well Led	Establish board governance that regularly reviews digital and data strategy, cyber security, services, delivery and risks, underpinned by meaningful metrics and targets	**3.43**
1	3	Well Led	Ensure that your digital and data strategy has had wide input from clinical representatives from across the organisation	**4.14**
1	4	Well Led	Ensure board ownership of a digital and data strategy that is linked to the Integrated Care System (ICS) strategy and underpinned by a sustainable financial plan	**3.14**
1	5	Well Led	Identify digital and data solutions to improve care by regularly engaging with frontline users and citizens	**2.71**
1	6	Well Led	Invest in regular board development sessions to develop digital confidence, manage cyber security risk and achieve the sustainability agenda	**3.14**
1	7	Well Led	Invest in a multidisciplinary CCIO and CNIO function	**2.71**

2. WGLL Assessment "Smart Foundations" measure

ID-1	ID-2	Success Measure	Standard	Average score for ICS
2	0	Ensure Smart Foundations	Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable and resilient. Organisations have well-resourced teams who are competent to deliver modern digital and data services.	**3.86**
2	1	Ensure Smart Foundations	Invest in and build multidisciplinary teams with clinical, operational, informatics, design and technical expertise to deliver your digital and data ambitions	**2.71**
2	2	Ensure Smart Foundations	Ensure progress towards net zero carbon, sustainability and resilience ambitions by meeting the Sustainable ICT and Digital Services Strategy (2020 to 2025) objectives	**2.57**
2	3	Ensure Smart Foundations	Make sure that all projects and programmes meet the Technology Code of Practice and are cyber secure by design	**3.00**
2	4	Ensure Smart Foundations	Have a plan and move to cloud data hosting and management	**3.00**
2	5	Ensure Smart Foundations	Maintain a robust and secure network	**4.14**
2	6	Ensure Smart Foundations	Ensure hardware, software and end user devices are all within the suggested supplier life cycle and fully supported	**4.14**
2	7	Ensure Smart Foundations	Remove fax machines and non-emergency pagers, and maximise use of modern telephony and communication methods, for example, communications software	**3.86**
2	8	Ensure Smart Foundations	Ensure staff have access to the technology and devices that best support their roles	**3.71**
2	9	Ensure Smart Foundations	Maintain a central, organisation-wide, real-time electronic care record system	**3.57**
2	10	Ensure Smart Foundations	Extend the use and scope of your electronic care record systems to all services, ensuring greater clinical functionality and links to diagnostic systems and electronic prescribing and medicines administration (EPMA)	**3.00**
2	11	Ensure Smart Foundations	Contribute data to the ICS-wide shared care record in line with the Professional Records Standard Body's (PRSB) Core Information Standard	**4.00**

3. WGLL Assessment "Safe Practice" measure

ID-1	ID-2	Success Measure	Standard	Average score for ICS
3	0	Safe Practice	Comply with the requirements in the Data Security and Protection Toolkit which incorporates the Cyber Essentials Framework	**4.00**
3	1	Safe Practice	Fully use national cyber services provided by NHS Digital	**4.14**
3	2	Safe Practice	Have a secure and well-tested back-up, a plan to get off and stay off unsupported systems, and a rapid turn-around of High Severity Alerts	**4.00**
3	3	Safe Practice	Establish a process for managing cyber risk with a cyber improvement strategy, investment and progress regularly reviewed at board level	**3.57**
3	4	Safe Practice	Have an adequately resourced cyber security function, including a senior information responsible officer (SIRO) and data protection officer (DPO)	**4.14**
3	5	Safe Practice	Have an adequately resourced clinical safety function, including a named CSO, to oversee digital and data development and deployment across all care services	**3.57**
3	6	Safe Practice	Establish a clear process for reviewing and responding to relevant safety recommendations and alerts, including those from NHS Digital (cyber), NHS England and NHS Improvement, the Medicines and Healthcare Products Regulatory Agency (MHRA) and the Healthcare Service Investigation Branch (HSIB)	**3.71**
3	7	Safe Practice	Ensure clinical systems and tools meet clinical safety standards as set out by the Digital Technology and Assessment Criteria (DTAC) and DCB0129 and DCB0160	**3.00**
3	8	Safe Practice	Ensure you are compliant with NHS national contract provisions related to technology-enabled delivery (for example, clinical correspondence and electronic discharge summaries)	**3.14**

4. WGLL Assessment "Support People" measure

ID-1	ID-2	Success Measure	Standard	Average score for ICS
4	0	Support People	Your workforce is digitally literate and is able to work optimally with data and technology. Digital and data tools and systems are fit for purpose and support staff to do their jobs well.	**2.57**
4	1	Support People	Create and encourage a digital first approach and share innovative improvement ideas from frontline health and care staff	**3.29**
4	2	Support People	Support all staff to attain a basic level of data, digital and cyber security literacy, followed by continuing professional development	**3.14**
4	3	Support People	Ensure that the systems that your staff use are intuitive and easy to use	**3.29**
4	4	Support People	Support your staff to work flexibly, remotely, and across multiple wards or sites	**4.29**
4	5	Support People	Provide front-line staff with the information they need to do their job safely and efficiently at the point of care, for example ICS shared care record	**3.71**
4	6	Support People	Provide access to digital support services 24 hours per day, resulting in high first-time fixes	**3.57**

5. WGLL Assessment "Empower Citizens" measure

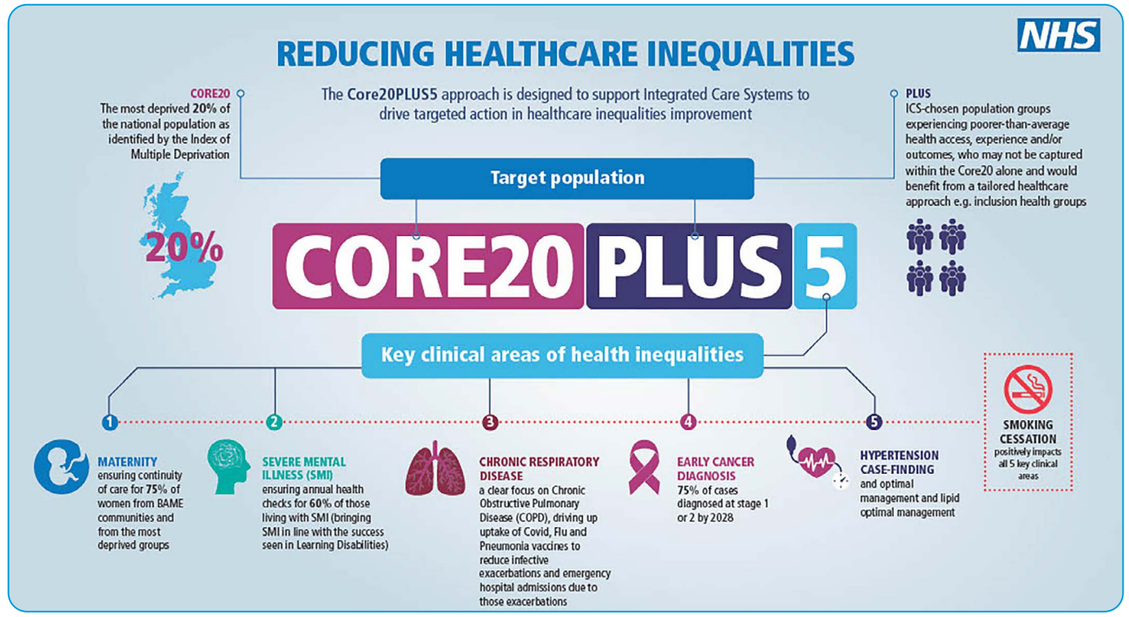
ID-1	ID-2	Success Measure	Standard	Average score for ICS
5	0	Empower Citizens	Citizens are at the centre of service design and have access to a standard set of digital services that suit all literacy and digital inclusion needs. Citizens can access and contribute to their healthcare information, taking an active role in their health and wellbeing.	**1.86**
5	1	Empower Citizens	Develop a single, coherent strategy, in conjunction with your ICS, for citizen engagement and citizen-facing digital services that is led by and has been co-designed with citizens	**2.57**
5	2	Empower Citizens	Make use of national tools and services (the NHS website, NHS login and the NHS App), supplemented by complementary local digital services that provide a consistent and coherent user experience	**2.57**
5	3	Empower Citizens	Use digital communication tools to enable self-service pathways such as self triage, referral, condition management, advice and guidance	**2.43**
5	4	Empower Citizens	Ensure that people can access and contribute to their health and care data	**1.86**
5	5	Empower Citizens	Ensure that citizens have access to care plans, test results, medications, history, correspondence, appointment management, screening alerts and tools	**1.86**
5	6	Empower Citizens	Have a clear digital inclusion strategy, incorporating initiatives to ensure digitally disempowered communities are better able to access and take advantage of digital opportunities	**2.86**

6. WGLL Assessment "Improve Care" measure

ID-1	ID-2	Success Measure	Standard	Average score for ICS
6	0	Improve Care	Health and care practitioners embed digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing. Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place.	**2.57**
6	1	Improve Care	Use data and digital solutions to redesign care pathways across organisational boundaries to give patients the right care in the most appropriate setting	**2.71**
6	2	Improve Care	Promote the use of digital tools and technologies that support safer care, such as EPMA and bar coding	**3.14**
6	3	Improve Care	Provide decision support and other tools to help clinicians follow best practice and eliminate unwarranted variation across the entire care pathway	**2.43**
6	4	Improve Care	Provide remote consultations, monitoring and care services, promoting patient choice and sustainability	**4.14**
6	5	Improve Care	Enhance your collaborative and multidisciplinary care planning using an array of digital tools and services alongside PRSB standards	**2.71**

7. WGLL Assessment "Healthy Populations" measure

ID-1	ID-2	Success Measure	Standard	Average score for ICS
7	0	Healthy Populations	Organisations use data to inform their own care planning and support the development and adoption of innovative ICS-led, population-based, digitally-driven models of care.	**2.14**
7	1	Healthy Populations	Use data to inform care planning and decision making in your organisation	**3.29**
7	2	Healthy Populations	Contribute data and resources to the ICS-wide population health management platform and use this intelligence to inform local care planning	**2.57**
7	3	Healthy Populations	Support the implementation of new ICS-led pathways and personalised care models that use digital platforms to coordinate care seamlessly across settings	**2.57**
7	4	Healthy Populations	Make data from your organisation available to support clinical trials, real-world evidencing and the development of AI tools	**1.86**
7	5	Healthy Populations	Drive digital and data innovation through collaborations with academia, industry and other partners	**2.43**



https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

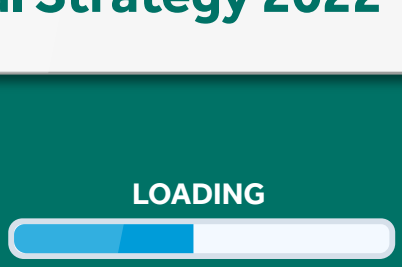
Current overall Hertfordshire and West Essex ICS WGLL maturity assessment average scores*

WGLL Measure	Ave Score	%
Well Led	3.2	64%
Ensure Smart Foundations	3.5	69%
Safe Practice	3.7	74%
Support People	3.4	68%
Empower Citizens	2.3	46%
Improve Care	3.0	59%
Healthy Populations	2.5	50%
ICS total - all measures	**3.1**	**63%**

*Average scores calculated July 2022

Hertfordshire and
West Essex Integrated
Care System

Digital Strategy 2022 – 2032



Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Primary Care Board				**Meeting Date:**	**24/11/2022**	
Report Title:	**Primary Care Digital Roadmap**				**Agenda Item:**	**11.1**	
Report Author(s):	Dr Rachel Hazeldene, Clinical Lead for Digital Primary Care, HWE ICB						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	Primary care digital roadmap plan discussed at Primary Care Digital Group, HWE, ICB						
Executive Summary:	Hertfordshire and West Essex Integrated Care Board (HWE ICB) is a new partnership between organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health, servicing a broad range of patient demographics, with varying health and care needs. The ICB is committed to improving digital opportunities to its communities. An ICB Digital Strategy has been developed highlighting the goals and objectives along with timeframes for delivery. Primary Care has several digital programme and initiatives which are deployed to accelerate digital solutions within this space, to enable patients and their clinical team to interact effectively and efficiently to improve health and wellbeing. A project is in place to bring together Primary Care Digital Strategy to align with the ICB Digital Strategy and to map out the current programmes and initiative into to clearly defined roadmap. Primary Care does not have resource within to undertake this work and is therefore seeking an external provider to carry out this work.						
Recommendations:	▪ Paper for information, Primary Care Digital Roadmap Report to come back for approval						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☒			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☐			
	GP at John Tasker House Surgery, west Essex						

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	To be completed alongside report
	Quality Impact Assessment:	To be completed alongside report
	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	☒

1. Executive summary

Hertfordshire and West Essex Integrated Care Board (HWE ICB) is a new partnership between organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health, servicing a broad range of patient demographics, with varying health and care needs.

The ICB is committed to improving digital opportunities to its communities. An ICB Digital Strategy has been developed highlighting the goals and objectives along with timeframes for delivery.

Primary Care has several digital programme and initiatives which are deployed to accelerate digital solutions within this space, to enable patients and their clinical team to interact effectively and efficiently to improve health and wellbeing.

A project is in place to bring together Primary Care Digital Strategy to align with the ICB Digital Strategy and to map out the current programmes and initiative into to clearly defined roadmap

Primary Care does not have resource within to undertake this work and is therefore seeking an external provider to carry out this work.

2. Background

Hertfordshire and west Essex Digital Leads have been working collaboratively for the last few years on several initiatives including the successful shared care record programme. In spring 2022 Hertfordshire and West Essex ICS Digital Leaders developed the ICS Digital Vision:

Our teams come together to deliver an effortless, integrated digital experience without boundaries to improve health and care outcomes for all people'

The ICS then commissioned a piece of work to develop the ICS Digital Strategy. The team engaged with stakeholders including system leadership, transformation teams, clinicians, digital leaders and supporting roles across social care, the third sector and our health care partners. Five key themes were identified:

- Digital Collaboration
- Digital Platforms
- Digital Direct Care
- Digital Innovation
- Digital Skills

The Hertfordshire and West Essex ICS digital strategy now provides a framework of principles and goals in which ICS-wide digital priority programmes will support the ICS transformation initiatives and support how investment decision making is made. It does not replace organisations' digital strategies: rather it informs, provides a reference point and context for those. Business as Usual (BAU) digital and information technology plans and digital solutions specific to one organisation's specialist needs are also out of scope of the HWE ICS digital strategy.

Primary Care needs to develop a Primary Care Digital Roadmap not only to link with the principles and themes of the ICS strategy; but to understand the BAU and solution specific needs and priorities of Primary Care across HWE ICB. This is particularly pertinent given the three CCG areas are now

being overseen by a single Primary Care Board, will soon share a single IT service provider; and primary care is now responsible for commissioning pharmacy, dentistry, and optometry services.

Main Aim:

The overarching aim is to provide a digital roadmap incorporating primary care within HWE ICB, to align the works being carried out to the ICB digital strategy and the primary care strategy.

Deliverables:

The project manager will be expected to:

- Define a project plan
- Capture a Stakeholder Map
- Provide a communications plan
- Define a suggested governance structure
- Define a Risk and R.A.I.D log
- Define a reporting structure

The project manager will deliver this work to the ICB through (as a minimum):

- PowerPoint presentation
- Written editable report (Word opposed to PDF)

3. Issues

RISKS	MITIGATIONS
Primary Care Winter Pressures, leading to urgent need for digital support/equipment	Use an agile approach to development of the roadmap, working in partnership with HBL to tackle urgent need as problems arise
Lack of stakeholder engagement	Prioritise and map stakeholders at an early stage, use a variety of communication and engagement channels to best suit the stakeholder
Inadequate time for sufficient engagement given broad stakeholder group including new services	Additional resource being recruited to support Roadmap development, to allow time for engagement. Develop plan for ongoing engagement with new providers as part of the Roadmap
Competing priorities of primary care workstreams needing support and engagement	Work collaboratively with Primary care, Transformation, Estates, and Workforce teams to avoid unnecessary duplication of engagement and share learning/insight
Inadequate support from primary care and digital teams	Names executive, clinical and digital leads to support development of roadmap

4. Options and Resource implications

External resource has been commissioned to support the development of the primary care digital roadmap, to allow sufficient time for stakeholder engagement and project delivery. Funding is available through the Digital First Primary Care programme.

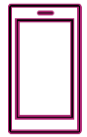
5. Recommendations and next steps

The project work will be undertaken, and the full findings and recommendations will be brought back to this Board in Spring 2023.

Status	**Green**		
Project Name	**Primary Care Digital Roadmap**		
Objective	The overarching aim is to provide a digital roadmap incorporating primary care within HWE ICB; to align the works being carried out to the national directives, the ICB digital strategy and the primary care digital strategy		
Deliverables	The project manager will be expected to: · Define a project plan · Capture a Stakeholder Map · Provide a communications plan · Define a suggested governance structure · Define a Risk and R.A.I.D log · Define a reporting structure		
Measurables	The project manager will deliver this work to the ICB through (as a minimum) a Power Point Presentation and a Written Report		
Benefits	· Identification of primary care digital priorities and requirements following Covid-19 pandemic · An understanding of the digital needs of the wider primary care community including pharmacy, dentistry and optometry · Alignment of primary care digital roadmap to ICS digital strategy and primary care strategy, identifying areas for collaboration and shared learning		
Scope	Now	Next	Delegate
	✓ Review of ICS digital strategy and its Five Identified Themes ✓ Engage with primary care team to link with primary care strategy plans ✓ Engage with partner primary care workstreams e.g. estates, workforce, transformation ✓ Undertake multifaceted engagement with primary care including practices and wider PCN teams ✓ Undertake engagement with wider primary care teams including pharmacy, dentistry and optometry	✓ Review and analyse key findings ✓ Develop Primary Care Digital Roadmap aligning to ICS Digital strategy ✓ Present report to primary care board and key stakeholder groups ✓ Identify outcomes and potential benefits	✗ Roadmap delivery and benefits realisation report
Roadblocks	Red	Amber	
	• Primary Care Winter Pressures • Inadequate time for sufficient engagement given broad stakeholder group including new services	• Lack of stakeholder engagement • Competing priorities of primary care workstreams needing support and engagement • Inadequate support from primary care and digital teams	

What is Digital Inclusion?

1. Digital inclusion is about ensuring digital technology, is available for everyone to access and use equally.
2. Requirements to be digitally included.



Digital skills.

Connectivity :

Accessibility:

3. Benefits of being digitally included in healthcare.

Patients & Carers:

Workforce:

ICB & Healthcare:

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1. Digital exclusion can be defined as exclusion from the use of digital technology, either directly or indirectly, to improve the lives and life chances
2. Barriers facing digital exclusion include:

Access	Skills	Motivation	Trust	Confidence
Devices & Hardware	Design	Awareness	Capability & Capacity	Unconscious Bias's

Community Research – ‘We are Digital’

Recognise the patient voice regarding Digital Inclusion and how it impacts them accessing health care.

Patients’ levels of digital exclusion

Patients’ experience of remote primary care

Patients’ digital health literacy

Approach

Realise our communities limits and needs to create equitable access to all in our local communities

Quantitative survey	**Telephone or online** **Baseline analysis** **Identify underlying relationships**	**605 valid responses** **583 patients** **82 cared for patients** **665 responses for analysis**
Qualitative interviews	**Telephone interviews** **Opportunity to hear patients’ voices** **Explore issues**	**107 interviews** **Seven interviews discarded** **100 transcripts for analysis**
Focus groups	**Ideally in person** **Designed for at-risk groups** **Deep dive on access barriers and solutions**	**Six Focus groups with 42 participants** **Three with disabled patients** **Two with carers** **One with homeless patients**

Summary of Findings

An estimated **87,000 patients in contact with primary care lack the skills or confidence to access digital services** and over 64,000 have internet safety concerns that prevent them using digital channels to access personal healthcare services.

15% of patients **strongly disagreed that they are confident to use digital services** and 8% strongly agreed that the internet is not secure enough to share information about their health online.

The more digitally excluded patients were, the harder they found it to access primary care services. The majority (62%) of the most digitally excluded group found it "Very difficult" to access primary care services.

Many patients have had a negative experience of primary care digital services and will be unlikely to want to do this again. **Nearly a quarter (24%) said they had found it difficult to make an appointment via digital channels**.

Digital exclusion is affecting a significant proportion of primary care patients in HWE. **Over a quarter of surveyed patients (26%) strongly disagreed that they always prefer to use websites to access services than speak to somebody**.

Using a web interface such as eConsult requires users to create and submit content to describe their health concern but this is the least likely digital activity for patients to have been undertaking, with nearly **60% stating that they never created content online**.

Half (50%) of interviewed patients said their experience of contacting their GP practice was negative and nearly a quarter (24%) said this was because their GP practice's online services were poor or did not work properly.

Digital primary care services perceived to be easier than alternatives are readily adopted by patients. **75% of those requesting repeat prescriptions did so via their GP practice's website.**

Digital exclusion is likely to be preventing older and disabled patients, and those with complex needs accessing remote primary care. **16.2% of interviewed patients were unable to access the services they needed from their GP practice.**

Digital exclusion is likely to be causing patients to take inappropriate action to address their medical concerns. **Only 18% of interviewed patients used only official NHS online sources of information about health and healthcare**.

33% of patients (the largest group) preferred website only communications with service providers whereas **most (56%) patients preferred to contact healthcare providers by phone only**.

Patients who are more digitally included are more likely to contact their GP practice via digital channels. **No patients in the most digitally excluded group had contacted their GP practice via its website or by email**.

40% of interviewed patients were unable to fully discuss their health concerns remotely with a medical professional, which was exacerbated by patients who had difficulty affording internet connectivity and devices.

Deaf patients found it particularly difficult to use primary care services with many saying that support for British Sign Language communication was not offered or properly implemented.

Patients in the most digitally excluded group being **twice as likely to have had contact with their GP practice twelve or more times** in the previous year than any other group.

Male, older and disabled patients and those registered with GP practices in deprived areas are more likely to be digitally excluded and, **older patients particularly, are more likely to have a strong preference for contacting their GP practice via non-digital channels**.

Remote GP appointments have been difficult for many patients because they were not given appointment times. 51% of interviewed patients had had appointments without being given a time.

Overall patients' health has declined since March 2020. 47.4% of patients are in worse health compared to just 12.4% who are in better health.

Most remote primary care appointments have been ineffective at meeting patient's clinical needs. Three quarters (74.5%) of interviewed patients who had a telephone appointment had to have a follow-up face-to-face appointment.

Patients who are more digitally included are more likely to contact their GP practice via digital channels. **No patients in the most digitally excluded group had contacted their GP practice via its website or by email**.

Recommendations and Next Steps

Theme	Short Term	Medium Term	Long Term
Digital Inclusion Support	PCN level digital inclusion pilots	Commission a Digital Inclusion support service	Provide workforce training
Service Design	Quick wins to improve access	Review access and GP contact processes and ensure they are simple	Ensure all digital services are compatible on all devices with minimal data transfer
Further Research	Investigate a small number of practice where patient feedback is positive despite service delivery change	Seek to better understand views and experiences of patients of minority ethnicities and cultures, including those who do not have English as their first language	

Any Questions?

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Primary Care Board				**Meeting Date:**	**24/11/2022**	
Report Title:	**Digital Inclusion**				**Agenda Item:**	**11.2**	
Report Author(s):	Joanne Richardson, Digital Primary Care Programme Manager, Megan Knight, Digital Primary Care Project Support, HWE ICB.						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	Community Research, Remote Access to Primary Care discussed at Primary Care Digital Group, HWE, ICB ▪ Final Version						
Executive Summary:	Digital First Primary Care is a national programme, devised to encourage and support GP Practice services to implement and embrace digital technologies, in the aim to streamline work processes for staff and most importantly, improve access of treatment and/or support for patients. Digital inclusion plays a huge role within the success of this overall programme; therefore, a specific workstream was initiated to focus on this matter, looking at what barriers patients across our ICS may face when using technology, and how we can lessen the divide of exclusion, and avoid widening health inequalities.						
Recommendations:	Papers attached are for information and include recommendations derived from the insights of the research						
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	☒

1. Executive summary

Digital First Primary Care is a national programme, devised to encourage and support GP Practice services to implement and embrace digital technologies, in the aim to streamline work processes for staff and most importantly, improve access of treatment and/or support for patients.

Digital inclusion plays a huge role within the success of this overall programme; therefore, a specific workstream was initiated to focus on this matter, looking at what barriers patients across our ICS may face when using technology, and how we can lessen the divide of exclusion, and avoid widening health inequalities.

A piece of research was commissioned to 'understand patients' remote access into primary care throughout HWE ICS'. The aim of the work was to ensure HWE ICS understands the local community's digital needs and its limitations. By identifying key target groups, this allowed us to commence the development of tailored solutions and strategies, to improve digital inclusion, highlighting those with the greatest need and/ or long-term health conditions.

2. Background

Hertfordshire and West Essex ICS is a partnership between local healthcare organisations. It comprises of 3 main localities: East and North Hertfordshire, South and West Hertfordshire, and West Essex. Its key aim is to meet healthcare needs across the local area, by planning and coordinating services in a way that improves population health and reduces inequalities between different groups of people.

The DFPC contracted "We are Digital" to carry out the research, due to lack of resource within the team. We Are Digital, are a leading provider of digital inclusion services. We asked them to explore patients experience and use of technology in daily life and how this affects their remote access to primary care. Furthermore, we requested they include insights and provide us recommendations, in which can be used as a foundation when providing support for primary care.

Main Aims:

- To broaden digital literacy and participation for our healthcare staff and patients within primary care.
- Raise the awareness of the advantages of accessing health information and services via online avenues.
- Create relationships and work in partnership with related, local organisations/projects, who focus on these (excluded) groups most in need, to address the unwarranted disparity in care.

Deliverables:

- Sharing our learning on local Digital inclusion to Primary Care, via recommendations for best practice.
- Highlight the advantages of accessing health information/services online and encourage digital participation for our healthcare staff and patients in primary care.

- Realize the community's digital needs and limitations and identify key target groups, establishing tailored solutions to improve digital inclusion, paying attention to those with greatest need and long-term health conditions.
- Devise a digital resource hub allowing practices to signpost patients to services providing technology, training, and ongoing assisted digital support.
- Recommend a primary care digital inclusion strategy to encourage inclusivity covering digital skills, connectivity, accessibility.

3. Issues

Research limitations included:

- Most research participants were female (76.1%)
- Very few young adults aged 18-24 took part in the research
- It was difficult to engage the most digitally excluded patients directly
- Patients in BAME groups were somewhat underrepresented in the research
- No patients with poor English language took part in the research
- It was difficult to establish themes through the qualitative interviews due to the variety in services offered by GP practices

4. Options

We require the research to deliver:

- Understand how confident patients are when accessing Primary Care in each scenario for example contacting a practice for illness, requesting a repeat prescription etc.
- Understand what the patient's awareness is of the digital options offered by their practice, do they know what they can do and how they can gain access?
- Understand if the journey to access Primary Care remotely differs for patients to carer
- Understand what barriers are perceived by patients?
- Understand where the risks are for example patients with language barriers, dyslexia, visual impairments etc.
- Understand whether a patient has longer term/ chronic condition?
- Understand if patients engage with search engines such as Google for help with their medical concerns and which medical apps do they use?
- Understand from our patients if and why they transact online for example do they shop, bank, socialise etc. and is there anything Primary Care can learn from other industries?
- What challenges do they face with other online businesses and opportunities?
- Understand the user experience and do patients have ideas on how access could be improved on a remote/ online model?
- The research should be evenly split across core groups and available in mixed formats.

The aim of the research was to:

- Provide a summary of the analysis
- Provide insights to help find solutions for those who are presenting as being digitally excluded
- Identify our patients needs and understand from them how can we raise awareness of digital opportunities within Primary Care
- Provide a data drive approach allocating patients into cohorts to tackle their needs for digital inclusion
- Provide an understand of our 'high risk' and 'at need' patients
- Provide an understand of how HWE ICS can adapt internal processes to suit our patients needs
- Allow HWE ICS to holistically consider data capture in improve Population Health Management
- Provide evidence to Primary Care for any changes needed to inclusively improve the patient journey and evolve practice's operating systems and procedures.

5. Resource implications

Unfortunately, the DFPC programme does not have the required skills, nor staff resource, to efficiently conduct or evaluate the research, therefore we commissioned "We are Digital" to carry out this work.

6. Recommendations and next steps

The full findings and recommendations can be found within the attached report. The table below summarises the next steps for our workstream.

Theme	Short Term	Medium Term	Long Term
Digital Inclusion Support	PCN level digital inclusion pilots	Commission a Digital Inclusion support service	Provide workforce training
Service Design	Quick wins to improve access	Review access and GP contact processes and ensure they are simple	Ensure all digital services are compatible on all devices with minimal data transfer
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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)*	☐			
	HWE ICB Primary Care Board				**Meeting Date:**	**24/11/2022**	
Report Title:	**HWE ICB Primary Care Strategy Development: Principles and Approach**				**Agenda Item:**	**12**	
Report Author(s):	Avni Shah Director Primary Care Development HWE ICB James Gleed, Associate Director Primary Care Commissioning, HWE ICB						
Report Signed off by:	Avni Shah Director Primary Care Development HWE ICB						
Purpose:	**Approval**	☒	**Decision**	☐	**Discussion**	☒	**Information** ☐
Report History:	N/A – no previous reports in this series						
Executive Summary:	Hertfordshire and West Essex Integrated Care Board (HWE ICB) is a new partnership between organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health, servicing a broad range of patient demographics, with varying health and care needs. Primary Care is at the heart of transformation in the ICB to deliver the objectives and vision of the ICB. Whilst the three predecessor CCGs had written strategies for the development of primary care for respective areas and the HWE STP had also previously developed a Primary Care Strategy, it has been agreed to review this and align to the developing system wide strategies and clinical programmes using a population health management approach and national publications including the Fuller Stocktake. The development approach is to bring together all the key components of primary care (General Practice and all independent contractors) in a system wide approach. To note that the ICB is not starting from beginning and it is about building on this but also having a vision an clear implementation plan to take this forward. Aim is to develop the strategy and road map of implementation by March 2023.						

Recommendations:	▪ To discuss the approach to develop a primary care strategy for HWE			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☒
	Members of the Primary Care Board that are practicing GPs are directly affected by decisions relating to investment in primary medical services which may fall within the scope of a clinical strategy. The scope of this paper however is limited to the approach to strategy development.			
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	☒		

1. Executive summary

Hertfordshire and West Essex Integrated Care Board (HWE ICB) is a new partnership between organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health, servicing a broad range of patient demographics, with varying health and care needs. Primary Care is at the heart of transformation in the ICB to deliver the objectives and vision of the ICB.

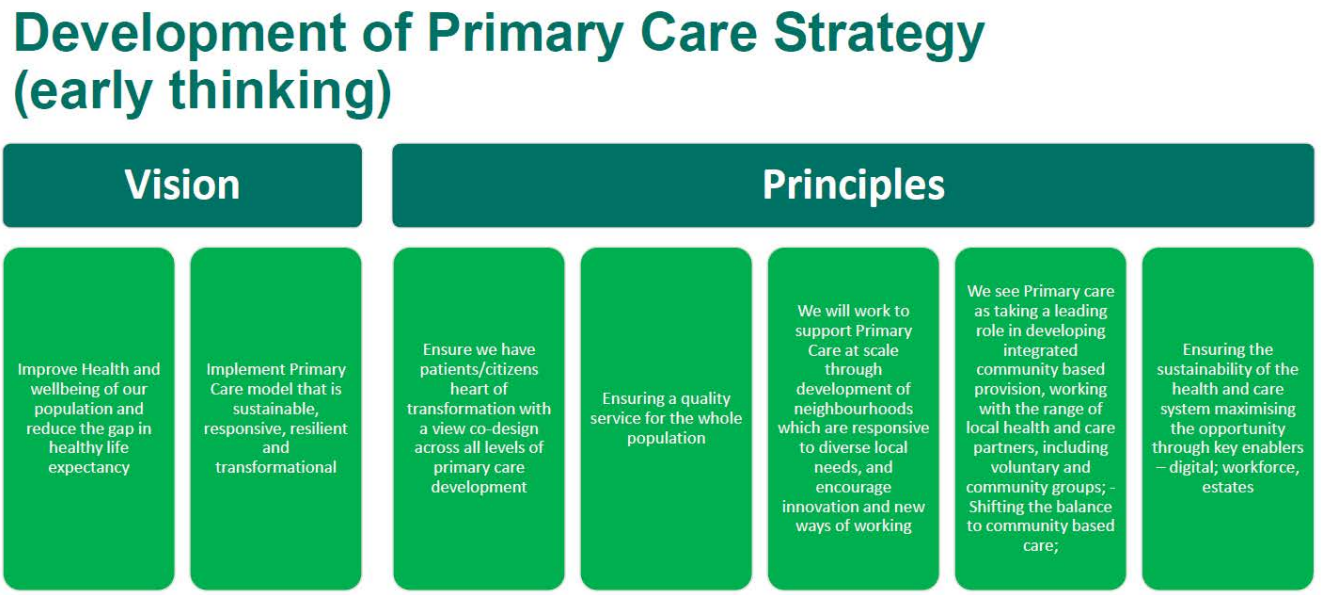
Whilst the three predecessor CCGs had written strategies for the development of primary care for respective areas and the HWE STP had also previously developed a Primary Care Strategy, it has been agreed to review this and align to the developing system wide strategies and clinical programmes using a population health management approach and national publications including the Fuller Stocktake.

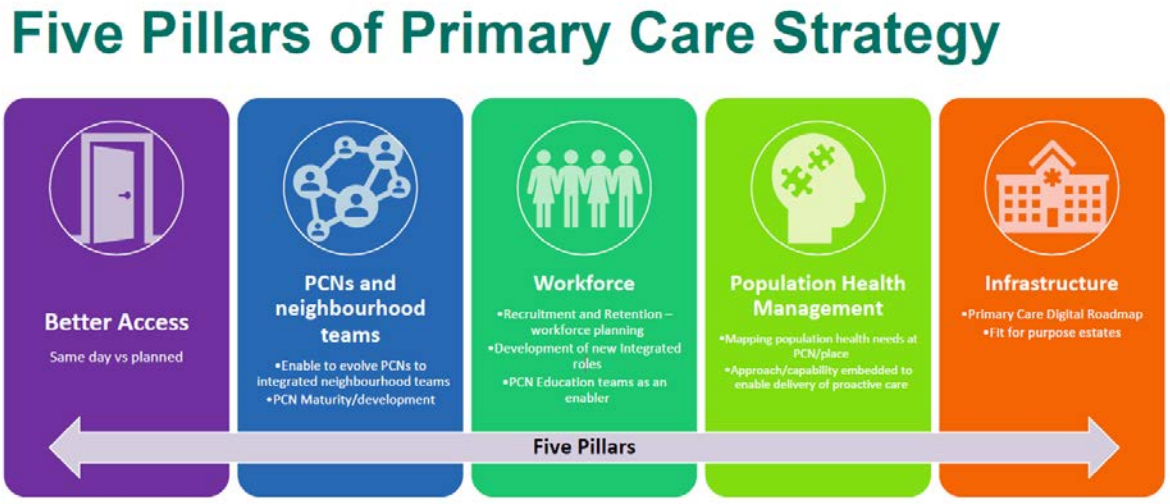
The development approach is to bring together all the key components of primary care (General Practice and all independent contractors) in a system wide approach. To note that the ICB is not starting from beginning and it is about building on this but also having a vision an clear implementation plan to take this forward.

Aim is to develop the strategy and road map of implementation by March 2023.

2. Background

The ICB has not yet developed a strategic plan for the transformation and development of primary care, there has however been some very early thinking which was discussed as part of an induction meeting of the ICB Primary Care Clinical Leads earlier this month.





3. What is Primary Care

There is no one single definitive definition of the term ‘Primary Care’, however in England it is widely accepted as being the four independent contractor groups:

- Community Pharmacy
- Community Optometric services
- Community Dental
- General Practice

HWE ICB currently has delegated commissioning responsibility from NHSEI for General Practice and will receive delegated responsibility for the commissioning of the remaining three independent contractor groups from April 2023.

There are relationships and interdependencies between the four contractor groups and other health and social care services that patients registered with GP practices in HWE frequently access; consequently, it is not possible to develop a strategy for general practice in isolation.

In addition, with the expansion of the additional roles in the primary care, there are a range of health and care professionals now working across general practice and hence it is key for any future primary care strategy to take into account the impact on community and how we can integrate to ensure there is a resilient workforce to deliver the new ways of working and transformed models of care.

There are multiple strategies being developed across the HWE footprint which creates a risk of incongruence between the various plans, these strategies include:

- The three healthcare partnerships have discretion to develop clinical strategies e.g. ENH Care Closer to Home Strategy, Transformation areas for South and west and also
- Development of the ICP Integrated Care Strategy
- Recently approved ICS Digital Strategy – development of the road map for primary care digital
- Recently approve ICS People's Strategy – development of the primary care workforce plan
- East of England -Development of Community Pharmacy Strategy, transformation and priorities for dental and optometry.
- All PCNs are developing an individual clinical strategy and premises strategy – a national programme of work led by Community Health Partnership (CHP) and Health Integration Partnership (HIP). Funded through NHSE. Aim to have outputs of this by end of March 2023.

Developing a strategy is important in terms of setting out the future desirable characteristics of primary care and being able to chart progress against achieving this, however a strategy alone will not deliver change.

A delivery plan with milestones will be required to operationalise the strategy and enact the transformation building on the principles and finessing the areas of strategy for transformation through anchoring our Primary Care Network to support.

a. Prevention – helping people stay well for longer
b. Chronic and complex care – delivering proactive and personalised care through multidisciplinary approach
c. Integrated Urgent Care – making it easier to access urgent care and advise for those people who need services infrequently but want to access it quickly.

Our challenge in developing this strategy will be create the conditions for health and care organisations to work together to design and delivery services with all stakeholders especially our patients who are at the heart of this which will enable us to excel against these three measures in the future, in particular around the areas of workforce, estates, technology and data.

5. Resource implications

The new HWE ICB Primary Care Directorate structure includes new primary care strategic planning roles: Associate Director Primary Care Strategy and a Primary Care Strategy Manager. The above roles are currently vacant however the expectation is to have appointed by January 2023 at the latest.

The development of the strategy will require matrix working not just within the primary care directorate but also across ICB directorate to ensure the strategy is aligned.

Delivery of the transformation set out in the strategy will be led by the place-based primary care transformation /development teams; it is likely that plans will be nuanced according to specific local needs and opportunities.

6. Risks/Mitigation Measures

Primary Care Services receive a majority of their funding through a nationally negotiated contract transacted by the ICB and currently NHSE at individual practice level.

Participation in new models of care delivery, transformation, integration and innovation requires buy-in from general practice and all other independent providers.

The needs of primary care, wider system partners, patients and the available resources may, in some instances, not always wholly align.

Principles for strategy development:

- Engagement and consultation will be genuine and meaningful
- Engagement and consultation activities undertaken with primary care colleagues will be undertaken in a manner that requires investment of the least amount of time possible
- Practices and PCNs and other primary care providers will only be asked for data that is not already available through other sources
- The patient view will help inform the work, with an emphasis on groups for which there is inequality of access
- System partners' input and advocacy will be sought
- The strategy should focus on those things which cannot be achieved by individual practices developing in isolation within their existing resources
- The work will be clinically led throughout
- The focus on management of ill-health management will be balanced with a commitment to preventative healthcare – the strategy will encompass initiatives and interventions that may not realise their full impact for up to 10 years or beyond

- The strategy will establish the responsibilities of service users, not just the input and actions of health and care services

- The value of communities and ‘social capital’ will be captured

- The strategic plan will ensure we capitalise on the critical role that the voluntary sector can (and must) fulfil in helping patients that seek help in the primary care environment

- Investment in primary care will be informed by patient need and will follow activity, this may mean that the current picture of investment across HWE will change

- The aims and aspirations for the development of primary care will align with, and complement all other strategic planning across the ICB

- The final document will be produced in a format appropriate for the intended readership – public-facing documentation will be written in plain jargon-free language and communicated through other mediums such as animations to ensure the widest possible reach.

7. Recommendations

To develop an ICB Primary Care Strategy in accordance with the principles outlined in this paper.

8. Next Steps

- Recruit to the new ICB Primary Care Directorate Structure

- Establish the ICB Primary Care Transformation Group with the Primary Care Clinical leads under leadership of Dr Prag Moodley

- Develop an engagement plan to be implemented between end of Jan through to month of February.

- Aim to have draft strategy for March 23.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Primary Care Board				**Meeting Date:**	**24/11/2022**	
Report Title:	**Voluntary, Community, Faith and Social Enterprise (VCFSE) Health Creation Strategy**				**Agenda Item:**	**13**	
Presentation Author(s):	Jo Marovitch, CEO Herts Mind Network and Chair of the HWE VCFSE Alliance Tim Anfilogoff, Head of Community Wellbeing, HWE ICB						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation, HWE ICB						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☒	**Information** ☐
Report History:	• Integrated Care Partnership Board, January 2022 early discussion of principles • Health Creation Strategy direction of travel approved by ICB Commissioning Committee, 10 November 2022						
Executive Summary:	The slides present the context of the Health Creation Strategy: • Role of VCFSE in addressing wider determinants of health that the NHS cannot easily address • Co-designed with new VCFSE Alliance to complement all other strategies and developments (ie focusing on the unique contribution of the VCFSE) • Sets out current make-up of Alliance Steering Group • Gives some examples of non-clinical VCFSE interventions with clear clinical outcomes • Sets out the ten key themes of the strategy with specific reference to No Wrong Door and Health Inequalities • Identifies next steps around developing governance The draft strategy is appended as Appendix 1 The strategy looks at more effective commissioning of the VCFSE in general, based on evidence of need and impact but has no financial implications in the immediate short term.						

Recommendations:	• Endorse direction of travel • Suggest opportunities to further enhance the partnership between primary care and community to improve the health of the population			
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐
	Financial	☐	***Non-Financial Personal***	☐
	None identified			☐
	N/a as this relates to the whole of the VCFSE sector in HWE and not the commissioning of any particular provider etc			

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

The Herts and West Essex Voluntary, Community, Faith and Social Enterprise (VCFSE) Alliance & the joint Health Creation Strategy for the ICS

Tim Anfilogoff, Head of Community Wellbeing, HWE ICS
Jo Marovitch, CEO Mind in Mid Herts and Chair of the VCFSE Alliance

Hertfordshire

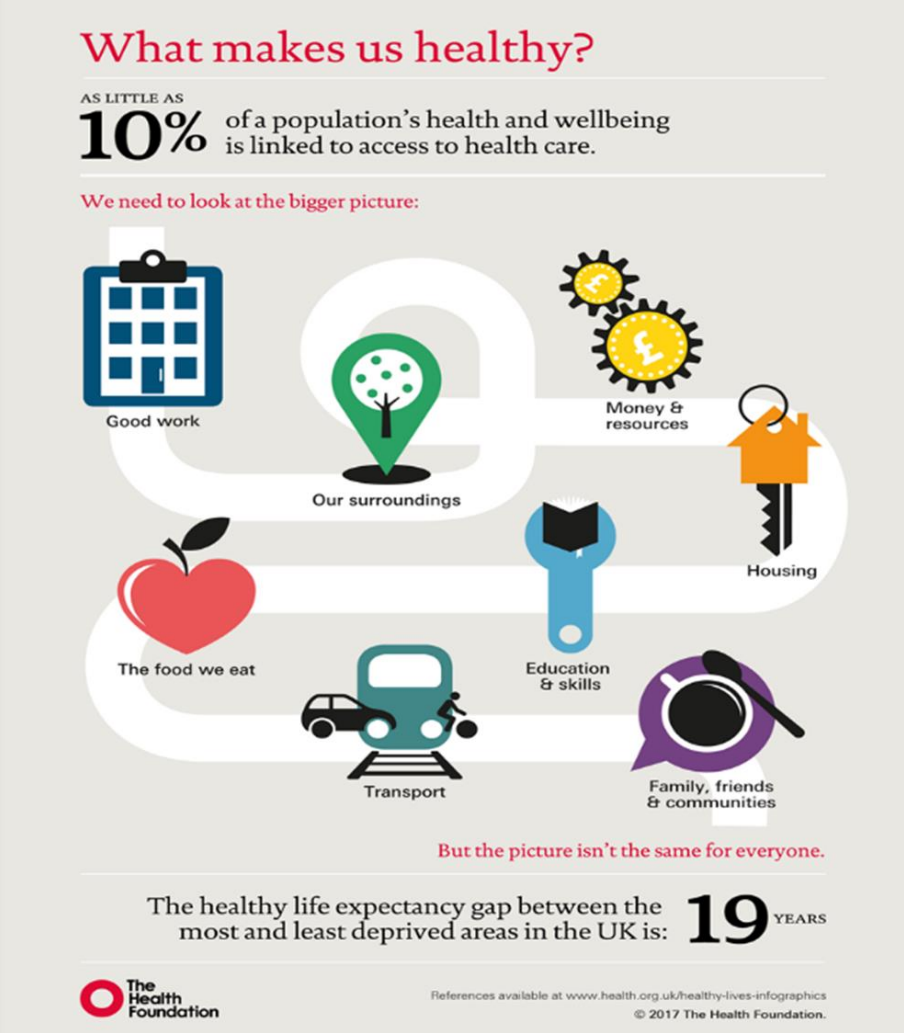
Essex County Council

Fair Question?

‘What's the point of treating people and then sending them back to the conditions that made them sick in the first place?’

Professor Sir Michael Marmot

Wider Determinants of Health



- People often go to NHS because they don't know where else to go
- Social problems and distress can be 'pathologized'
- 1 in 5 visits to GP prior to Covid 'non-clinical'
- Social Prescribing (linking people to help in their communities) can change this

What's unique about the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector?

- Volunteers
- Rooted in communities
- Not for profit – surplus goes on benefits to community
- Charitable donations
- Flexible, local, responsive, approachable

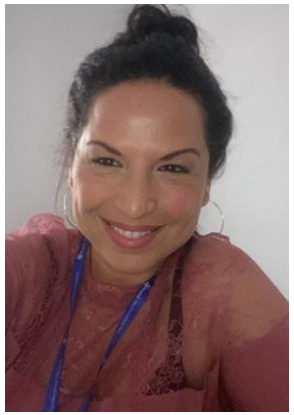
Principles of VCFSE Health Creation Strategy

- Will work with all the other strategies – no duplication
- Focuses on unique contribution of VCFSE to any given area
- Seeks to ensure all developments and services look at ‘community end of the pathway’
- Co-designed with the **VCFSE Alliance**, creating an equal partnership so VCFSE contribution valued, acknowledged, promoted and properly resourced in line with agreed approach

West Essex		South and West Hertfordshire		East and North Hertfordshire	
Nominated	Elected	Nominated	Elected	Nominated	Elected
Sam Glover Healthwatch Essex	**Kate Robson** **Citizens Advice** Uttlesford	**Sarah Wren** Herts Independent Living Service	**Joanna Marovitch** Herts Mind Network	**Hannah Morgan-Gray** North Herts and Stevenage CVS	**Charlotte Blizzard-Welch** Citizens Advice Stevenage
Clive Emmet Uttlesford CVS	**Alison Wilson** Mind in West Essex	**Simon Aulton** Community Action Dacorum	**Rushna Mia** Herts Asian Women's Association	**Geoff Brown** Healthwatch Herts	**Mark Hanna** Age UK Hertfordshire

Steering Group Vice Chair
Kate Robson

Steering group Chair
Joanna Marovitch



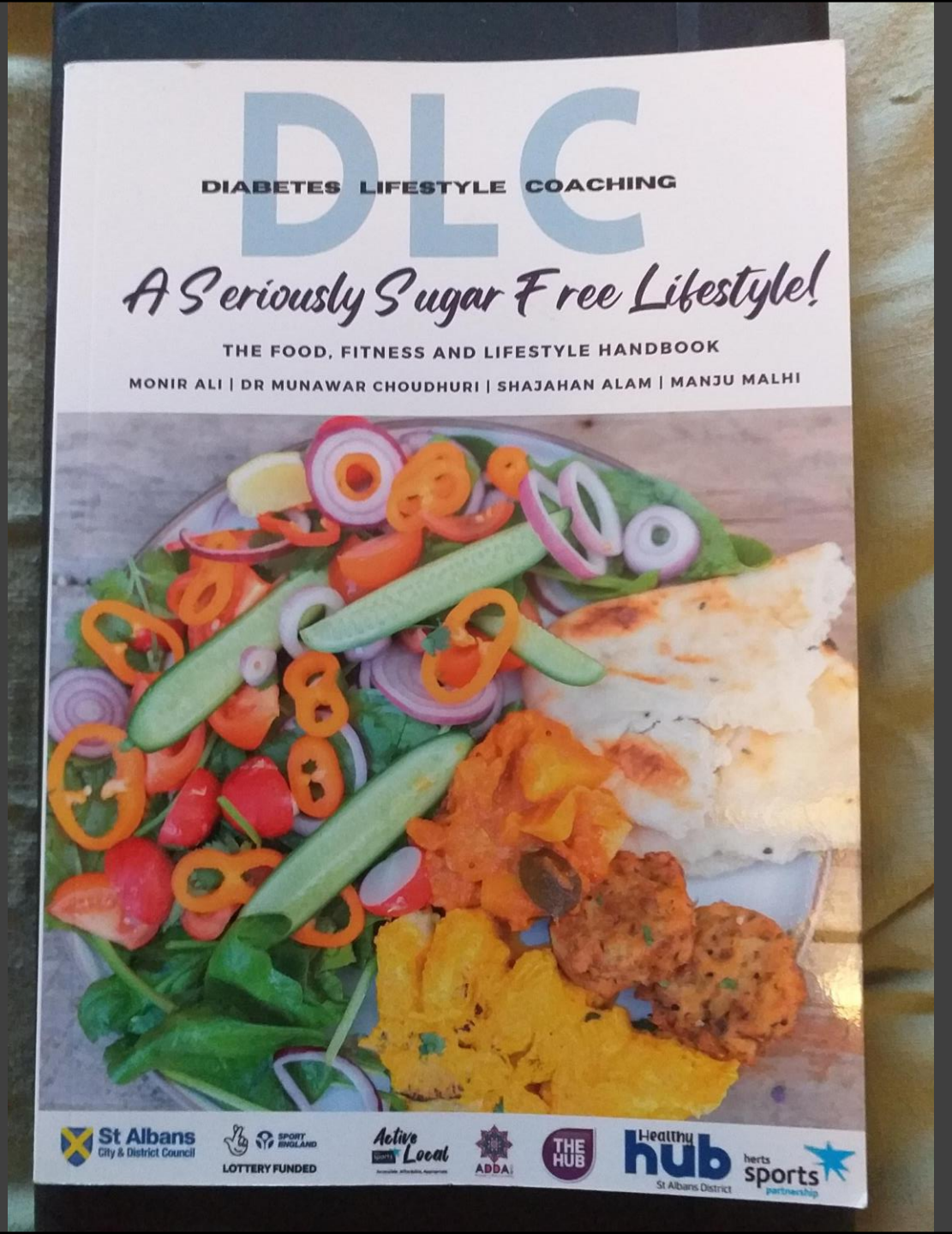
Steering Group Vice Chair
Charlotte Blizzard-Welch

Hertfordshire and West Essex Voluntary, Community, Faith and Social Enterprise Alliance

info@vcfseAlliance.org

Community-led health

- Example of work led by Asian community
- Culturally appropriate self care, prevention and lifestyle coaching
- Developing the prevention end of the type 2 diabetes ‘pathway’



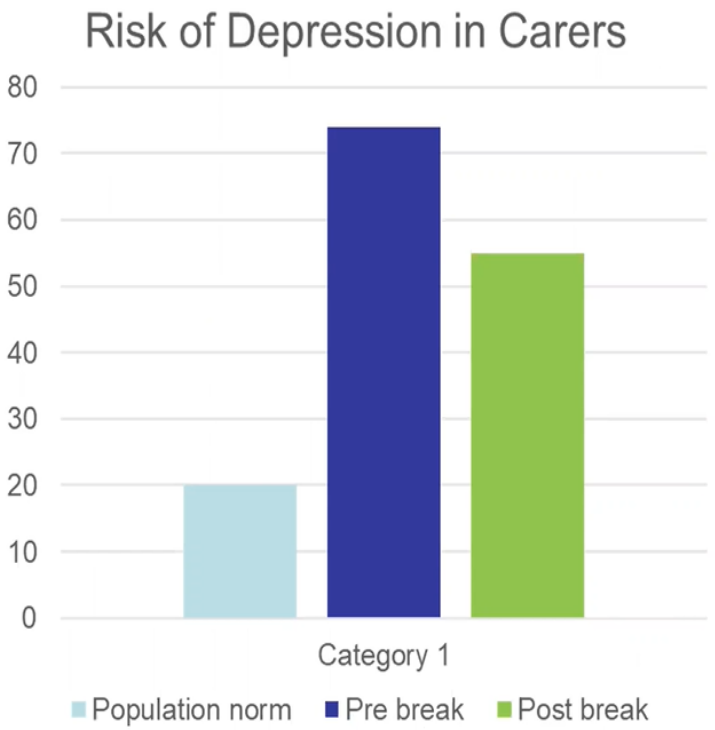
Growing People

Letchworth Healthy Living Centre

- Social and Therapeutic Horticulture for wellbeing and positive mental health
- Non-stigmatising

Impact from Make a Difference for Carers

Data from SF12v2



(£255 saving per person) without taking into account any benefits to carers other than reduction in risk of depression

Case Study

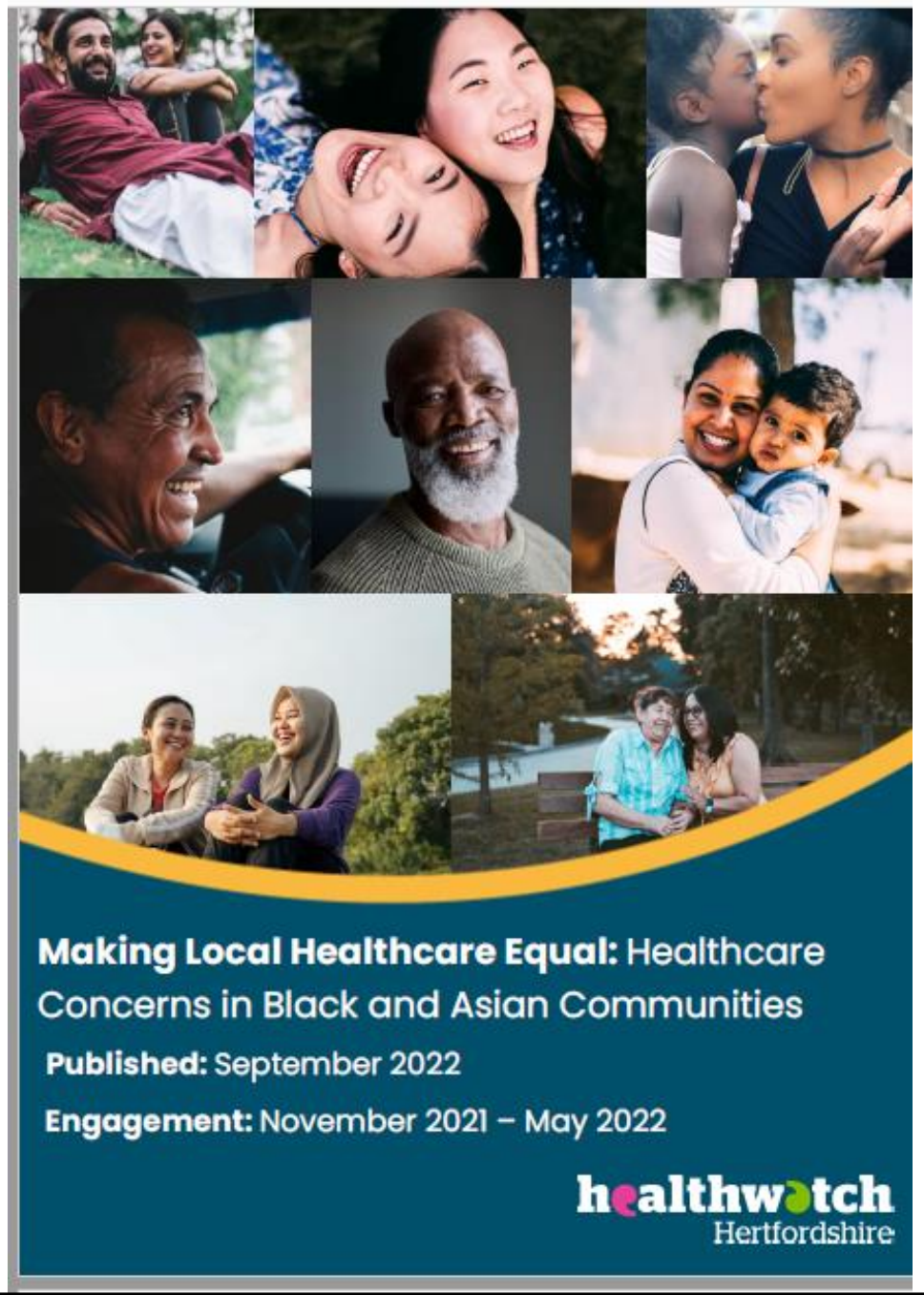
Took break away from home.

- ”this has saved my life”.
- For the first time in 27 years carer felt supported enough to leave son and go on holiday.
- Carer is considering volunteering for Carers in Hertfordshire.

Improving Access

- Research
- Advocacy
- Bridge to communities - eg Covid Recovery Ethnically Diverse (CRED) Project and Information Champions…

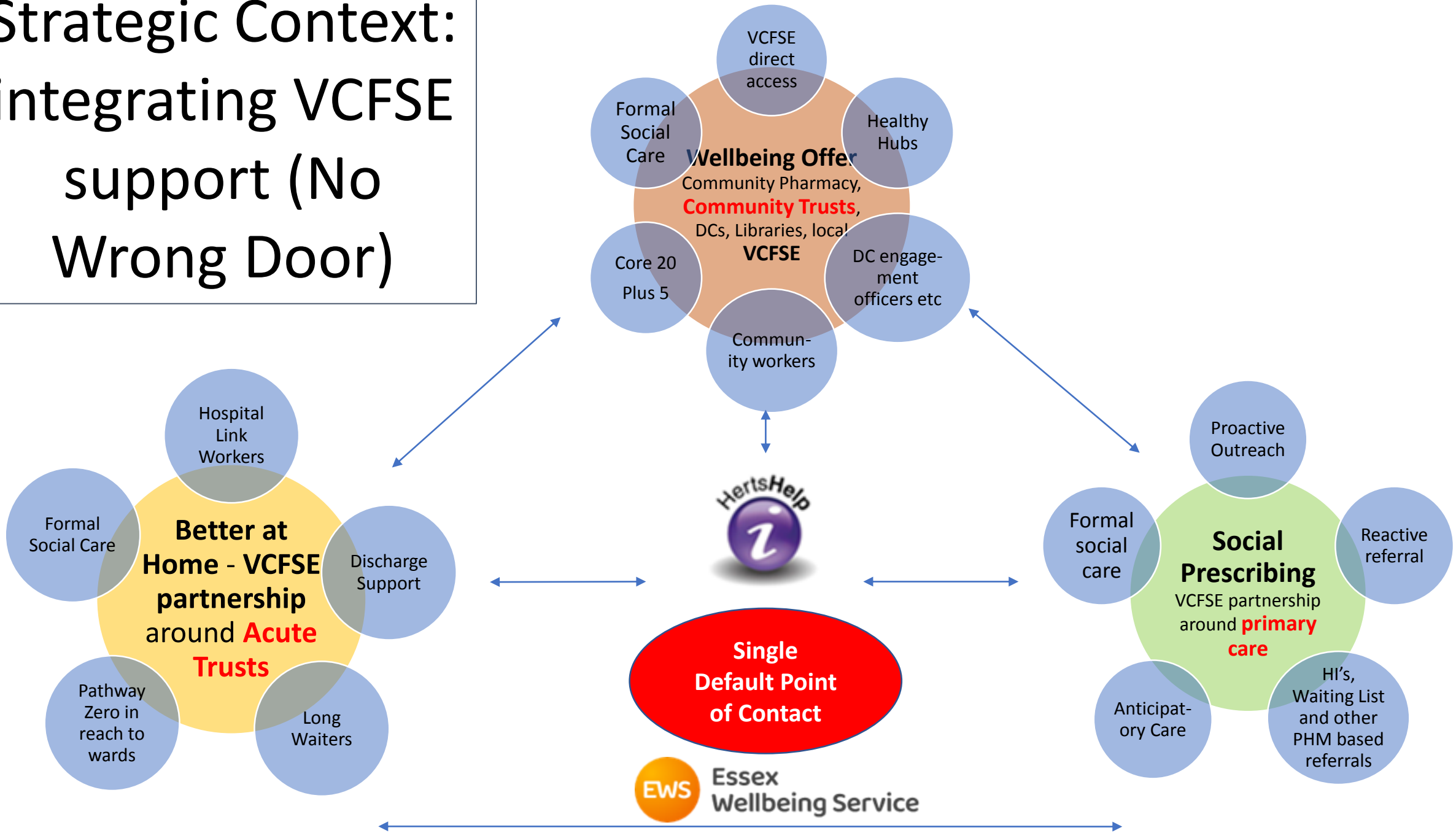
Boosting vaccine take up in under-served communities (London Colney Islamic Centre)



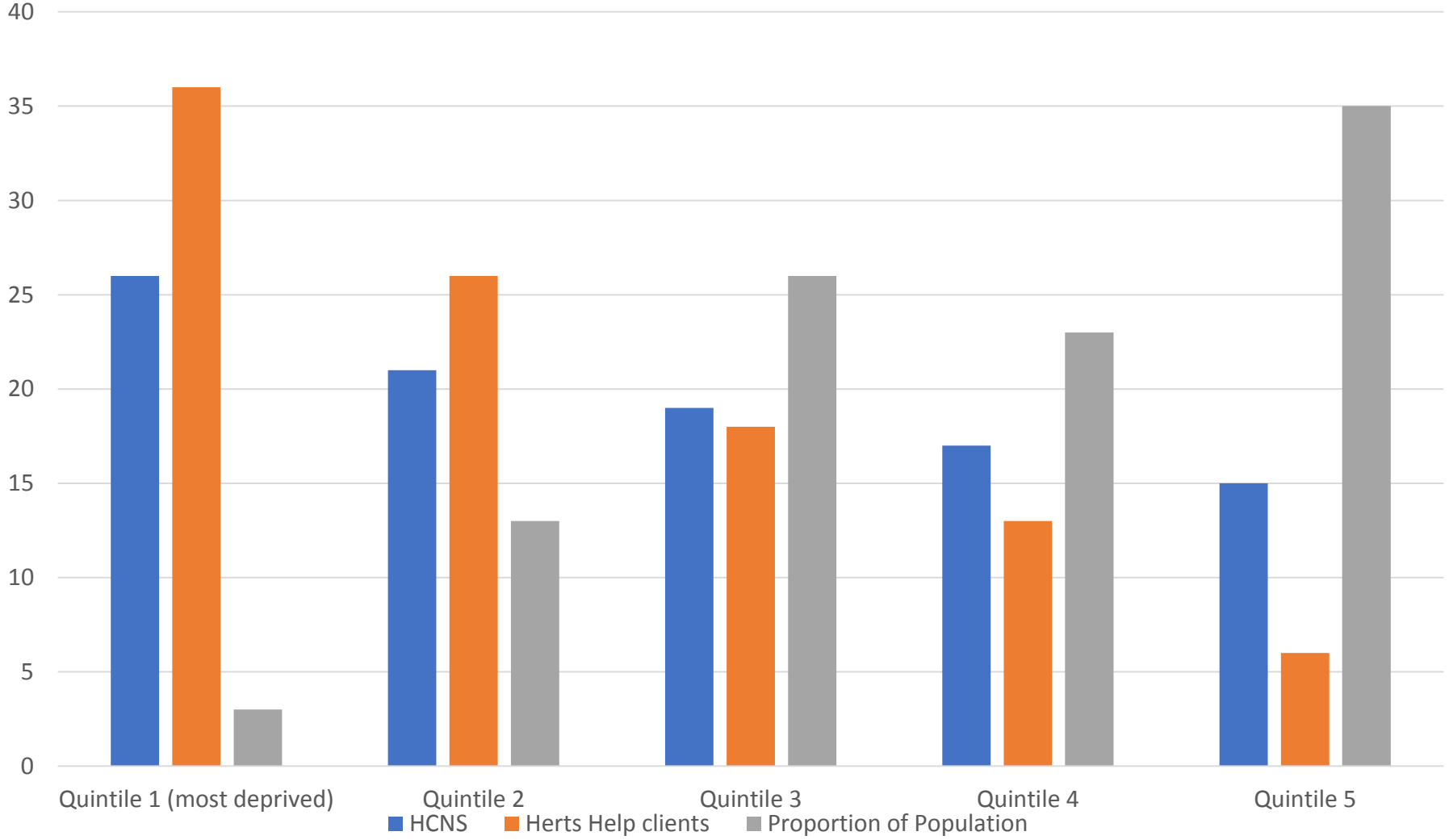
Key Themes Identified so far

1. Build on what is already working locally (community assets)
2. **NO WRONG DOOR** (addressing inequalities around ‘access’)
3. Health Inequalities (addressing the preventable factors that cause ill health like cold homes or caring without support)
4. Making it easy for you to find help to stay well (Improved system-wide ‘Wellbeing Offer’)
5. Improving the health and wellbeing of family/unpaid carers
6. Volunteering (because it’s good for the volunteer as well as society)
7. Good quality data (identifying need and showing the impact of VCFSE)
8. Making sure community voices are hear and have influence (Co-production and ‘culture’)
9. High Quality Commissioning (funding what’s needed and what works)
10. Annual Planning and Reporting (what’s been achieved: public value, return on investment, savings; what were the blocks and challenges etc)

Strategic Context: integrating VCFSE support (No Wrong Door)

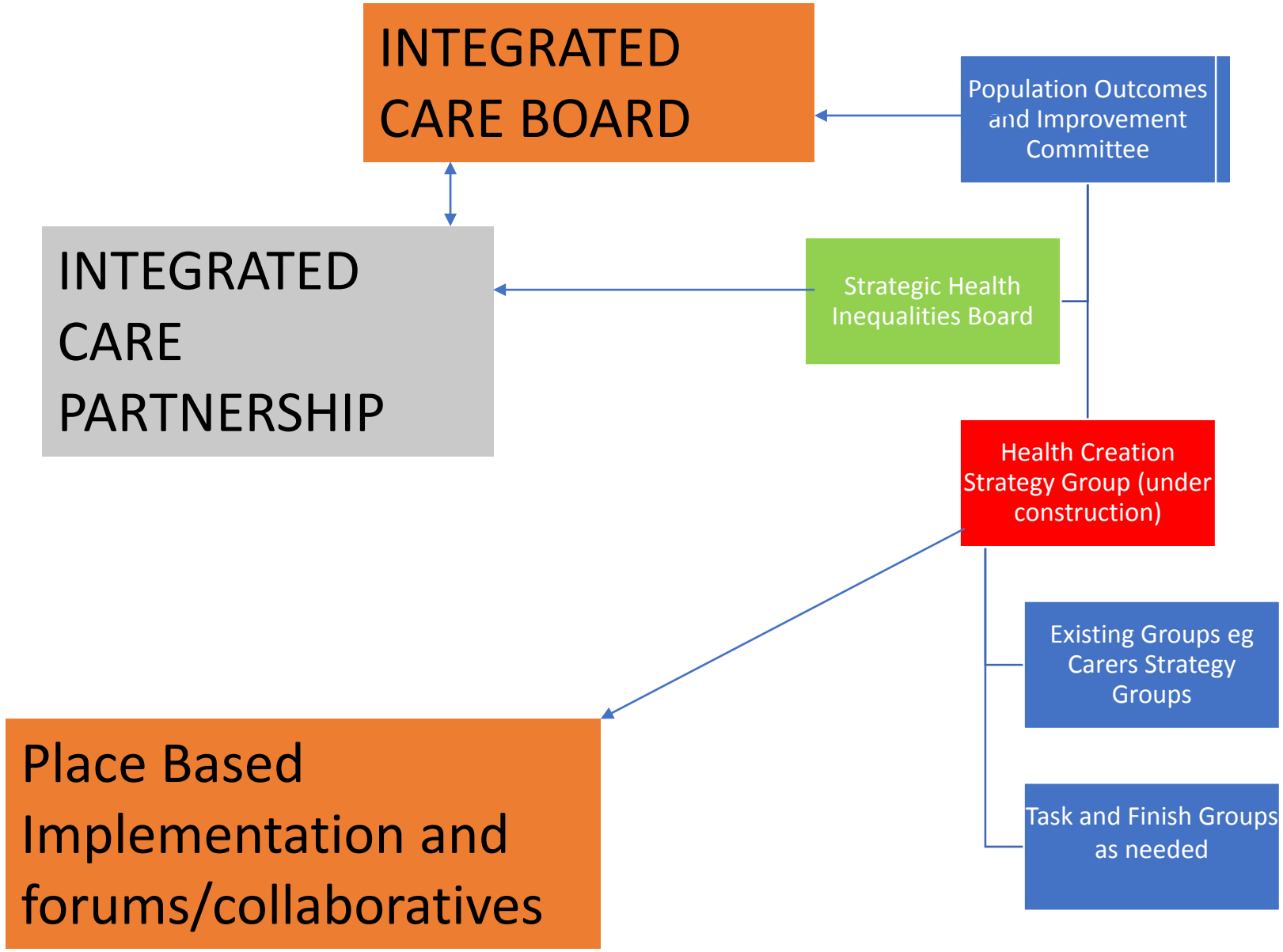


Health Inequalities: HertsHelp and HCNS (social prescribing) clients and HWE population by deprivation



Next Steps

- Take the strategy through Governance and create annual plan (including social prescribing strategy for the ICS)
- Direction of Travel agreed by ICB Commissioning Committee, 10 November
- Will be discussed by Integrated Care Partnership in December (and linked into development of Integrated Care Strategy)
- HCC Health and Wellbeing Board, March 2023, and discussing with ECC
- Developing new ICS Health Creation Strategy Group
- Interviews for Alliance co-ordinator, November 2022
- Creating new and deeper links between VCFSE and statutory sector across the piece


INTEGRATED CARE BOARD
Population Outcomes and Improvement Committee
INTEGRATED CARE PARTNERSHIP
Strategic Health Inequalities Board
Health Creation Strategy Group (under construction)
Existing Groups eg Carers Strategy Groups
Task and Finish Groups as needed
Place Based Implementation and forums/collaboratives

Voluntary Community Faith and Social Enterprise Sector (VCFSE) Alliance, Herts and West Essex

&

Herts and West Essex Integrated Care System (ICS)

Health Creation Strategy

Working together for a healthier future

1. Introduction

This strategy has been written and co-designed by colleagues from across the statutory and VCFSE sectors in Herts and West Essex.

Before drafting this document with the new VCFSE Alliance during November 2022, engagement happened organically in a range of forums over many months:

- Initial presentations to Hertfordshire and West Essex ICS Partnership Board, April and June 2021
- Ongoing discussions of principles with Volunteer and Personal Assistance Cell (VPAC) Response Group in Herts and other VCFSE forums across the ICS
- Specific work with carers' organisations and carers on the Carers' Vision (draft) with final session with West Essex on 31 May 2022
- Presentations at 'place' throughout the period to mixed audiences
- Paper to ICS Partnership Board, leading to request for formal strategy, January 2022
- Presentations to 6 sessions with developing Alliance, November 2021 to May 2022
- Two task and finish groups, April and May 2021
- After formation of the VCFSE Alliance in June, virtual drop-in and one to one engagement exercises with Committee members & other stakeholders through August.

The strategy is a direction of travel document, to help all parts and levels of the ICS to build on the excellent partnership working prior to, but especially during, the Covid pandemic and to ensure that the importance of the work the VCFSE sector does is factored in and acknowledged across the system.

It seeks to openly address the challenges of effective joint working with the VCFSE sector, often due to fragmented and complex local delivery models within the sector, differing service provision, resourcing challenges, fragmented funding and uncertain funding streams.

It also starts to lay the foundations needed to ensure the VCFSE sector are treated as equal partners in the ICS.

It does not seek to replace any other strategies but to work with them all, identifying the unique contribution that the VCFSE does or could make to improving the wellbeing of our residents, their experience of health and social care and other services, and factors that affect their health. The

strategy includes some other strategies as strands within it – such as the ICS Social Prescribing Strategy and will align with the ICP Strategy ambitions. This Strategy will be signed off by Alliance and ICS following due process and will link into Integrated Care Strategy for December 2022 and this will then form the basis of a Memorandum of Understanding (MOU) between the ICS and Alliance (as required by NHSE). There will yearly workplans agreed at 'place' sitting beneath this overarching strategy which will be monitored at quarterly Alliance Committee meetings and through various governance structures of the ICS.

2.0 Background

2.1 The Role of the VCFSE in Helping the ICS address its core objectives

The VCFSE has a key role to play in all four:

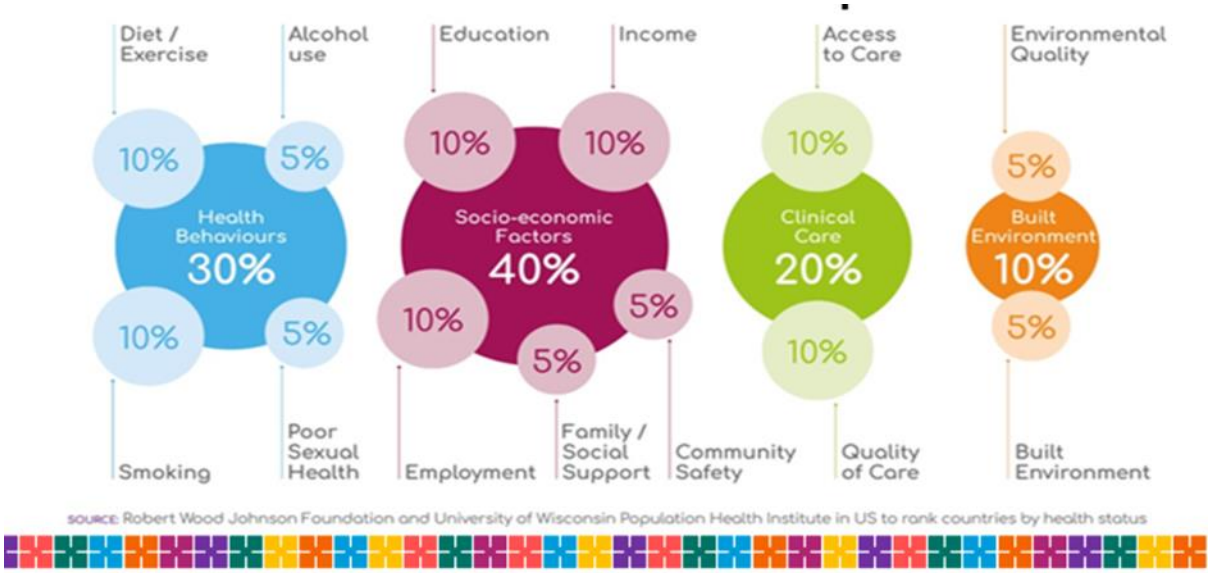
- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money across the ICS
- help the NHS support broader social and economic development

The sector is worth more than £1bn in HWE and reaches many residents facing health inequalities and other challenges who are wary of the statutory sector. It employs thousands of paid workers and co-ordinates thousands of volunteers and is often guided by communities themselves to focus on what matters most to them and to innovate to solve problems.

VCFSE staff and volunteers often have more flexibility and local networks than the statutory sector, allowing them to act more holistically. This helps them to adapt quickly to changing needs in a community (as was so clearly demonstrated during the Pandemic). They tend to be well embedded within their local communities, both understanding the needs of residents and their service users, and the local resources that are available to help. They are often able to give people time in a way that busy and pressured statutory professionals cannot.

2.2 The Importance of the Non-Clinical ('the wider determinants of health').

A wealth of research demonstrates that as little as 10% of what determines how healthy we are is the result of the work done by the NHS itself. This is why it is so critical that the whole system works together to improve health. In the words of Professor Sir Michael Marmot: 'What's the point of treating people and then sending them back to the conditions that made them sick in the first place?' Evidence from social prescribing interventions across the ICS indicates this happens quite often, for example the patient sent home from hospital after the flare up of a lung condition to a cold, damp house, only to return soon after. It is not the function of the NHS to help people get their housing problems sorted out. But in this strategy, it *is* the responsibility of all parts of the system a) to help people on the journey to find such support if they need it and it is available and b) to look at ways of making such support available if it currently is not



2.3 Health Inequalities, the Social Gradient in Health, Personalisation and Prevention

This strategy is based on the philosophy that people are diverse in both their needs and how they respond to those needs. It acknowledges that everyone will have their own path to achieving, improving or maintaining health and wellbeing, and that the system must work to remove barriers and challenges to accessing quality help for clinical and wider non-clinical care and support. This means that the system needs to understand the lives people live, not just the clinical condition they are suffering (or may be at risk of suffering) from.

Deprivation in its many forms is one of the main reasons there is such a wide variation in life expectancy by postcode across the ICS. Data shows that conditions as varied as tooth decay in five year-olds, death from Covid, obesity in year six children, all follow the same gradient, with the most deprived always the most likely to suffer. As well as being an issue of inequality, it also provides obvious scope to help the system target prevention interventions to help people stay well. And where deprivation is an issue, personalisation will obviously include work to ensure people have access to all the benefits they are entitled to, as well as crisis help like food banks and debt and housing advice. The VCFSE are crucial here both in terms of their local knowledge, their non-clinical expertise and their ability to engage with people that may feel marginalised from current help. They can also help clinicians to delivery 'pathways' which are more holistic, linking people to sources of help clinicians may not know about.

2.4 How do we work together at the moment?

Historically, due to the fragmentation and complexity of delivery and provision of locally delivered VCFSE services, collaboration between clinical care, social care and the VCFSE has often been limited both in terms of scope and partners. Commissioners have often focused on single county-wide or 'Place' delivery options, using larger partners or closed consortium arrangements. Although undoubtedly these agreements have delivered a positive impact to wider population health and brought funding into the sector, it could be argued that these arrangements have often prevented the diversity of community-specific, local, grassroots organisations from becoming a full partner in solving problems in their communities. In more recent years, County Councils have started to develop 'directories' of services and centralised resources to support 'navigation' of services and the NHS has tried to address the wider determinants of health through the development of Social

Prescriber roles within more localised care networks. All partners recognise more work is needed to further develop, sustain and integrate the local VCFSE to provide the 'prescriptions' in the community that such social prescribers need to be able to refer on to, to improve health and wellbeing within our local communities.

3.0 VCFSE Alliance Health Creation Strategy

Our Ambitions		
	We will build on community assets	• Develop and strengthen existing provision and frameworks, and build on what is already working • Make use of the community's insights • Build on progress from social prescribing towards empowering all professionals and volunteers in the ICS to become access points to support • Create an integrated social prescribing 'system' as a key supporter and motivator which can help people facing challenges and stigma to access support • Improve information and advice infrastructure about affordable 'activities' people can access to help them improve their health and wellbeing
	We will make every contact count	• There should be ***no wrong door*** • Every professional in the system should know how to make referrals to HertsHelp/Essex Wellbeing Service so people can access local help even if the professionals don't know what may be available • Address inequalities around 'access' including through outreach • Work together as a system to make it as easy as possible for people to maximise their own wellbeing and get the help they need from the VCFSE as early as possible • Particularly in the aftermath of Covid and facing a cost-of-living crisis, to work to ensure maximum access to good quality money and mental health advice for those who need it
	We will find out, who's missing out	• To improve the wellbeing of those facing health inequalities through targeted action, including piloting new ways of working • To develop the pro-active aspects of No Wrong Door (outreach and case-finding based on evidence of which groups are most likely to be missing out on help to stay connected and well) • To help the system address preventable factors that cause ill health like cold homes or caring without support • Ensure the advantages of 'digital' do not create further disadvantages for some and build on successful 'digital inclusion' work together • Improve the health and wellbeing of family/unpaid carers • Make full use of evidence-based outreach approaches (examples include reaching out to people on waiting lists or newly discharged from hospital, reaching out to people from minority ethnic communities who are not making use of available help to manage their condition) rather than waiting for people to hit crisis

		• Make full use of (and share with communities) the evidence about who is missing out in relation to evidenced health inequalities and to develop networks and work with local services to address • To identify where residents have additional challenges as a result of Covid and address those challenges (this includes financial hardship, but also isolation, reduction in exercise, increased waiting lists, anxiety about 'coming back out' etc) • To ensure the significance of financial, food and housing insecurity are factored in systemically to the work
	We will ensure there is always someone who can help	• Creating accessible community spaces/hubs so as not to further pathologise social problems (eg promoting access to Crisis Cafes rather than people having no choice but to go to A&E) • Make it easy to find help to stay well (improved system-wide 'Wellbeing Offer) • Improve access, particularly for those facing greatest challenges, to the opportunity to stay well and healthy through what the VCFSE has to offer • Build relationships across the system so that sectors trust each other more, using evidence and case studies to help this happen • To ensure and promote single points of access (HertsHelp, Essex Wellbeing Service) as part of a systemic offer ('there is always someone who can help') which is fully understood by all professionals and volunteers and residents in both sectors – this is not to bypass more local access points where they exist and professionals know about them but to ensure no one misses out • Improve access to identification and support from the VCFSE at crucial touch points with NHS such as: • Admission to hospital • Discharge from hospital • Registration with primary care • Waiting for treatment
The 'How'		
	By using our influence within the ICS, representing and engaging at key meetings	• Raise awareness of the VCFSE sector and its impact • 'Place' representatives from the Alliance linking in with HCPs • Mapping of ICS groups and existing VCFSE links and/or gaps to ensure VCFSE fully joined up
	By maximising efficiencies through collaboration & partnership opportunities	• Explore when VCFSE can *provide* something better than the statutory sector (eg certain crisis services), when it can *complement* (eg 'waiting well' or 'befriending') when it can *prevent* (social prescriptions instead of anti-depressants) - developing agreed data and logic models with the ICS • Gain a better understanding of needs and assets across our communities • Reach out particularly to those communities with the greatest challenges • Enhance the information and advice infrastructure and support communities to network with people who can help develop local 'assets' (in both sectors and including commissioners) • Enhance the integration of key public-facing partners in promoting the ways-in together (Healthy Hubs, Pharmacies,

		Libraries, GP surgeries, District Councils etc) so the public can see we are working together to put their needs first • Prioritise areas where, working in partnership, we can demonstrate improvements in the wellbeing of particular groups through the work of the sector • Systematically 'test' all services across the system to ensure accessibility and barriers to access have been addressed within the design or amendment to delivery of a service • Create more and deeper partnerships at neighbourhood level so communities are fully engaged and have maximum control over developments – this includes the statutory sector ensuring communities have easy access to relevant data
	By shifting the lens towards the wider determinants of health (see above Robert Wood Johnson graphic)	• Work together to create the most effective possible partnership between the sectors • Develop the relationship between (not exclusive) local VCFSE and Primary Care Networks and District Council engagement workers, with the social prescribing link workers as key local networkers in communities • Promote social prescribing and health coaching and other roles in the system designed to support motivation for those facing challenges in looking after their own health and wellbeing
	By promoting the voices of people with lived experience to shape and influence strategic decisions	• Ensure a culture that sees caring as a natural part of life (given that 1 in 3 people take on caring roles at least once in their lifetime) but doesn't expect people to care alone without support • Ensure that the VCFSE and ICS work together to promote improvements in family/unpaid carer wellbeing as part of all work commissioned in the VCFSE • Shift power from professionals to communities • Collect, co-produce and promote a suite of toolkits, case studies and positive stories of change where communities have worked with services – 'we can do this together'
The 'Tools'		
	Data	• Using Data Driven Decisions, enabling sustainability • Identifying need • Demonstrating impact • Annual planning & reporting on the impact of the strategy • Create a culture where anonymised data about health and wellbeing needs are shared between the sectors to maximise the benefits to residents • Create a culture which values the non-clinical and the evidence-base for its impact on health and wellbeing (including access to the arts, social activities, money advice, green space etc) and collects and promotes this evidence • Skills-share between statutory and VCFSE sectors so that each resident gets the best possible mix of formal and informal support

		• Agree proportionate and 'real life' ways of evidencing impact of this work across the system • Value and promote individual case studies and stories, as well as 'hard data' and relevant research • Agree that expectations that VCFSE should produce detailed data in specific formats should be linked/proportionate to adequate funding of systems/work required • Agree on an expectation that the public sector will help provide data in a form that communities can use in a powerful way, in partnership and as a 'critical friend' • Demonstrate the maximum levels of transparency possible about need and outcomes and who is benefiting, as this builds trust with communities
	Co-Production	• The development of meaningful and sustained relationships within communities, using expertise, resources and relationships held by VCFSE, to understand the local social, demographic and cultural factors, recognising that solutions differ according to location, reflecting the unique priorities, needs and strengths of each community (Office for Health Improvement & Disparities) • A supportive infrastructure in place for meaningful co-production including ways of valuing, recognising and incentivising ongoing involvement, particularly given the added pressure of the cost of living • Clarify and be transparent about how and when the partnership is prioritising full 'co-production' (ie starting with a blank piece of paper with the VCFSE, residents, service-users and carers and co-producing new policies or services) and when, because of time and resource pressures, a lower level of engagement is envisaged, while always committing to the maximum level of engagement feasible
	Commissioning	• Work to promote ongoing financial stability and sustainability including that all contracts with the sector should ensure full cost recovery and entitle charities to have a reasonable operating reserve • Models and commissioning processes are needed at 'place' and at ICS level and need to be integrated • Funding what's needed and what works • Longer term funding to aid recruitment and retention • Correlate community-centred, asset-based approaches to provision, with prioritised funding • Deliver integrated commissioning with the VCFSE and system partners to the best outcomes for population health. • Support long term sustainability with the sector, by building into pathways and service models from the outset, as part of initial cost modelling. • Fund at levels that allow the sector to maintain competitive pay and reward structures • Be based on evidenced need and system data

		• Ensure that services commissioned are accessible to those they are designed to service. If services are Universal - ensure they are universally accessible. • Be sufficiently flexible to ensure that increased demand/ service development is funded. • Encourage collaboration, but recognise the additional cost of partnership, and avoid unnecessary reporting or the need for multiple formats • Ensure statutory commissioners work with the VCFSE (and each other) in a joined up, strategic way, to ensure that processes around funding the sector are, as far as possible: o ● Predictable o ● Transparent o ● Timely o ● Evidence-based o ● Equalities-focused and fair o ● Integrated (with all statutory commissioners working together effectively to address need and support evidence-based interventions) • Support stability and sustainability in the VCFSE, including longer contract terms and extensions wherever possible and appropriate to build on existing assets and relationships
	Workforce	• Build on relationships and resilience at a local level (Primary Care Network/ District) • Work together to ensure the best possible use of resources – maximising collaboration and minimising competition that does not add value • Identify where VCFSE solutions may complement and add value to, but also where they might have better outcomes and/or be better value than existing/traditional statutory ones (eg when social prescriptions are cheaper and have better outcomes than prescribing anti-depressants)
	Volunteers	• Acknowledge and promote volunteering as a natural and valued part of being a citizen and one that improves the volunteer's wellbeing as well as that of society • Ensure that all commissioning of the VCFSE costs-in quality support for volunteers and acknowledges that volunteering is not free • Ensure that volunteering is an opportunity available to all (including through access to back to work and benefits advice) not just those living in less deprived communities • Promote volunteering as a multi faceted benefit which promotes self-esteem, develops skills and experience, helps toward employment, connects communities and supports lived experience • Make it more attractive and exciting to get involved – including an integrated communications strategy using real examples of community successes to promote the approach • Develop an ICS volunteering strategy, building on existing work and using as a touchstone for developing our approaches the

		recently published ten-year vision on volunteering www.visionforvolunteering.org.uk • Ensure volunteering is factored into all workforce strategies • Promote (and acknowledge the cost of) best practice in volunteer management • Factor volunteering into developments around Anchor Institution work, Corporate Social Responsibility and other ways we can increase volunteering across society • Normalise the offer of volunteering opportunities to people on retirement, when they are students, and as part of back to work and opportunities for enhancing skills

How will we know if having this strategy is making a difference?

We will negotiate agreed system measures to show:

- Reach of VCFSE into deprived sections of the population (Index of Multiple Deprivation/postcodes data)
- Reach into Black, Asian, Minority Ethnic, Refugee and other minority communities
- Distance travelled for individual clients eg before and after ONS4 and Campaign To End Loneliness Tool and similar wellbeing improvement measures
- Evidence of commissioning following need, including Equality Impact Assessments and mapping of investment to the most deprived geographies and similar
- Citizen Advice-type measures of public benefit etc – pulling together the best measures from across the VCFSE sector over time so as to be more able to demonstrate the sector's value more consistently, systematically and powerfully

We will produce clear, simple plans about how we will deliver on the strategy

- Year one – embed the principles across the ICS partnership and ensure they are being fully discussed at 'place/s'
- Year one – agree priorities on the basis of evidence from the VCFSE's day to day experiences, triangulate with ICS's priorities
- Year one – establish, using the strategy principles, the most urgent areas to protect and/or grow investment in the sector to address health and wellbeing challenges.

HERTFORDSHIRE AND WEST ESSEX TRAINING HUB

HWE ICB PRIMARY CARE WORKFORCE IMPLEMENTATION GROUP

27th October 2022

13:00 – 14:30

Microsoft Teams Meeting

Notes

Attendees		
Dr Nicolas Small (NS)	Training Hub Clinical Lead **(Chair)**	Hertfordshire & West Essex ICB
Joyce Sweeney (JS)	Interim 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
Dr Sarah Dixon (SD)	Workforce and Education Lead	Hertfordshire & West Essex ICB
Dr Hannah Cowling (HC)	Associate GP Dean	HWE / HEE
Helen Bean (HB)	Education & Workforce Manager	Beds and Herts LMC
Sara Kumari	Training Hub Project Support Officer	Hertfordshire & West Essex ICB
Dr Jayna Gadawala (JG)	GP Clinical Lead	Hertfordshire & West Essex ICB
Dr Richard Stanley (RS)	GP Trainer and Placement Expansion Lead	Hertfordshire & West Essex ICB

1	**Welcome & Introductions** Confirmation that meeting is quorate. NS welcomed attendees to the meeting.
2	**Declaration of Interests** There were no declarations of interest.
3.	**Meeting Notes from the last meeting on 22nd June 2022** The minutes of the meeting held on 22/09/2022 were approved as an accurate record. The action log was reviewed, and updated as follows: **Action 77** - Primary Care Racism & Discrimination survey **Close.** JS informed that AS, JS and DS had met with Parul Karia, LMC on 27 September 2022 to discuss the Humberside Survey. It was agreed that whilst the survey was interesting the outcomes were well known. The view was do we want to keep asking Primary Care the same question and what added value would that make. HWE offer training opportunities ie Here for you, Equality and diversity workplace webinars, mandatory training. JS had contacted colleagues in other training hubs to find out what others had done, and the Mid and South Essex Training Hub are in the process of closing their survey of which replicated the Humberside survey. They are going to share the outcome and the solutions/training/actions they will be putting forward from the results. They have ringfenced some funding to support.

	The tread of the discussion to followed up and not lost. It was suggested to contact Paul Curry as the lead for ICB lead for equality and diversity. **Action 102:** Pilot – Generalist Programme – **Close.** Reinstate to agenda when required. **Action 107:** HUC – **Close.** Update as not an agenda item: Communications have gone out, HUC cover will be for the 9th November 2022 13:30 – 17:30. 4 PCNs do not require for various reasons ie too short notice to organise, had organised for another date. 2 PCNs in Southwest Herts and 2 in East and North Herts. We have given a timeframe and asked for clarification / confirmation as to whether cover is required or not. To support with the questions from the PCNs and Practices a FAQ document is being created and will be circulated. **Action 109:** Deep End Overview**. Close.** Meeting being arranged. **Action 110:** Terms of Reference. **Close.** Have been circulated and can be reviewed again in due course **Action 113:** The People Board. **Close.**
4.	**<u>Quality Framework – Expansion – Guest Speaker Dr Richard Stanley</u>** Working closely with the Quality Team, along with Hannah (Cowling) and Emma (Salik) and the Training Programme Directors (TPDs). Able to quickly and effectively deal with any issues that may arise as we work through the expansion agenda. This would include helping new trainers with the paperwork and training in preparation for their interview and existing trainers prepare their recognition application. Richard has been in contact with 65 - 70 aspiring trainers since he started in post; this number would include the conversion of Tier 2 trainers to Tier 3, new trainers and new training practices. RS - A key development at the moment is trying to link in all the expansion agenda in with the PCN training teams and use this for forward momentum to help in assisting new training practices in PCNs which have existing training practices and developing those links. Trying to encourage increasing the number of Clinical Supervisors as well as Educational Supervisors with newly qualified post Certificate of Completion of Training (CCT) GPs. Richard is keen to discuss this with the PCN training teams in future meetings. LE - highlighted that there is also a need for GPN trainers and the importance of expanding all students across all disciplines – and this should be incorporated into the Learning Organisation review, or we will lose this workforce. RS – Could we utilise the PCN training teams to help collate accurate numbers for reporting and data, such as GP Trainers numbers. There is a lot of instability and constant changes so being able to have dynamic data on GP trainer numbers and anticipated changes would be beneficial. JS - confirmed that this is high on the Training Hub agenda – Once the current consultation is completed and we have enough staff onboard, there will be discussions with the PCN training teams to take this forward. Richard raised his concern with Estates a while ago, highlighting that room capacity is a severe constraint. There are a number of potentially excellent training practices which do not have the physical capacity to expand.

	NS advised that he had been in an Estates meeting earlier, and they understand, and it is depressing how little extra money is available. We are going to have to persuade the system to invest in primary care premises or finding existing useable premises.
5.	**NASGP – Locum Deck for Nurses** NASGP were used as they could support non-GP work. GPN bank proposal to review if we could extend to incorporate GPNs if there is funding within the flexible pool. LE - put forward the benefits if we could transition some of the 400 Nurses that are part of the HCT Reservist model, along with Hospital, or community nurses and the retired workforce. SD – raised the issue that Nurses are not always trained to cover all specialities, unlike a GP Locum who will be able to slot in and fill the gap. LE – advised that a template has been created where nurses would tick all their specialities, while a practice wouldn't be able to replace like for like, they could obtain cover for certain clinics. HB – Queried the governance, who will they be managed by contracts etc. NS – highlighted his concern with the lack of market presence that NASGP has in South and West Herts, its not very high as in the other 2 areas with GPs, if we are planning on moving forward with GPNs there is room for negotiation, and further discussions on the productivity of their approach. SD – Herts VTS had a meeting which included Richard Fieldhouse from NASGP which was very good, sure he would attend meetings to support as required. NS – general consensus we need to refresh and remind people of the GP scheme as well. If we are going to recommend this, we will need Joyce and Avni to sign off to obtain formal approval once we have agreed terms. *Note: Proposal approved in principle subject to final negotiations. Joyce and Avni to complete final sign off. A request that when this is launched it is across the 3 places and is part of the Tuesday Lunchtime webinars.*
6.	**GPN Update** Have had really good engagement for second Business Admin and Nursing Associate Apprenticeship webinars, with 3 NA student nurses proving videos for the events. Since PCN Educators induction day, 3 South and West Herts GPs have made contact to enquire about NAs. GPN appraisal training that starts w/c 31st October. There are 2 cohorts, unfortunately the 2nd clashes with the Target event and has been moved to February 2023. £36k from HEE – to be used for extending Student Placements in all PCNs. ACP work is now on the website click here to review. Sourced funding will be going out to advert for an ACP who is trained to work 1 day a week to help increase supervision. NS – Wanted to acknowledge the work that has been done and is underway to increase the profile and support for nursing colleagues and asked in there could there be an update provided once there is some data available on the appraisal scheme – maybe presented as a lunchtime webinar to keep the momentum going. If this is a success, we need to see how we can incorporate into business as usual; also look to incorporate into one of the PCN training teams updates going into next year.

7.	**ARRS Update** JG - has been in contact with Davinia Rogers, Clinical Learning Environment Lead for HEE, to discuss how to improve AHP student placements within HWE. Links have been created with University of Hertfordshire to help put together resources for practices taking on students and create a resource pack for each stage of the process, ensuring that they have the right information and know what is required and involved should a practice / PCN want to take on a student. Once created, will be uploaded to the website under resources. NS – enquired about the uptake, what are the practice numbers, how many are actually doing this sort of training and taking placements. JG – Numbers are not high, there is the issue with estates – no space to place any additional staff. Will try and obtain numbers before the next WIG for reference. **New Action 114: Review action log.** LE responded – The numbers are small. We need to be pushing to expand student placements to allow the opportunity for Primary Care experience. We are trying to provide access to online Assessor / Supervisor training to increase accessibility. LE highlighted the additional ARRS funding from HEE for Nursing Associates – a 2 year top up to the RGN course. This information will be uploaded to the website and circulated. NS suggested that once we are in a position to provide working examples, possibly in the new year - we could have a more detailed focus on areas such as placements and training. NS also highlighted the discussion that will need to happen at an ICB level, to acknowledge that while we are working to increase capacity, we will need premises to accommodate the expansion of the entire workforce, as it is vital to the success of all care and keeping people out of hospital.
8.	**PCN Training Teams** JS – An induction meeting took place on 6th October 2022, with over 50 people in attendance, The meeting was to introduce the Training Hub team, and Health Education England and discuss the roles and responsibility of PCN teams moving forward. The majority of PCNs do have a team in place but in southwest Herts, there are 2 PCNs who have one GP in post and still need to recruit to the other 2 posts. East and north Herts there are 3 without any team in post, one with a GP in post and another with a GP and GPN. They are all working on the required recruitment. West Essex has 3 PCNs which just have a GP in the team at the moment. All the MOUs have been received, and each PCN was asked to send in slides with names and contact details for their teams along with a deadline of 31st October. Lucy (Eldon) has organised a meeting with the GPN leads and has planned 2 welcome forums on the 2nd November and 14th December. Sarah (Dixon) and Jayna (Gadawala) have organised a AHP welcome forum for the 10th November and GP forum for 15th December. All communications have been sent directly to the teams and there will be a secure area of the Training Hub website available shortly where we will be able to share information. SD – The training teams are all at different stages, and we have struggled to find GPs, GPNs or an AHP to take on the role – it is a shame that we have these gaps, we just can't seem to recruit – SD asked the group for any recruitment ideas on how to support those PCNs who would like to build a team.

	LC – suggested an all-staff mailer combined with the flyer or could do a targeted mailer to specific groups. HC – Suggested that Appraisers could be contacted. LE – supported the mailer approach as people are still not aware of the training teams. Will be more uptake from other areas once there are results, people will then take notice. The PCN teams need to actively market themselves as well.
9.	**Educational Webinars** LC – Shared the schedule for the rest of the year, this included lunch time and evening webinars. The next webinar is on the 16th November 2022 and is an update on long COVID 2 years on. There are usually 100 attendees to each webinar, invites are sent out to 600 people. Biggest challenge at the moment, is how to communicate to primary care. LC is focussing on how to get the senior managers of all three areas to use these webinars as a pathway to communicate and educate using the HWE Training hub as the route – the first port of call for people wanting to educate primary care. There were 25 attendees for the suicide prevention evening webinar. LC – asked the group for additional priority topics / ideas for the future clinical evening webinars. SD – is collating information related to the protected learning at present, which has information related to priority topics for the ICB and place, as well as the PCN priorities. Lots of ideas on long term conditions and mental health and planned care – some of these will be suitable for the lunchtime webinars, some will be more suited to the evening webinars. LC – suggested a culmination of the information to one centralised document to create an expertise contact list. NS – Even if we have different pathways in different places, we can bring the information together and provide updates and highlights. Overtime, things will be recommissioned and become more joint, people will become more aware and start asking questions about information that isn't available on their pathway but is available elsewhere.
10.	**Community Pharmacy Project – Enhanced role for Community Pharmacy PCN Leads** JS - The community Pharmacy project is a proposal for funding the development of an enhanced role for Community Pharmacy PCN Leads across the Herts and West Essex area and was written by the Chief Officers, Community Pharmacy team. It is proposed that the Community Pharmacy Leads work 2 days a month over 10 months, excluding August and December as these are the busiest months. The idea is for the leads to embed the community pharmacy voice within the PCNs and link in with service development opportunities and develop good relationships with all pharmacies aligned to the PCNs. Engage in at least 2 meetings a year with clinical pharmacies and PCN Clinical directors, set up a good communication plan and strategy to ensure communication on the ground and engage with leadership and development training. AS presented the initiative to Health Education England who were very supportive of the idea and have provided funding and extended the project across the other training hubs in the region.

	The next steps are to set up a project group to take the project forward. **New Action 115: JS to share paper with WIG**
11	**Any Other Business** i. Training Hub banner LE – As we now have an ICB logo can we now move ahead with a training hub banner for use at all events and conferences – the cost is just under £200 for 2. NS - Approved banner request – also asked for different coloured backgrounds when we are on MS Teams. LE will follow up with her contact.
12.	**Date of next meeting**: 24th November 2022 – 13:00 – 14:00

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

DRAFT

Meeting:	**ICB Primary Care Digital**			
	Meeting in public	☐	*Meeting in private (confidential)*	☒
Date:	**Thursday 6 October 2022**			
Time:	**10:00am**			
Venue:	**VIA MS TEAMS**			

NOTES AND ACTIONS

Name	Title	Organisation
Members present:		
Ian Perry (IP)	Partner member Digital Estates Infrastructure Lead (Chair)	HWE ICB
David Coupe (DC)	GP System architect	HBLICT
Gopesh Farmah (GF)	Primary Care Clinical Digital Lead	East and North place lead
James Gleed (JG)	Associate Director Commissioning Primary Care	HWE ICB
Rachel Hazeldene (RH)	Primary Care Digital Lead	ICS wide and West Essex place lead
Parul Karia (PK)	Primary Care Digital Lead	South and west Herts place lead
Adam Lavington (AL)	Director of Digital Transformation	HWE ICB
Gemma McKelvey (GM)	Communications & Engagement Lead	HWE ICB
Sarah Ost (SO)	Programme Director Digital Transformation Strategy	HWE ICB
Joanne Richardson (JR)	Digital First Primary Care Programme Manager	HWE ICB
Avni Shah (AS)	Director of Primary Care Transformation	HWE ICB
Phil Turnock (PT)	Managing Director	HBLICT
Annette Pullen (AP) Notes	EA to Avni Shah	HWE ICB
In attendance		
Ruth Boughton (RB)	Information Governance Manager	HWE ICB

PCD/01/22	**Welcome and apologies**
1.1	IP welcomed all to this inaugural meeting with introductions made. • Apologies received from: Trudi Mount/Shane Scott. • AS outlined purpose of meeting with a focus on primary care digital aligned to objectives of the the ICS Digital Strategy and developing Primary Care Principles and Strategy including the most recently published fuller stocktake report. • Aim to achieve consistent approach across ICB. • Outlined reporting committees/governance structure. • Evolve with Community Pharmacy/Optometry and Dental contractors which come over to the ICB from April 23. • Connectivity key to ensure best care for patients. • Set strategic direction to deliver with 1 provider.
PCD/02/22	**Declarations of interest**
1.2	• None declared
PCD/03/22	**Terms of Reference**
1.3	• Approved
1.4	**Primary Care Digital Board approved the Terms of Reference**
PCD/04/22	**Update of GPIT to date**
4.1	PT shared slides highlighting the following points: • Overview from HBLICT perspective. • Responsible for delivery of GPIT service in line with national operating model. • Informatics team led by Shane Scott. • Supports our partner organisations strategies. • Current core provision detail within slides. • Project teams in place to support delivery/any ongoing procurements. • Good relationships to ensure national alignment. • Continuous improvement of service to deliver future solutions. • Work collaboratively with practices. • Aware of financial/budgetary accountability
4.2	The following points were raised in discussion: • Accessibility issues in WE – particularly during emergencies. • Extension of remote working – use od VDI across HWE. • Manage suppliers with any inefficiencies. • Optimise system usage to continually improve. • Business change analysts working directly with practices. • Scope for future /identifying benefits important to fully utilise service. • Consideration to measure outcomes of clinical/patient benefits. • Team working closely to integrate with Primary Care. • GP representation to continually feedback. • AS asked on follow through including evaluation and realising benefits as part of any project delivered through HBLICT. PT noted that should be part of the service delivered through HBLICT and will work through as develop further
4.3	**Primary Care Digital Board noted the GPIT update**
PCD/05/22	**Digital First Primary Care – outline of the programme to date, achievement and next steps**
5.1	JR shared slides, highlighting following points:

	• Four main areas including advanced telephony, Websites, digital front door/inclusion outlined. • Next steps with road map provided. • Structure in place with team. • Current vacancies. • Program to evolve, scoping developing, test to evaluate. • Working jointly with HBLICT. • Evidence based approach building transformation agenda. • Supporting practices key areas. • Qualified individuals input to gain understanding. • Transformation work commenced using blueprints in Harlow area. • E-consult live in several practices. •
5.2	**Primary Care Digital Board noted the Digital First report**
PCD/06/22	**ICS Digital Strategy** **a) Overview** **b) Next steps – engagement with Primary Care with a view to development of primary care roadmap**
6.1	RH/AL shared slides highlighting following points: • Strategy/vision outlined. • Team working to create HWE digital strategy. • Commitment to deliver effortless, integrated digital experience. • Improve health and care outcomes for all. • 5 key themes identified from interview workshops. • Innovation to prevent repetitive tasks using technologies. • Embed/enable change. • Any areas of concern to be identified to research/develop further opportunities for shared learning. • Collaboration within wider system/across ICB. • Successful key examples shared in place with current providers. • Benefits shared via information agreement. • Shared GP records across providers. • Several digital platforms delivered across Practices. • Next steps outlined. • AL/RH will present at ICB Primary Care Board – 24 November. **RH provided further slides updating on current challenging procurement**. • Outlined current support in place during pandemic. • AccRux in place from 2020. • Provided data /dashboards further detail which will be shared. • Successful launch digital model in Harlow to be shared via GP's lunch & learn session.
6.2	The following points were raised in discussion: • Clear guidance Standard Operating Plans. • Structured priorities on delivery, managing conflicts. • Ensure benefits measurable to understand value of investments. • Articulate /using opportunity to view from Primary Care lense.. • Defined outcomes to be clearly listed with benefits. • Exploring business intelligence function. • Workforce to manage efficiencies.

	• Keep in mind data provided may not be strictly accurate.
6.3	**Primary Care Board noted the Digital Strategy update**
PCD/07/22	**Accelerating patient access to records**
7.1	RB introduced paper with highlights as follows: • NHS England programme. • All patients over 16 will have full access to patient records from 1 November 2022. • TPP/EMIS systems working with GP colleagues to prepare. • Day/Evening training sessions in place being run by ICB's Data Protection Officers. • Set of Q&A formed following questions raised all sessions. • Advise on revoking access provided. • Test patient facilities to be provided. • Access through app which proved high usage for covid vaccinations.
7.2	The following points were raised in discussion: • Group voiced real concerns unrealistic particularly time of year to launch. • Red risk which should be escalated. • Unintended consequences to patient/GP.
7.3	**Primary Care Digital Board noted the Digital First Primary Care update**
PCB/08/22	**Any other business**
8.1	• Meeting dates to change from alternative Tues/Thur to Thursdays a.m.
8.2	**Action: AS to confirm change of meeting AP to share once clarified**
PCB/09/22	**Reflections and feedback from the meeting**
	Meeting closed 11:40am
PCB/10/22	**Date and Time of next meeting**
	Tuesday 15 November 2022 - 4pm

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	*Meeting in public*	☒	*Meeting in private (confidential)*	☐			
	HWE ICB Primary Care Board				**Meeting Date:**	**24/11/2022**	
Report Title:	**Primary Care Communications and Engagement**				**Agenda Item:**	**14.C**	
Report Author(s):	Heather Aylward: ICB Engagement Manager, Gemma Mckelvey, ICB Senior Communications Manager						
Report Signed off by:	Avni Shah, Director of Primary Care Transformation Hertfordshire and West Essex ICB						
Purpose:	**Approval**	☐	**Decision**	☐	**Discussion**	☐	**Information** ☒
Report History:	N/A						
Executive Summary:	This report outlines primary care engagement and communication						
Recommendations:	To note, for information						
Potential Conflicts of Interest:	***Indirect***	☐	***Non-Financial Professional***	☐			
	Financial	☐	***Non-Financial Personal***	☐			
	None identified			☒			

Impact Assessments (completed and attached):	***Equality Impact Assessment:***	N/A 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***	☒
	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	☐

1. Executive summary

Engagement
Herts and West Essex Integrated Care Board (ICB) commissioned the Patients Association (PA) to work with ICB engagement leads to provide development support for GP practice patient groups (PPGs). This project is time limited until December 2022 however, it is intended that support will continue to encourage take up of the participation Enhanced Commissioning Framework (ECF) and to provide more tailored guidance when appropriate.

The Patients Association has asked engagement leads, Heather Aylward and Lauren Oldershaw to present findings from this project at their annual national celebration event in November as an example of good practice.

Communications
Following a few sessions with patients and conversations with practices a refreshed communications and engagement strategy was developed.

As we move forward into winter the work to increase patient understanding of local services as well as self-managing and keeping well becomes even more important to managing demand on both General Practice and Urgent and Emergency Care.

The communications and engagement team is part of an ICB GP access group looking at actions to implement improvements to access across the area.

2. Background

Engagement
The aim of the ICBs partnership with PA has been to work with local staff and patient volunteers to ensure that practices and their patient group have the tools and support structures to increase patient involvement and diversity which can be developed in a sustainable, practical and realistic way.

The set up of the project involved raising awareness through ten presentations at locality practice managers groups, primary care and clinical leads meetings and an engagement session which over 100 patients /staff registered for. Those not able to attend were sent a recording of the discussions. A steering group of patients, primary care leads, practice managers and Healthwatch Herts was established to provide guidance and advise throughout the project.

A baseline survey was distributed, to understand the current position, and to identity challenges and support required to improve and strengthen participation.

The survey was targeted at both patient group members and practice staff, as well as some Primary Care Networks and Integrated Care Board staff. With 250 responses - 217

respondents named 88 practices and 33 responses were from unnamed practices, providing coverage of around 65-70% from 135 practices.

A full report of findings and a summary report were produced in October 2022.

Three online workshops have been planned to cover topics identified in the survey. Working with the steering group a comprehensive programme has been developed which was designed to meet the needs identified by both patients and staff:

1. **Topic One**: Getting started – why have a patient group and what's in it for the practice and patients? This was held on 8 November with participation of around 65.
2. **Topic Two:** Effectively working together in partnership
3. **Topic Three:** Recruitment, increasing diversity and communicating with the wider patient population

All workshops will be recorded and shared, together with a series of good practice tools on the ICB website.

Communications
Since Covid we have been trying to make it clear that practices are open but need to be accessed in a different way. As we move forward and expectation is higher we need to ensure this is managed with patients. Increasing demand, issues reaching the practice by telephone and confusion over the roles in practice have meant increased frustrations from patients.

Work with patients found we needed to:

- Explain the triage process
- Promoting the different roles in GP practices, who they are, how they can help and how you may not need to see a GP
- Different ways to access care – including telephony issues and services online
- Other healthcare services and how to use them such as NHS 111 and pharmacy

A range of work on these areas have been created and shared with some further work to do. This is supported by the wider MDT group on GP access.

A new website on the ICB website has been set up at
https://hertsandwestessex.icb.nhs.uk/local-servcies/general-practice

There are agreed messages with some clinical leads and shared with the LMCs for practices to use. Some of these messages are on the public website at
https://hertsandwestessex.icb.nhs.uk/news/article/20/demand-on-general-practice-%E2%80%93-message-from-hertfordshire-and-west-essex-icb

3. Issues
None identified

4. Options

None identified

5. Resource implications

Continued support will be offered by the ICB communications and engagement team within current resources. However additional funding opportunities are being explored to ensure that tailored support can be offered to individual practices.

Some additional resources may also be required to establish a 'buddy' scheme which is one of the current recommendations.

6. Risks/Mitigation Measures

None identified

7. Recommendations

To note activity and next steps

8. Next Steps

Engagement next steps:

The success of the project will be evaluated by:

- A follow up survey to understand what the impact of the support has been and to confirm how broad engagement has reached
- Feedback from the workshops will be used to develop any further sessions or to share other examples of good practice
- Discussions are taking place to retaining the project steering group to support ongoing development
- Consideration of the development of a 'buddy' system to link well functioning patient groups with those which need some guidance. This works on an informal basis currently.

Communications next steps:

- A promotional campaign with newly designed ARRS materials
- Increase self-care, pharmacy and online services messages
- Set up of a wider communications group with patient involvement
- Working with Digital First Primary Care on new websites for practices