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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
AGENDA

7.00 pm	Wednesday 19 April 2017	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

Conservative (3)	Residents' (1)	East Havering Residents'(1)	Labour (1)
Michael White (Chairman) Dilip Patel (Vice-Chair) Carol Smith	June Alexander	Alex Donald	Denis O'Flynn

For information about the meeting please contact:
Anthony Clements 01708 433065
anthony.clements@oneSource.co.uk

Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

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Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

What is Overview & Scrutiny?

Each local authority is required by law to establish an overview and scrutiny function to support and scrutinise the Council's executive arrangements. Each overview and scrutiny sub-committee has its own remit as set out in the terms of reference but they each meet to consider issues of local importance.

The sub-committees have a number of key roles:

1. Providing a critical friend challenge to policy and decision makers.

2. Driving improvement in public services.

3. Holding key local partners to account.

4. Enabling the voice and concerns to the public.

The sub-committees consider issues by receiving information from, and questioning, Cabinet Members, officers and external partners to develop an understanding of proposals, policy and practices. They can then develop recommendations that they believe will improve performance, or as a response to public consultations. These are considered by the Overview and Scrutiny Board and if approved, submitted for a response to Council, Cabinet and other relevant bodies.

Sub-Committees will often establish Topic Groups to examine specific areas in much greater detail. These groups consist of a number of Members and the review period can last for

anything from a few weeks to a year or more to allow the Members to comprehensively examine an issue through interviewing expert witnesses, conducting research or undertaking site visits. Once the topic group has finished its work it will send a report to the Sub-Committee that created it and will often suggest recommendations for the Overview and Scrutiny Board to pass to the Council's Executive.

Terms of Reference:

Scrutiny of NHS Bodies under the Council's Health Scrutiny function

AGENDA ITEMS

1 ANNOUNCEMENTS

Details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation will be announced.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – receive.

3 DISCLOSURE OF INTEREST

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any time prior to the consideration of the matter.

4 MINUTES (Pages 1 - 6)

To agree as a correct record the minutes of the meeting held on 26 January 2017 (attached) and to authorise the Chairman to sign them.

5 PMS REVIEW AND PRIMARY CARE UPDATE (Pages 7 - 26)

Report and presentation attached.

6 ICP AND LOCALITIES MODEL (Pages 27 - 36)

Report attached.

7 PUBLIC HEALTH SERVICE PERFORMANCE REPORT (Pages 37 - 42)

Report and presentation attached.

8 Q4 PERFORMANCE INFORMATION (Pages 43 - 52)

Report and perfoprmance information attached.

9 HEALTHWATCH REPORTS (Pages 53 - 168)

Reports from Healthwatch Havering attached for consideration by the Sub-Committee.

10 URGENT BUSINESS

To consider any other item of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item be considered as a matter of urgency.

Andrew Beesley
Head of Democratic Services

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MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
26 January 2017 (7.00 - 8.40 pm)

Present:

Councillors Dilip Patel (Vice-Chair), Denis O'Flynn, Alex Donald, Carol Smith and June Alexander

Dr Susan Milner, Interim Director of Public Health
Barbara Nicholls, Director of Adult Services
Carol White, Integrated Care Director – Havering Integrated Care Directorate, North East London NHS Foundation Trust (NELFT)
Sarah Tedford, Chief Operating Officer, Barking, Having and Redbridge University Hospitals' NHS Trust (BHRUT)
Dr Remi Odejinmi, Divisional Director for Anaesthetics, BHRUT

25 **ANNOUNCEMENTS**

The Chairman gave details of the arrangements in case of fire or other event that might require the evacuation of the meeting room or building.

26 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

Apologies were received from Councillor Michael White.

27 **DISCLOSURES OF INTERESTS**

There were no disclosures of interest.

28 **MINUTES**

The minutes of the meeting of the Sub-Committee held on 26 October 2016 were agreed as a correct record and signed by the Chairman.

29 **HEALTH SERVICE WINTER PRESSURES**

BHRUT had recently seen a marked increase in patients presenting at the Emergency Department (ED). The winter peak period had begun in November 2016 and was still ongoing. The department saw up to 550 patients per day and the lack of a substantive workforce in the ED was also a problem. A lot of bank and agency staff were used in the ED which was a financial pressure for the Trust.

More patients with respiratory problems were seen during cold weather although the Trust had not seen any Major outbreaks of Influenza or the Norovirus as yet.

Other impacts on the Trust of winter conditions included icy conditions leading to an increase of fractures etc, potential problems with electricity and gas supplies and schools closing due to snow which impacted on nursing staff etc with families. This meant it was important to communicate effectively with the public in order to direct them to the most appropriate place for their care.

Staffing across both hospital sites was reviewed three times a day and staff were moved between sites if necessary. There was 24:7 consultant cover at Queens ED and this was available four days per week at King George. Conference calls were also held on a daily basis with health and social care partners to discuss how pressures could be alleviated. Across the Christmas period, these conference calls were held on a London-wide basis.

The most challenging weeks for the Hospitals' Trust had been 2-8 January where additional beds had been opened in the community and it was felt that all organisations involved has worked well together over this period. Most ambulance patients were now handed over to a clinical member of staff in the ED within 30 minutes. The winter pressures work undertaken by BHRUT had recently received praise in the Health Service Journal.

Compared to two years ago, there had been a 23% rise in the number of patients attending the ED and a 19% rise in the numbers arriving by ambulance. Fewer patients were however being admitted to hospital via the ED. The rise in ED patients was due to a range of reasons including a lack of GP appointments in some cases and in others, people having seen their GP and wanting a second opinion. Other sections of the diverse population locally were unused to the GP system.

A redirection process had been established as many people who arrived in the ED could be more effectively treated in a pharmacist, walk-in centre or could wait to see their GP. This had allowed around 120 patients per day to be redirected from the ED, approximately 25% of the total. Details of the NHS 111 service were also given to patients attending the ED but officers agreed that consideration also needed to be given to how the NHS 111 service worked.

The redirection service did not run overnight and during this period all patients were assessed in the ED with the sickest patients treated first. There was normally only one ED consultant available overnight and it was therefore necessary to manage demand in this way.

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

30 HEALTH TOURISM

BHRUT officers explained that there was a legal obligation on Health Trusts to establish if a patient was an overseas visitor. As of April 2016, BHRUT was owed a total of £2.5 million for treatment of non-UK residents. In the succeeding six months, some 487 BHRUT patients had been identified as not eligible for free NHS care. Paperwork to identify these patients was distributed in each of outpatients, the ED and the ante-natal department. Officers would forward an example of the forms used.

These patients were seen by the Trust's overseas team and would be billed if they were not eligible for free care. It was accepted however that it became difficult for the Trust to obtain payment once the patient had left hospital. Many overseas patients did not have credit cards and it was also difficult for doctors or nurses to ask patients for their payment details. Officers felt that, to ask for payment details whilst a patient was in the ED would take time away from the clinical teams. National Insurance numbers were not asked for from patients as this would cause too much administration for the Trust. If possible, treatment would not be given until payment had been made and the Trust also passed relevant details to the Home Office.

Approximately £400,000 of the charges for overseas treatment had been recovered by the Trust but the Clinical Commissioning Groups underwrote around half the £2.5 million total figure. Under the Trust's improvement plan, overseas patients would be asked to pay a deposit for elective care prior to treatment. The Trust did take the issue of health tourism seriously but officers accepted that it was very difficult for BHRUT to recover this money. There had not been a major increase noted in the numbers of health tourists in either hospital or community services.

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

31 JSNA ANNUAL REPORT

The Interim Director of Public Health explained that the Joint Strategic Needs Assessment (JSNA) was the statutory responsibility of the Health and Wellbeing Board but that Council Leads and the Clinical Commissioning Group (CCG) were also obliged to input into the document. The JSNA allowed members of the Health and Wellbeing Board to understand the health needs of the local population.

Core products of the JSNA included the quarterly 'This is Havering' document which gave a breakdown of the Havering population and an annual overview of Health and Social Care needs in the borough. Interactive ward health profiles were also now produced. Other in depth work included the obesity needs assessment and work to develop the business case for

the Accountable Care Organisation. Borough level profiles were also produced in an accessible format covering areas such as cardio-vascular disease, smoking etc.

In addition to the existing work, locality profiles would be established under the JSNA in the coming year and the Pharmaceutical Needs Assessment – a legal requirement for the Council, would also be rewritten. The Needs Assessment was mainly used by NHS England to control the entry of new pharmacists into the local market and guidance was currently awaited on this.

It was clarified that pharmacists were paid by the NHS. It was possible that the number of community pharmacists could reduce but it was also planned to expand the role of pharmacies. Officers explained that pharmacists wished to stay in High Street locations but there were not currently any Council funds available to commission further services from pharmacists. Services such as blood tests in pharmacies would need to be commissioned by the CCG but the logistics of collecting blood samples may make this difficult.

Most targets for flu jabs had been met and officers would provide current figures. Flu levels in Havering were monitored and were low currently.

It was confirmed that the Stop Smoking service had been decommissioned although the service for pregnant women had been recommissioned. There had however been a low take up for this. The service was advertised in maternity services.

32 ACCOUNTABLE CARE ORGANISATION

The Director of Adult Services explained that the Accountable Care Organisation was now called the Integrated Care Partnership (ICP) and agreed that progress on this work had slowed recently. Officers were however now working more closely with patients themselves.

Borough Health and Wellbeing Boards had oversight of the ICP and the ICP Partnership Board was chaired by the relevant Lead Member from Barking & Dagenham. Havering's Leader and Lead Member also attended the Partnership Board as did Chief Executives and Chairs of the Councils, CCGs and providers involved.

Consideration was currently being given to which areas the ICP would look at first. The ICP Board also had representation on the board of the Sustainability and Transformation Plan for North East London which covered seven CCGs and 8 Local Authorities across the sector. It was suggested that an update on governance of the Sustainability and Transformation Plan could be given at a future meeting of the Sub-Committee.

Locality models were being developed as part of the ICP work. The areas of the three localities for Havering were almost confirmed and the localities would be population based as research had shown that the best health outcomes were seen with localities of 70-90,000 population size. Areas such as Romford or Rainham where there were likely to be considerable rises in population had also been mapped as part of this work.

The key priorities for locality models were children's health, referral to treatment issues and urgent care pathways. A recent workshop on the locality models had been held successfully with representation from GPs, other clinicians and a urology consultant from BHRUT. An officer from NELFT added that it was wished to have discussions with people at any contact point, not just health and social care. Contacts promoting health could therefore take place in housing offices, libraries, leisure centres etc. A client with for example difficulties paying their rent could well have issues with anxiety and could therefore be referred from the housing service direct to talking therapies available in the locality. This would represent better value for public money.

The ICP also aimed to make services more efficient and to avoid any repetition between health and social care. The Havering Locality Design Group included representatives from Healthwatch, the Local Pharmaceutical Committee, the voluntary sector as well as the Council's Directors of Adults and Children's Services. A workshop with the community and voluntary sector was also planned for March 2017.

The locality model had been designed in conjunction with staff and patients and would be a small programme initially. The ICP wished to improve self-care as many people did not need any other support in order to stay healthy. More intensive interventions would be as planned as possible under the new model.

The Locality Design Group would continue to meet fortnightly until April to develop the proposals and engagement would also continue with key stakeholders including the Local Medical Committee and the community & voluntary sector.

Members welcomed the proposals, feeling that early intervention was the best policy for improving local health outcomes. It was confirmed that GPs were involved in the design of the model although there remained workforce issues with many GPs approaching retirement age. The role of community pharmacies also needed to be determined.

Officers felt that there was now more appetite from GPs to look at how they could work differently. The Director of NELFT added that there were variations in how people accessed health services across the UK. In London, GPs had been somewhat deskilled and other areas such as hospitals had been overskilled. There was an image that a hospital was the best place for health care but this was not necessarily the case.

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

33 CARE BEDS POLICY

The Director of Adult Services confirmed that the Council would pay care home fees for the first four weeks of a resident's hospital stay. Beyond this period, 60% of fees would be paid for by the Council. The social work process would be used to ascertain how long beyond the four weeks fees would continue to be paid.

The maximum fees the Council would pay per week for a patient in a residential home had a lower rate of £471.51 with a nursing higher rate of £528.21. Fees for dementia care ranged £518.60 to £545.46 and all fees paid were currently under review.

34 CORPORATE PERFORMANCE INFORMATION (Q3)

Performance had improved on the successful completion of drug treatments target and the new provider was now working with commissioners.

It was suggested that a performance report for the public health service plan could be taken as an agenda item for the next meeting of the Sub-Committee. Information on Delayed Transfers of Care that had recently been presented at the Individuals Sub-Committee could also be brought to this Sub-Committee.

35 URGENT BUSINESS

There was no urgent business raised. The next meeting of the Sub-Committee was scheduled for Wednesday 19 April at 7 pm in the town hall.

Chairman

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 19 APRIL 2017

Subject Heading:	PMS Review and Primary Care Update
Report Author and contact details:	**Sarah Perman** **North East London Commissioning Support Unit**
Policy context:	**The information presented will allow effective scrutiny of local primary care issues**
Financial summary:	**No impact of presenting of information itself which is for information/scrutiny only.**

SUMMARY

Information will be presented giving the latest position on the review of the Primary Medical Services (PMS) for GPs and on local primary issues generally.

RECOMMENDATIONS

1. The Sub-Committee to note the information presented and make any appropriate recommendations.

REPORT DETAIL

Officers will present and summarise details (attached) of the position with renegotiation of the Primary Medical Services Contract with some local GPs. The Sub-Committee is asked to note the position and any other information re local primary care services that is presented.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

NHS
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Clinical Commissioning Group

PMS review and primary care update

Health overview and scrutiny sub-committee
19 April 2016

Natalie Keefe, primary care team, Havering CCG

NHS
Havering
Clinical Commissioning Group

Background - reminder

- In February 2014 NHS England (NHSE) issued national guidance that all PMS contracts must be reviewed

- PMS contracts allow GPs to receive extra payments for providing enhanced services to meet local needs (as opposed to General Medical Services [GMS] contracts) – BUT great variation in payments between practices and little evidence that they have improved outcomes for patients

- The review aims to move to a consistent, equitable approach, ensuring GPs are paid equally for providing the same services, and that PMS contracts are promoting innovation and improvement as originally intended.

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Background - reminder

- CCGs were asked to come up with “commissioning intentions”, to form the basis of their local PMS offer. This would be in addition to core contracts which would be consistent across the capital and were known as the “London offer”

- Contract negotiations paused in spring/summer 2016 while NHSE and Londonwide LMCs (LW-LMC) discussed the content of the London Offer in the context of the GP Forward View

- NHSE and LW-LMCs agreed a “one size fits all” approach will not work for London and wrote out to ask CCGs to progress the review at local level.

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Key principles: PMS review

- Will make system fairer by paying every practice in a borough the same basic amount per patient
- No reduction in level of GP funding in the CCG area: the review will give patients access to the same range of services regardless of what type of contract is held by the practice they are registered with
- We aim to ensure no GP practice is unfairly disadvantaged by the review, and we believe most will be better off
- We understand any practice whose basic income is seen to be reducing as a result of the review will be worried: putting in place a transition plan and will work closely with them to help manage this change
- This review is just part of a wider transformation plan, which will bring investment in new technologies and ways of working, and give GPs the opportunity to enhance their income through innovation and performance.

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Key principles: local negotiations

- NHS England and LW-LMC have asked individual CCGs to determine their own core GP contracts and PMS premium, so they can recognise and address local health needs
- BHR CCGs now working to draw up new core contracts, and decide which additional services should be provided by PMS practices and how much the new premium for providing those will be
- This will of course take time, but it gives us the opportunity to design a modern local GP offer, and specify the services all residents should have access to
- At the end of this process all patients will have access to the same range of services, reflecting the unique needs and challenges of their borough, and GPs will be paid equitably for providing the same services.

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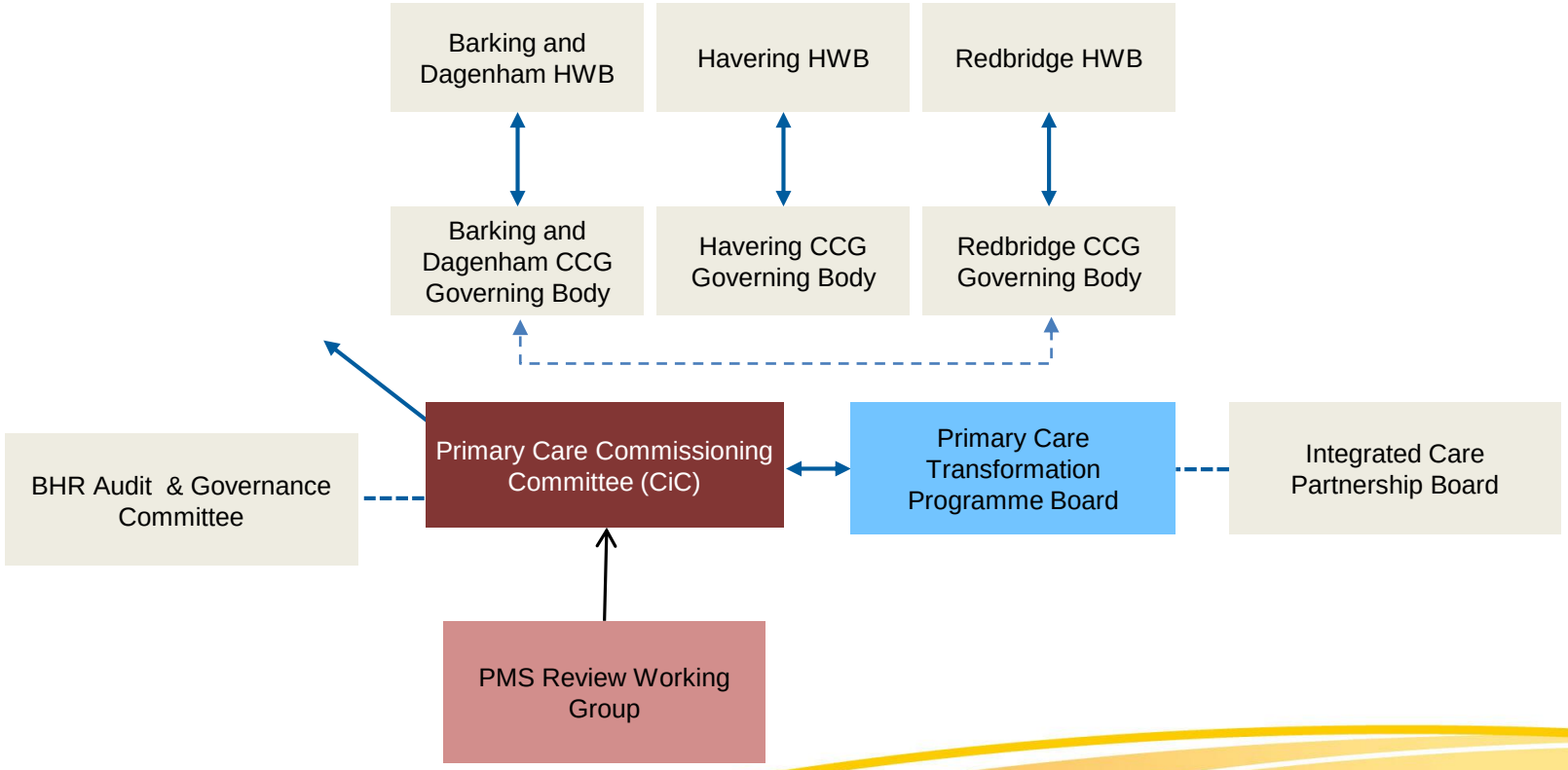
Governance overview



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Local context in BHR - reminder

CCG	Number PMS practices	Total premium value	Ranking of premium value in London	Min/Max premium (£pwp)
Barking and Dagenham	11/38	£2.4m	2nd highest premium	£9.50 / £58.13
Havering	12/44	£1.03m	3rd lowest premium	£10.17 / £11.51
Redbridge	13/45	£1.02m	8th lowest premium	-£2.16 / £27.77

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Financial affordability: principles

- Over five years GMS/PMS increase of £7.3m (from £62.9m to £70.2m) across BHR – exceeding our funding increase
- STPs required to remain overall within their control totals during timeframe of the plan
- BHR CCGs must remain within overall affordability total – individual CCG agreements must account for this
- North East London STP seeking equity for providers across the region, BHR remain more challenged in terms of funding
- Each CCG area is in a different state regarding current funding to practices. Will be necessary to reflect this in different agreements, including phasing and transition timing
- A balance in timing must be achieved for equalising PMS and GMS contracts.

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Affordability: solutions to be explored

A number of options need to be explored to ensure contract expenditure remains within allocation.

This may include (but is not limited to) reviewing:

- current PMS offer assumptions
- premium transition costs
- Phasing of GMS alignment
- Current primary care investment funding
- GP Forward View initiatives (inc improved access)
- Economy-wide solutions.

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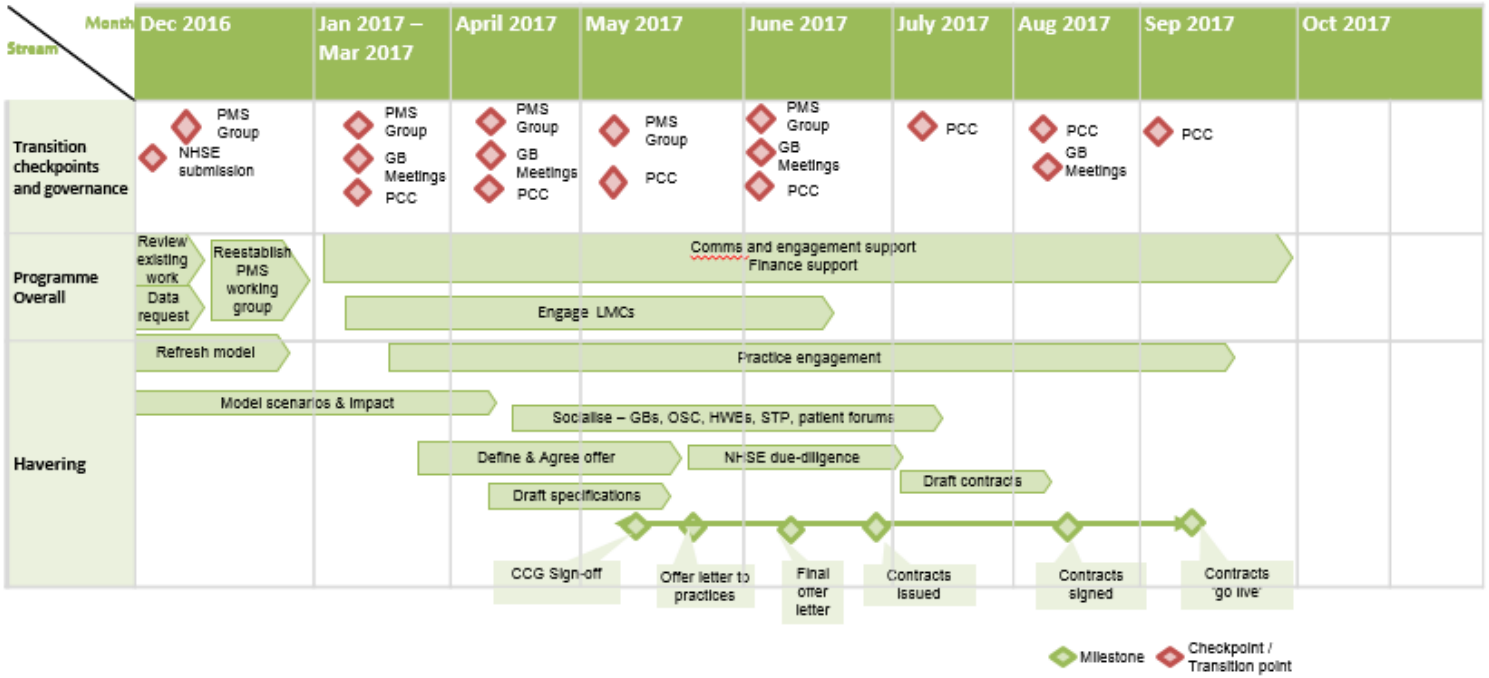
Draft implementation plan



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CQC inspections update

CCG	Total number of practices	Number of visits taken place with published reports	% of visits taken place with published reports	No. rated 'Inadequate' (special measures)	% rated 'inadequate'	Number rated 'requires improvement'	% rated 'requires Improvement'	Number rated 'Good'	% rated 'Good'
B&D	38	30	78.95%	3	10.00%	7	23.33%	20	66.67%
Havering	44	35	79.55%	1	2.86%	14	40.00%	20	57.14%
Redbridge	45	28	62.22%	2	7.14%	9	32.14%	17	60.71%
Total	127	93	73.23%	6	6.45%	30	32.26%	57	61.29%

- CQC advise all visits have been completed – but 26.77% in BHR still to be published

- Barking and Dagenham CCG (and Havering) in bottom five nationally for highest percentage of practices rated ‘inadequate’ or ‘requires improvement’

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CQC: support offered to practices

- **Template policies and procedures emailed to practices** – include confidentiality, correspondence, dealing with medical device and safety alerts, repeat prescribing, recruitment, significant event review template and complaints procedure

- Access to **online training** resource sent to practices October 2016 – includes complaints handling, equality and diversity, fire safety, health and safety, infection control and manual handling

- **Face to face training and workshops** – include infection control (clinical and non clinical staff), safeguarding, fire safety, health and safety, chaperone training, CPR

- **Support programme for practices rated 'requires improvement'** – intending to provide support programme to these practices, to help them make improvements and achieve a good rating at re-inspection
    - All Havering practices that have been rated 'requires improvement' will be offered opportunity to voluntary participate in the programme.

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GP networks

- Local practices have been working together to set up GP networks
- Three networks – for north, central, and south Havering have been established and are meeting regularly. Each network has two named lead GPs.
- Havering Partnership Network Board has been established, and network leads are to take part in leadership development programme commissioned from UCLP
- Quality improvement will be a key priority, with a quality improvement programme to be rolled out across all three. Recruitment for six QI facilitators is under way.

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Dear stakeholder

RE: PMS GP contract review

We wrote to you last year to tell you about the review of GP contracts that Barking and Dagenham, Havering and Redbridge CCGs (BHR CCGs) were conducting in partnership with NHS England (NHSE). The aim of this review was to reduce inequalities between practices in terms of the amount paid for providing the same services, ensuring better value for money for the NHS and fairer and more equal access to care for patients.

It was intended that the basis for all GP contracts across London would be the same, with local CCGs then being able to choose any additional services that GP practices could provide in exchange for extra payments, and which would focus on tackling specific local health needs. NHSE was leading on developing that core “London offer”, with close involvement from London wide Local Medical Committees (LW-LMCs) who represent most GP practices in the capital.

You may recall that local work on the PMS Review paused over the summer, while NHSE and LW-LMCs negotiated the London offer. It has since been determined that a ‘one size fits all’ approach is difficult to achieve for a city as diverse as London, and all parties agree that making progress on the review is the most important priority. CCGs have therefore been given responsibility for agreeing the PMS contracts as well as agreeing which ‘extra’ services practices should provide, and how much they will be paid per patient for those services.

This does mean effectively starting the review from the beginning, but it gives us an opportunity to look at our current GP service to see how we can ensure it will be resilient in the light of challenges being faced by the whole health and care economy. Through this review, we can help ensure that everyone in BHR will have equal access to the same types of service, no matter what sort of contract their GP has. We can create a service that is targeted to the unique health challenges and needs of our area – while ensuring all GPs are paid fairly and equitably for the services they provide.

We still have work to do in deciding what this service will look like and what the payments to GP practices will be. This will take time, but it is crucial that we get it right, and that we do it in a way that will not destabilise local general practice or unfairly disadvantage individual GPs. We hope that our partners will bear with us while we work out the detail, and we will of course keep you informed when we have more specific detail to share. I enclose a short briefing document which explains more about how GP contracts work, the reasons for the review, and the next steps.

If you would like to discuss any of this in more detail, please do not hesitate to contact me.

Sarah See, Director, Primary Care Transformation, BHR CCGs

Personal Medical Services (PMS) contract review

Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups, as delegated commissioners for primary medical services alongside NHS England, have been conducting a review of all GP practices operating on a Personal Medical Services (PMS) contract.

The review is based on the principle that all GP practices should receive the same core funding for providing the core services expected of them. In order to receive additional 'premium' funding, practices need to be able to demonstrate that this will result in improved services, better quality, or to meet the specific needs of a particular population.

What is a PMS contract?
These are locally-agreed contracts between NHS England and an individual GP practice. PMS is an alternative to the nationally agreed General Medical Services (GMS) contract and allows for local variation in the range of services the practice provides and how it is paid for those services.

Currently, practices on a PMS contract are likely to receive more money per patient than those operating under a GMS contract. The premium is paid per patient per year, and the amount that PMS GP practices receive varies widely – both from borough to borough and within individual boroughs – and there is little evidence that the premium results in improved care or outcomes.

Forty GP practices across BHR currently operate under a PMS contract:

CCG	Number of PMS contracts	Total number of GP contracts
Barking and Dagenham	11	38
Havering	12	44
Redbridge	13	45
Total	36	127

Why carry out the review?
The purpose of the review is to ensure that in future the NHS gets the best value for money from the 'premium' element of PMS funding. We need to ensure that where practices receive enhanced payments from the NHS, they are providing premium services to merit this, and that any money spent on a GP practice above the agreed contract level will:

- secure services or outcomes that go beyond what is expected of core general practice, or improve primary care premises
- help reduce health inequalities
- give equality of opportunity to all GP practices, irrespective of their contract (provided that they are able to satisfy the local-determined requirements)
- support fairer distribution of funding at locality level.

A local working group was established in October 2015 to take forward the review in BHR, and it will continue to do this under the new locally delegated arrangements for the review. It is chaired by Redbridge CCG's lay member for patient and public engagement, Khalil Ali, and members include the primary care clinical director lead for each CCG, as well as relevant CCG finance and primary care staff. Outside the CCG, the committee includes representatives from NHS England, as well as the Local Medical Committees (LMCs) to ensure input from general practice providers

Engagement

The CCGs have briefed all affected practices to inform them of the changes to how the review is being carried out, and we will continue to attend LMC meetings. To ensure the local authorities are kept informed, we will be attending local Health Scrutiny Committees and engaging with Health and Wellbeing Boards as soon as we have details of the proposed new contract arrangements. In terms of patient engagement, we will continue to provide updates to Healthwatch for each borough, and meet with the CCG Patient Engagement Forums when there is information to update on.

Next steps

Our PMS working group will continue to meet monthly. It will make recommendations to the BHR Primary Care Commissioning Committee (PCCC), which is responsible for decision-making for primary care commissioning. The PCCC will approve and sign-off the PMS contracts on behalf of the CCGs.

The indicative timeline for implementation is between 1 July and 31 October 2017, however BHR CCGs are working toward having the PMS review process completed locally by 1 July.

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 19 APRIL 2017

Subject Heading:	Integrated Care Partnership
CMT Lead:	Barbara Nicholls, Director Adult Social Care & Health
Report Author and contact details:	Keith Cheesman, keith.cheesman@havering.gov.uk 01708 433 742
Policy context:	This paper describes the work underway which will support the delivery of all four strategic priorities of the Health and Wellbeing Board, to promote and protect the health of the community, work with those at risk and intervene early to improve outcomes, to provide the right health and social care advice at the right time at the right place and to improve the quality of services and user experience.

SUMMARY

This report provides an update on the progress being made with the development of the Integrated Care Partnership arrangements, especially the Havering Localities. It also describes the link with the development of Integrated Localities teams as part of the project within the Community Services Integration Programme.

RECOMMENDATIONS

The Committee is asked to:

1. Note the contents of this report.

This report is for information only. Members are asked to consider and note this update.

REPORT DETAIL

Background

Our health and wellbeing system is facing significant challenges. The existing model of commissioning and providing prevention and care is struggling to meet the current levels of demand as a result of pressure from population growth, rising levels of long term conditions, variable levels of deprivation, and a constrained financial situation.

As a result of Devolution opportunities from central government and our subsequent development of a Strategic Outline Case for Barking and Dagenham, Havering and Redbridge (BHR), there is a much clearer picture of what can be done together to address these challenges. This work was previously referred to as the development of an Accountable Care Organisation.

The Integrated Care Partnership was formed as part of that work to become the leadership group, comprising senior political and clinical leaders from across the BHR partnership (see Appendix A).

Havering Localities

The development of a locality model of care is being explored which presents the opportunity of a more intelligent way of delivering health and care, built around a defined population rather than around institutions, with a focus on delivering better outcomes.

Locality boundaries have been agreed and partners are working to develop a key suite of supporting information to enable key decisions around workforce requirements in line with need to be made alongside informing the operational model. These are set out in Appendix B.

Work to map the services currently provided across the system is underway and 'locality profiles' are being developed by Public Health. High level locality activity and population profiles have been produced.

A 'Havering Locality Design Group' has been established up to April 2017 (when terms of reference and membership will be reviewed) to take forward development of the locality model. This group includes leads from; Havering Local Authority, Havering Clinical Commissioning Group, NELFT, The Local Pharmaceutical Committee, Havering Healthwatch and the Havering Community and Voluntary Sector Compact. Further details about this group are set out in Appendix A.

Services will be co-designed with local people and delivered closer to them. What this means in practice is local health and care services along with community and voluntary sector, and other services such as housing etc., working together as a

virtual team with the primary aim of improving the quality of life and circumstances of a person. The intention is to focus on what a person needs, rather than offering a set menu of services with criteria that the person may not meet.

In Havering, scoping is underway to define what this model could look like, and plan to involve stakeholders including the community and voluntary sector, GPs, patients, and health and care staff in the development of the proposals going forward. The design needs to ensure that the strong relationships that already exist across Havering between different organisations are built upon to facilitate closer working.

Havering Localities Design

The design principles and core design of the localities model for both Children's and Adults arrangements is much further advanced. It is expected that the locality model could deliver a large number of potential benefits, including:

- Improved outcomes for the local population
- Better use of resources and providers working together to address the needs of a defined population
- Trusted assessor agreements may begin to develop through relationships born of co-location
- Recruitment and retention may also be improved through better use of resources and directing people to the right service, first time, meaning that staff feel less overwhelmed by the volume of activity. There will also be greater opportunity for multidisciplinary working and shared learning, and with the possible creation of new workforce roles to ensure that those with the right skills are seeing the right people, more opportunity for staff to progress in their careers
- Increased clinical time with patients and service users (through better use of resources as noted above)
- Address the key health and wellbeing, care and quality and financial and productivity issues currently facing the Havering and the wider BHR and north east London system as a whole

Childrens Locality Model

The children's model focusses on children's emotional wellbeing, drawing in schools and GP's around earlier identification and intervention of issues.
It will take a whole family approach, rather than an individual one. Those looking to access the service will do so through a single access point, where their case will be quickly triaged by a virtual "multi-disciplinary team" who will assign a key worker to their case, dependent upon their individual needs. That key worker will then ensure the family have the support and information they need. It will feel more seamless and joined up, delivering better outcomes for our service users. It will focus on emotional health and wellbeing, building resilience in children and families, marking a move away from tiered services with strict criteria. It will aim to be much more preventative, avoiding the need for more intensive services later in life.

One of the key benefits of the children's model is the reduced duplication within the system, including the number of times that people have to repeat their 'story' and the number of times that they are assessed for similar services. This will not only be a better experience for those using the services, but will reduce the burden of

administrative duties on front line staff, increasing the amount of clinical time that they have with their service users and patients.

Adults Services

The adult's model is centred on a new 'intermediate care' tier of services which will seek to create a more seamless 'urgent' care offer for those who need urgent support. This will reduce duplication across the borough and create a more seamless service that makes best use of our resources. It is intended that services move from a position where a set menu of services is offered to address high levels of need, to a position that focuses on an individual's strengths and assets, as well as their networks (such as families and friends) as being integral within the care and support planning process, thereby reducing the level of support that may be needed from Adult Social Care. . The model again seeks to ensure a reduced duplication within the system, including the number of times that people have to repeat their 'story'

Integrated Localities Project

The Community Services Integration Programme (CSIP) has previously provided this Committee with insight to the Integrated Localities development underway in Adult Social Care.

There are clear connections and overlaps between the Integrated Localities work within this programme and the Havering Localities development; these are being explored in detail currently with a view to bring the two together as soon as possible, using the project as the delivery vehicle for the Havering Localities changes. There are some logistical implications expected in terms of how staff work and are located, but there is no fixed or defined view at this point as what changes might be required to existing plans or arrangements. The ground work already completed in bringing the Adult Social Care community teams together with the North East London Foundation NHS Trust (NELFT) community services teams will enable the new model to be built on that platform.

Feedback from the staff affected by the first phase – the co-location – is generally very favourable. The quality of referrals and handovers between the teams has improved, there is more interaction between the teams and relationships are improved.

There are a few areas that need further attention and the focus in this next phase will be on a review of therapy roles across organisations, improved communication and further reduction of duplication. There will also be further training and improvements in the access to each other's IT systems.

Both the Front Door redesign and Intermediate Care (IC) are also part of the CSI Programme's scope, so there are clear benefits in bringing the scope of these together with the Havering Localities delivery. As described above, the Havering Localities design for the Adults model embeds Intermediate Care to the heart of its design.

Intermediate Care Tier

Typically, IC services are those short-term treatment or rehabilitative community based services designed to promote independence, reduce the length of time you might be in hospital unnecessarily, or help you to avoid unnecessary admissions to hospital. If a person has care and support needs that do not need 'acute' hospital based medical support they are likely to be supported with intermediate care. These might be services such as Reablement which the Council commissions or rehabilitation, some community treatment via community matrons. These will be 'free' to use for up to six weeks and many people will not have a continuing need for care after these interventions.

IMPLICATIONS AND RISKS

Financial implications and risks:
There are no financial implications arising directly from this report at this stage. As the models develop, appropriate consideration will be given to any implications arising by each of the organisations involved.

Legal implications and risks:
There are no legal implications arising directly from this report at this stage.

Human Resources implications and risks:
There are potentially human resources implications arising directly from this report regarding the localities model and how it may impact on existing staff. The service will need review the position as the model develops and may need to consult with staff both informally and possibly formally under the organisational change management procedure.

Equalities implications and risks:
The Havering Localities model provides an opportunity to transform care so that people are provided with better, more integrated care and support. It encompasses a range of existing services that will be brought together to become more accessible and more coordinated. The design work so far does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage.

It is expected that an Equalities Assessment will be carried out for the component parts of each of the models once the design phase is concluded. It is expected that the design and development will continue to include a range of representation of public and service user interests.

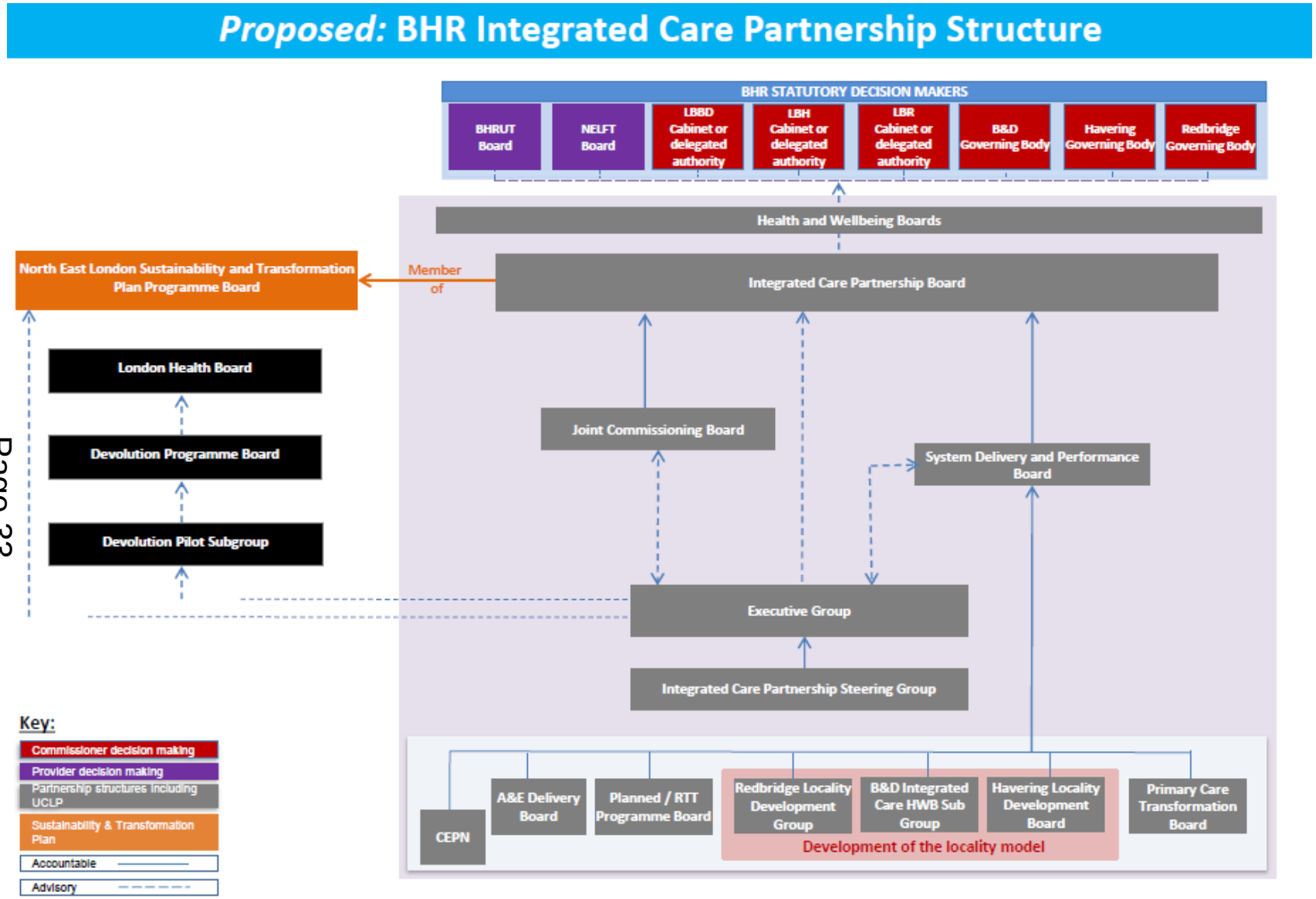
BACKGROUND PAPERS

None

Havering
LONDON BOROUGH

Appendix A – Governance Overview

The current governance structure and composition for the Integrated Care Partnership are as follows.



Meeting	Description/remit	Attendees

Integrated Care Partnership	The remit of this group is in discussion, and attendees are being confirmed, where attendees are proposed you will see their names in the box to the right. *Proposed: Joint Committee for Health and Social Care with a remit including commissioning, transformation (including oversight of the development of the locality model in BHR) and system performance for the BHR health and social care economy.*	• London Borough of Barking and Dagenham: HWB chair Maureen Worby; Social Care Stat officer to be confirmed • London Borough of Havering: Cllr Wendy Brice-Thompson; Cllr Ramsey; Social Care Stat officer to be confirmed • London Borough of Redbridge: HWB chair Mark Santos; Cllr Jas Atwal; Social Care Stat officer to be confirmed • BHRUT: Chair Maureen Dalziel; Matthew Hopkins; Dr Nadeem Moghal • NELFT: John Brouder; Chair; Caroline Allum • BHR CCGs: Conor Burke; Dr Waseem Mohi; Dr Atul Aggerwal; Dr Anil Mehta; Kash Pandya; Richard Coleman; Steve Ryan
Joint Commissioning Board	The membership and remit of this group is currently in development. It is anticipated that this group will be established in 2017	
System Delivery and Performance Board	The membership and remit of this group is currently in development. It is anticipated that this group will be established in 2017	
Executive Group	The Executive is a partnership group that was established to oversee the development and submission of the Strategic Outline Case. Its remit includes ensuring that system level programme management requirements are in place to meet delivery needs. It is comprised of Executive leaders from across the BHR system and reports to the Integrated Care Partnership Group.	• BHR Clinical Commissioning Groups: Conor Burke • BHRUT: Matthew Hopkins • London Borough of Redbridge: Andy Donald • London Borough of Havering: Andrew Blake-Herbert • London Borough of Barking and Dagenham Chris Naylor • NELFT: John Brouder
Integrated Care Partnership Steering Group	The ICP Steering Group is a partnership group established to coordinate delivery of the Integrated Care Programme. The group will be responsible for: • supporting the Executive Group to coordinate the overall programme • supporting shared learning between localities It is comprised of partners from across the BHR system and will report to the Executive Group. Partners within the group are accountable to their respective organisations and are responsible for disseminating information as appropriate.	Jane Gateley, Director of Strategic Delivery (Chair); Basirat Sadiq, Divisional Manager for Specialist Medicine Division (BHRUT); Jacqui Van Rossum, NELFT Managing Director; Anne Bristow, Deputy Chief Executive and Strategic Director for service development and/or Mark Tyson, Commissioning Director, Adults Care and Support –Service Development and Integration; Caroline Maclean, Operational Director of Adult Social Services (DASS) LBR; Barbara Nicholls, Assistant Director for Adult Commissioning and Social Care LBH; Kirsty Boettcher, –Deputy Director of Strategic Delivery; James Gregory, Senior Project Lead; Emily Plane, Strategic Delivery Project Manager

Havering
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Appendix A - continued

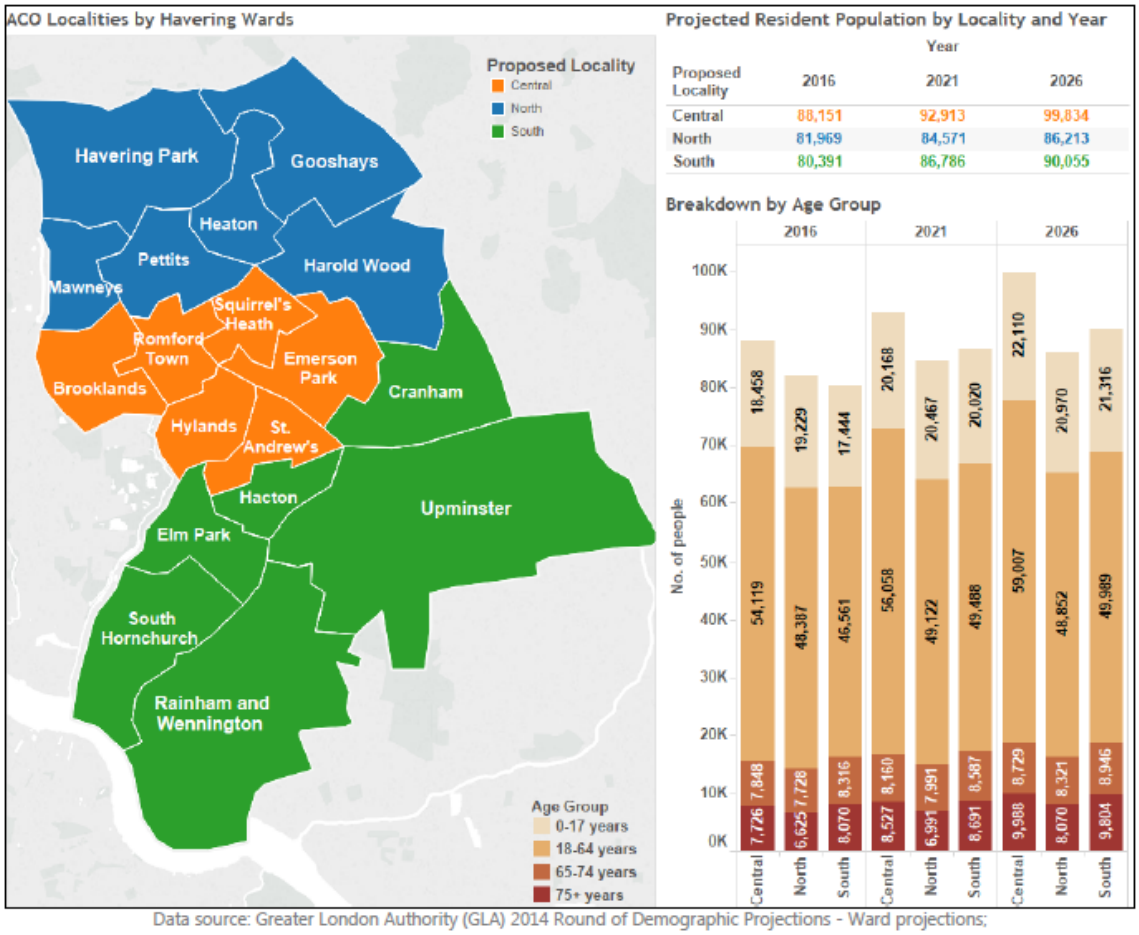
Havering Locality Design Group

Members are drawn from the eight participating organisations who are collaborating on the development of the Accountable Care Organisation across Barking & Dagenham, Havering and Redbridge in addition to partners key to the development of the locality model in Havering

Healthwatch Havering	Anne-Marie Dean and Ian Buckmaster
London Borough of Havering	Barbara Nicholls
NELFT	Carol White
Havering CCG Clinical Lead	Dr Ann Baldwin
London Borough of Havering	Tim Aldridge
BHRUT	Mairead McCormick
BHRUT	Elizabeth Sargeant
London Borough of Havering	Keith Cheesman
Havering Community and Voluntary Sector Compact	Tony Bloomfield
GP Provider lead	▪ Dr Gupta; Interest in Children / paediatrics ▪ Dr R Chowdry; Interest in Urgent care (particularly frequent attenders) ▪ Dr S Symon; Interest in Pathways (planned care)
Local Pharmaceutical Committee	Marc Krishek
Havering CCG	Alan Steward
BHR CCGs	Emily Plane

Appendix B – Localities Map and Population Breakdown / Growth

Proposed Havering ACO localities, by ward and estimated resident population of all ages, children (aged 0-17 years), adults (aged 18-64 years) and older adults (aged 75+ years) for this year (2016), and in five years (2021) & ten years (2026)



Data source: Greater London Authority (GLA) 2014 Round of Demographic Projections - Ward projections; SHLAA-based; short term migration assumption; Capped Household Size model (for projected population data)

Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 19 APRIL 2017

Subject Heading:	Public Health Service Performance Report
CMT Lead:	Pippa Brent-Isherwood
Report Author and contact details:	**Oriean Kay, 01708 432899, oriean.kay@havering.gov.uk**
Policy context:	**The information presented will allow more effective scrutiny of the performance of the public health service**
Financial summary:	**No impact of presenting of information itself which is for information/scrutiny only.**

The subject matter of this report deals with the following Council Objectives

Havering will be clean and its environment will be cared for	[]
People will be safe, in their homes and in the community	[X]
Residents will be proud to live in Havering	[]

SUMMARY

Information will be presented (attached) that will detail the current performance of the public health service.

RECOMMENDATIONS

1. The Sub-Committee to review the performance information presented and make any appropriate recommendations.

REPORT DETAIL

Officers will present and summarise recent performance information concerning the public health service. This is presented following a request from Members at a previous meeting of the Sub-Committee.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

Public Health Service - Action Plan - 2016/17

Review Date: **January 2017**

Complete	✓
On track	-
Off track	!

Service Plan Outcomes	Actions	Lead	RAG	Dashboard	Comments
1) Lead wider partnerships to improve health and narrow health inequalities	Develop a MOU for the core offer of public health advice and support to the CCG and BHRUT to underpin the joint appointment of the DPH	SM	-	**Yes**	Await sign off from CCG/BHRUT
	Lead specific elements of the 'Population' Health' work stream for the ACO business case development • Healthcare population metrics • Primary care dashboard • Public mental health • Workplace health	SM	✓	**Yes**	
	Produce the DPH Public Health Annual Report covering the 15/16 period	MA	✓	No	
	Lead a review of the HWB role and function. Assess / address any gaps in H&WB infrastructure re. health improvement/health protection	SM	-	No	
	Undertake public consultation on Phase 1 interim sexual health service redesign	MA	✓	No	
	Support the implementation of the CAMHS transformation plan	SM	-	No	
	Refresh Havering's Joint Health and Wellbeing strategy under the auspices of the HWB	SM	✓	**Yes**	
	Lead the implementation and evaluation of the Drug and Alcohol Strategy	EG	✓	**Yes**	
	Lead the implementation and evaluation of the Obesity Strategy	MA	✓	**Yes**	
	Support the implementation and evaluation of the End of Life strategy	SM	✓	**Yes**	
2) Maximise public health benefit of all Council services, commissioning and policies	Jointly appoint (with NHS) a substantive DPH	SM	!	No	
	Restructure PH team as required to provide capacity / capability of PH team to inform the integrated commissioning of health and social care services	OK	✓	**Yes**	
	Review 16/17 plans of all LBH services All Council teams aware as to how the health benefit of their activities can be maximised / any harms mitigated.	SM	-	No	
	Further develop business partner relationship with other Council services. All Council teams aware as to how the health benefit of their activities can be maximised / any harms mitigated.	BP's	-	No	Unable to clarify!
	Development of an integrated approach to the assessment of community wellbeing in all policies and programmes. Phase 1 - Pilot	SM	-	No	
	Development of interactive health impact tool for alcohol licensing. Phase 1 Pilot	EG	✓	**Yes**	Phase 1 Complete
3) Further improve quality and cost effectiveness of health improvement services	Re-procure local sexual health services as part of the Pan London and sub-regional Sexual Health Transformation Programme.	DR	-	**Yes**	PIN notice published
	Review oral health promotion contract	DR	✓	No	Service has been de-commissioned
	Commence phase 1 of the re-procurement of school nursing and health visiting services	DR	✓	No	Exisitng service until March 2018 with +2 yr option - SMT advised.
	Re-procure CYP substance misuse services	DR	✓	No	Award of Contract arranged for 1st April with mobilisation underway.
	Decommission selected health improvement services following the outcome of the current public consultation	DR	✓	No	
	Set up the Joint Commissioning Unit within CAH Directorate:- Phase 1 Co locate and Phase 2 Restructure and redesign	DR	-	No	Phase 1 Complete / Phase 2 in progress
4) Assure and improve health protection arrangements	Surveillance of the health protection arrangements for immunisation, screening, infection prevention and control and emergency planning under the auspices of the Health Protection Forum	LD	-	No	Completed draft 2016 HPF annual report - in circulation comment/input. Due for HWBB approval in March 2017.
	Develop a robust clinical governance system within LBH for all commissioned clinical services	SM	✓	**Yes**	
5) Improve safeguarding of children and vulnerable adults	Chair the Child Death Overview Panel and produce annual report	MA	✓	No	CDOP Annual Report signed off by panel in Q3
	Subject to available resources - conduct audit of drug-related deaths to provide more insight about possible opportunities to prevent future drug related deaths.	EG	-	No	
6) Strengthen public health capacity	Expand the 'Health Champion' programme within LBH and in the community to increase health literacy and resilience.	LS	✓	**Yes**	
7) Improve / increase PH support provided to health and social care commissioners	Provide leadership of the JSNA programme Agree and deliver work programme to inform health and social care commissioning. Deliver a range of specified knowledge products including; • This is Havering • Health and Social Care Overview • Ward Health profiles • SEN needs assessment • Diabetes needs assessment	AA	-	**Yes**	Programme complete with exception of 2nd Edition of Health and Social care Overview (due by march 17).

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Public Health Service - Performance Dashboard - 2016/17

Complete	✓
On track	-
Off track	!

Review Date: **January 2017**

Service Plan Outcomes

Lead wider partnerships to improve health and narrow health inequalities	SMT	-
Maximise public health benefit of all Council services, commissioning and policies	SM	-
Further improve quality and cost effectiveness of health improvement services	DR	-
Assure and improve health protection arrangements	EG	-
Improve safeguarding of children and vulnerable adults	MA	-
Strengthen public health capacity	LS	✓
Improve / increase PH support provided to health and social care commissioners	AA	-

JSNA Programme

This is Havering (quarterly refresh)	AA	✓
Overview of Health and Social Care Needs in Havering (annual refresh)	AA	-
Interactive Ward Health Profiles	AA	✓
SEND (Deep Dive)	MA	✓
Obesity (Deep Dive)	MA	✓
Diabetes (Deep Dive)	AA	n/a

Key Deliverables

2016/17 Budget	OK	✓
Deliver financial savings to meet 2017/18 cuts to PH grant	SM	✓
Recruitment to vacancies	OK	✓
ACO Business Case	SM	✓
Public Health Web Pages	OK	-
Staff Mandatory Training	OK	!
2016-17 Staff PDR's	OK	✓

Service Plan Performance Indicators (Q3)

Percentage of new patients attending sexual health services accepting offer of HIV test	DM	✓
Participation in the National Child Measurement Programme	DM	✓
Successful completion of drug treatment – opiates and non-opiates	DM	✓
New birth visits by Health Visitors (at 10-14 days)	DM	✓

Key Service Plan Actions for Monitoring

Develop a MOU for the core offer of public health advice and support to the CCG and BHRUT to underpin the joint appointment of the DPH	SM	-
Development of interactive health impact tool for alcohol licensing. Phase 1 Pilot	EG	✓
Re-procure local sexual health services as part of the Pan London and sub-regional Sexual Health Transformation Programme.	DR	-
Develop a robust clinical governance system within LBH for all commissioned clinical services	SM	✓

Public Health Strategies

Drug and Alcohol Strategy	EG	✓
Obesity Strategy	MA	✓
End of Life Strategy	SM	✓
Refresh of Joint Health and Wellbeing Strategy	SM	✓

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 19 APRIL 2017

Subject Heading:	Q4 performance information
CMT Lead:	Pippa Brent-Isherwood
Report Author and contact details:	**Oriean Kay, 01708 431899, oriean.kay@@havering.gov.uk**
Policy context:	**The information presented will allow more effective scrutiny of performance issues**
Financial summary:	**No impact of presenting of information itself which is for information/scrutiny only.**

The subject matter of this report deals with the following Council Objectives

Havering will be clean and its environment will be cared for	[]
People will be safe, in their homes and in the community	[]
Residents will be proud to live in Havering	[]X

SUMMARY

Information will be presented that will detail current Council performance issues within the remit of the Sub-Committee.

RECOMMENDATIONS

1. The Sub-Committee to review the performance information presented and make any appropriate recommendations.

REPORT DETAIL

Officers will present and summarise recent performance information covering the areas within the remit of the Sub-Committee. This is presented to the Sub-Committee on a quarterly basis to allow regular oversight of relevant Council performance issues.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

Havering

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www.havering.gov.uk

Quarter 4 – Corporate Performance Report 2016/17

Health O&S Committee

19th April 2017

Changes to Performance Reporting for 2016/17

- Performance data to be considered by O&S first, then O&S Board (every 6 months), then Cabinet

- This will allow the Cabinet reports to reflect any actions or comments the overview and scrutiny sub-committees may be making to improve performance in highlighted areas as well as shortening the overall performance reporting cycle

About the Corporate Performance Report

- Overview of the Council's performance for each of the strategic goals (Clean, Safe and Proud).

- The report identifies where the Council is performing well (**Green**) and not so well (**Amber** and **Red**).

- Where the RAG rating is '**Red**', '**Corrective Action**' is included in the report. This highlights what action the Council will take to address poor performance.

Quarter 4 Performance

OVERVIEW OF HEALTH INDICATORS

- 1 Corporate Performance Indicator falls under the remit of the Health Overview & Scrutiny sub-committee. This all relates to the SAFE goal and has a RAG status of '**Green**'.

Indicator	Value	Q4 Target	Tolerance	Q4 Performance	Short Term DOT		Long Term DOT	
SAFE - Using our influence								
Successful completion of drug treatment – opiates and non-opiates (S)	Bigger is Better	50%	±3%	52.3%	↑	49.9%	↓	56.90%

About the PI 'Successful completion of drug treatment – opiates and non-opiates'

- Performance of 52.3% is better than last quarter which was 49.9% and is above the annual target of 50.0% but worse than at the same point in the previous year of 56.9%.

- New provider (WDP Havering) was commissioned at end of Quarter 3 2015/16 and at the request of the Council, the provider undertook a remedial action plan until performance met the annual target of 50%.

Any questions?

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 19 APRIL 2017

Subject Heading:	Healthwatch Havering Reports
CMT Lead:	N/A
Report Author and contact details:	**Ian Buckmaster, Director, Healthwatch Havering, ian.buckmaster@healthwatchhavering.co.uk**
Policy context:	**The information presented will allow more the Sub-Committee an insight into recent work undertaken by Healthwatch Havering**
Financial summary:	**No impact of presenting of information itself which is for information/scrutiny only.**

The subject matter of this report deals with the following Council Objectives

Havering will be clean and its environment will be cared for	[]
People will be safe, in their homes and in the community	[X]
Residents will be proud to live in Havering	[]

SUMMARY

Information will be presented that will detail issues recently investigated and reported on by Healthwatch Havering.

RECOMMENDATIONS

1. The Sub-Committee to review the Healthwatch reports presented and make any appropriate recommendations.

REPORT DETAIL

A Director of Healthwatch Havering will summarise recent work undertaken by Healthwatch. The relevant reports published by Healthwatch are attached.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

Health Overview and Scrutiny Sub-Committee

19 April 2017

Healthwatch Havering – Enter & View programme: visits to GP practices

Over the past year, Healthwatch Havering has expanded its programme of Enter & View visits to cover GP practices and surgeries. Visits have been carried out at the following:

Berwick Surgery, Rainham

Greenwood Practice, Harold Wood

High Street Practice, Hornchurch

King's Park Surgery, Harold Wood (including the co-located pharmacy and the waiting area for the Harold Wood Polyclinic)

Mawney Road Surgery, Romford

Maylands Health Centre, Hornchurch (including the co-located dental practice and pharmacy)

Modern Medical Centre, Rush Green

Mungo Park Practice (at South Hornchurch Clinic)

North Street Surgery, Romford (as both local practice and part of the GP hub service)

Petersfield Surgery, Harold Hill

Rosewood Practice, Hornchurch (two visits) (as both local practice and part of the GP hub service)

Straight Road Surgery, Harold Hill (Drs Gupta and Prasad)

Suttons Avenue, Hornchurch

The visits were prompted for various reasons – for example, the Maylands visit followed the catastrophic flooding there in June last year, to see what had

happened and how the practices and pharmacy were dealing with the aftermath. In other cases, the visit followed publication by the CQC of an inspection report. Not all of the reports of the visits have been published as there is an extensive pre-publication process for them to go through. Visits to a number of further practices are planned for the coming months.

Every practice/surgery is different but some common themes have emerged. For example, in many cases the premises are in need of upgrading (both in terms of accommodation and equipment) and joint working with other, nearby practices might be beneficial for patients. Other concerns include inadequate car parking facilities (especially for patients who have mobility difficulties), possible lack of resilience within practices' business plans to take account of unforeseen disaster (which is also an issue for the CCG to consider) and the adequacy of practice opening times from the patients' perspective.

According to the *Health Service Journal*, a respected professional periodical, Havering has the highest number of GP practices inspected to date by the CQC that have been rated "Inadequate" or "Requires Improvement" in England (although it should be noted that the neighbouring/nearby boroughs of Barking & Dagenham, Thurrock and Waltham Forest have similar, though lower, proportions). Some practices have been rated "Good" but none (so far) has been rated "Outstanding".

A significant number of practices in Havering are operated by a single GP or a small number of GPs working together.

There are of course concerns at national level about the significant reduction in doctors entering General Practice and the number of existing GPs who are approaching retirement age. This is not an issue that can be tackled by local action alone although the CCG is understood to be actively seeking to recruit new GPs.

One particular issue appears to be the historic model of general practice operating as small, local businesses, usually professional partnerships; anecdotal evidence suggests that new GPs may be reluctant to take on the responsibilities of small business ownership, preferring to remain as employed locums concentrating on their clinical expertise. Again, this is a national problem for which local action may not be feasible, although an increasing number of practices are being acquired by health service provider companies (working under contract to the NHS) that then employ GPs to provide the actual clinical service but themselves provide

administrative and support services (one example is the Hurley Group at the King's Park Surgery/Harold Wood Polyclinic).

Healthwatch volunteers have worked with several practices to secure improvements for patients. In particular, they worked with partners and staff of the Rosewood Medical Centre in Hornchurch, where considerable improvements have been secured.

Ian Buckmaster
Executive Director and Company Secretary
Healthwatch Havering

Background papers

Enter and View reports (see http://www.healthwatchhavering.co.uk/gp-surgeries-and-health-centres):

GP Hubs and associated services – visited May-July 2016

Berwick Surgery (Rainham) – visited 18 November 2016

The Greenwood Practice (Harold Wood) – visited 7 November 2016

Rosewood Medical Centre – visited March 2016

Straight Road Surgery visited 9 November 2016

High Street Surgery, Hornchurch, visited 14 November 2016

Health Service Journal: GP quality – London: CQC ratings confirm challenge in East London – 28 March 2017

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Enter & View
GP Hub and associated services

May-July 2016

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is an Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Background and purpose of the visit:

Healthwatch Havering (HH) is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

GP Hub and associated services - introduction

General Practice (GP) – primary care or "family doctor" – services have long been the backbone of the National Health Service. Although primary care services account for only around 10% of the resources used for the NHS, by far the majority of people who have contact with the NHS do so through their GP or pharmacist. Other than through

attendance at Accident & Emergency (A&E) [1] departments, all hospital admissions begin with a GP consultation.

For some time, patients across England have complained about difficulty in accessing their GP outside normal working hours (now generally 8am-6.30pm, Monday to Friday), at weekends or for home visits, and also that it is rarely possible to get a same-day appointment, with some complaining of waits of several weeks or longer before an appointment is available. Indeed, many of the approaches to Healthwatch Havering have related to such issues. The evidence [2], anecdotal and empirical, suggests that where a patient is unable to obtain an appointment in what they see as a reasonable or acceptable time-frame, they will seek assistance from elsewhere within the NHS, most typically by attending at a hospital A&E department, even though it is clear that their condition is neither the result of an accident, nor an emergency [3]. It seems that, because people are more aware of GP and A&E services, they opt for the immediately familiar rather than using, for example, the NHS 111 telephone helpline service to see what alternative services might be available and, perhaps, more relevant to their immediate need.

GPs have resorted to various means of managing the consequential increase in demand for their services, including telephone triage and referring patients to other health care professionals, such as practice nurses and pharmacists. While undoubtedly clinically effective, however, such measures have not always met patients' expectations or been accepted by them – patients often perceive such alternative means of consultation as "fobbing them off" with a lesser service, preferring to see "their" GP whom they trust and respect.

[1] There is a move across the NHS to change the name of A&E Departments to "Emergency Departments (EDs)". However, A&E remains the term more familiar to the public and, for consistency and ease of understanding, A&E is used in this report.

[2] See, for example, Survey of Patients, Healthwatch Havering 2016, commissioned jointly by the Barking, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) – Appendix 2 of this report

[3] See Appendix 3 for a brief statistical analysis

In a very real sense, GPs – and A&E services – have become victims of their own success, both having a "brand" that is widely known and respected.

Following government concern at what was perceived as a failure in GP services, GPs were encouraged to try innovative solutions in order to improve patient access to their services.

A pilot scheme for out of hours' services (i.e. after 6.30pm and at weekends) was run in two GP practices – Petersfield, Harold Hill and Maylands, Hornchurch – from 9 November 2013 until 31 March 2015. The scheme was judged successful and, following funding becoming available from the Prime Minister's Challenge Fund, a consortium of GPs was formed as an independent company, Havering Health Limited, to take the concept of out of hours care forward. As a result, from 1 April 2015, two "GP Hubs" were set up in Havering (similar arrangements were set up in the neighbouring boroughs of Barking & Dagenham and Redbridge at the same time).

The two Havering Hubs were based at North Street Medical Centre in Romford (covering the north of the borough) and Rosewood Medical Centre in Hornchurch (covering the south. The Hubs use the facilities at the practice premises for consultations but are entirely separate and independent services from the "host" GP surgeries. They accept referrals of patients from a variety of NHS sources, patients themselves and any practice in Havering, including the "host" practices, for appointments after 6.30pm until 10pm Monday to Friday and at weekends between 12pm and 4pm/5pm.

The data on usage of the Hub service [4] during the eleven-week period 27 June to 11 September 2016 indicates that, of 3,898 appointments available during that period, by far the majority (3,186) were made by patients themselves. NHS 111 arranged 368 appointments and 11 were patients referred by the Urgent Care Centre but no appointments were

[4] Source – Havering Health Limited: Weekly attendance statistics

made following a referral by the patient's own GP or as a result of a visit to A&E or a walk-in centre, or by an out-of-hours call by a doctor.

Finally, it is pleasing to record here that, at the Annual General Meeting of Havering CCG in September 2016, the partnership working by Havering Health Limited was formally recognised by the CCG by the presentation of an Award – for providing over 22,500 urgent late evening and weekend GP appointments in 2015/16.

The Healthwatch Havering Review

Given the experimental nature of the Hubs, Healthwatch Havering decided to carry out a "one-year-on" review.

In order to do this, it was decided to carry out Enter & View visits to the two Hub surgeries, North Street and Rosewood, and to several other premises: Petersfield (the pilot scheme practice), Harold Hill Health Centre (which hosts four GP practices) and King's Park Practice (co-located with the Harold Wood Polyclinic and under the same management). As might be expected, the services observed by the visiting teams varied between the two Hubs and between the other surgeries. Unfortunately, it did not prove possible to visit every practice in a short space of time so there is an inevitable gap between the first and last to be visited.

In addition to visiting the surgeries in question, opportunity was taken in several cases to visit simultaneously adjacent pharmacies. Although the pharmacies are separate businesses in their own right, they clearly work closely with the neighbouring GP practices and are perceived by patients to offer what is, in effect, an integrated service. Given that government policy is moving towards greater integration of primary care services, it is likely that instances of pharmacies being co-located with surgeries will grow.

The visits

The visits were carried out by Healthwatch volunteer members between mid-May and mid-July. Different teams visited different practices at different times, and as noted earlier, their observations were accordingly different. Reports of each visit are set out in Appendix 1.

Overall conclusions

Availability of the Hub service

The evidence indicates that, at the time of the visits that are the subject of this report, the Hub service was able to meet the demand for appointments. However, the availability of the Hub service seems not to be as widely known as it might be. The survey of patients outlined in Appendix 2 revealed that many patients find the different types of urgent and emergency care on offer confusing – one respondent said:

> *the 'powers that be' in Havering, Barking & Dagenham and Redbridge are going about things the completely wrong way by opening up all these different centres for cases with different degrees of urgency and different types of need. What is needed is a 'one-stop-shop' where all the 'experts' are collected in one place, so, whatever the problem, it can be dealt with there-and-then, and handled in the correct manner, whatever the degree of urgency. That's why people go to A&E, and it is A&E that should be expanded and be the first-port-of-call, rather than having to go searching round for the correct place to go, depending on the situation.*

Our survey suggests that is not an uncommon view, even though it is in complete contrast to the direction of travel proposed by the NHS.

It seems, therefore, that the efforts of the GPs themselves and of those behind them, including NHS England and the government, have had little success in informing – or persuading - the public of why there is need for alternatives to GP and A&E services nor, more importantly, how to access them. A particular example of this was the finding that

some respondents to the survey claimed to be unaware of what an Urgent Care Centre (UCC) was, or where it was – despite the fact that, at the time of being questioned, they were actually sitting in one, waiting to be seen: they had assumed that, as the UCC at Queen's Hospital is co-located with A&E and shares an initial reception area, it was simply part of A&E.

There is anecdotal evidence that GPs' reception and other staff are not fully aware of the Hub service. For example, Healthwatch visited Rosewood Medical Centre in March 2016, as a separate exercise to the visits now reported on. In the report of that earlier visit, it was commented, in relation to patients interviewed during the visit, that:

> *It was noticeable that, of those interviewed, 70% had not heard of the Hub system for out-of-hours GP appointments, 20% had heard of the Hub but had not used it as appointments were too late* [i.e. at night] *for children and 10% had heard of the Hub but did not realise that one of the Hub bases was at the Medical Centre*. (emphasis and words in brackets added)

Since patients can only be aware of what they are told by the NHS and in particular by GPs and their staff, this clearly indicates that better communication of Hub services is essential. While most, if not all, GP practices display posters about Hub services, they are often not proactively supported, and unless patients who need their services are referred to them, they are unlikely to be aware of them. While care is needed to manage demand for Hub services, to ensure that the service does not become swamped, if the objective of relieving pressure on both the A&E Department and the GP sector is to be achieved, the capacity of the Hub service must be considered – if only to avoid the build-up of long waiting times to see a Hub GP, which would of course complete defeat the purpose of the Hub service.

The downside of this, which NHS policy makers (at all levels) need to be aware of and bear in mind, is that, while the Hub service is not as widely known as it might or should be, it is operating at near-capacity

already [5]. Other initiatives, such the triaging of patients attending the A&E Department leading to many being referred to GPs, will only increase demand for Hub services (both directly as a result of referral, and indirectly as available appointment slots at regular practices are taken up). It will be essential to ensure that the capacity of the Hub service is expanded to meet that additional demand.

Communication to waiting patients

Although the time-honoured method of communication in most practices is posters on the wall, a number of practices are installing electronic screens and TVs to inform, and in some cases entertain, patients while they await their appointments.

The effect is, however, rather spoilt in some places by uncorrected failure of the devices. In one practice that was visited, information was displayed but scrolled through at a speed that made reading it all but impossible; in another, the electronic screen had broken down and was displaying gibberish – this had been going on for several months (and indeed, at the time of publication of this report, still was) but no one appeared to have given any thought to putting it right.

Moreover, in many places, patients are told that their clinician is ready to see them not by some electronic display or device but by the expedient of the clinician going to the waiting area and calling their name.

Given the wide range of inexpensive devices available to page people when they are needed, it is surprising that so little use is being made of them in GP practices. While cost might be a consideration, especially in smaller practices, a clinician or receptionist having to call with raised voice to summon the next patient gives an unprofessional appearance. It is understood that NHS funding may be available in

[5] During July 2016, the available appointments at the Hub service were 90% taken up by around 4.30pm, despite one third or more of calls being unanswered – Source: Havering Health Limited

2017/18 for such systems and, that being so, it is hoped that Havering CCG will support practices wishing to develop such systems.

Patients' privacy

Although not directly an issue for the Hub service, Healthwatch volunteers commented about a lack of privacy for patients when they attend at their practice to book in for their appointment or to seek other assistance. Practices typically have a desk with a glass screen separating reception staff from the patients in an area where other patients are present, an arrangement that not only potentially compromises patient confidentiality, but presents an unattractive view to those who arrive for appointments.

Patients may, therefore, have to discuss quite intimate and personal information in very public surroundings. Many find this frustrating and it can be humiliating.

It is appreciated that practices have a duty of care to their staff and must assure their personal security; in an increasingly violent world, it is thus inevitable that some form of protection will be needed (though it is noticeable that there is a growing trend in banks and other health-related premises such as pharmacies, dental surgeries and even veterinary surgeries, to move away from screens for staff to a more open desk top approach). Screens do little to foster communication and often lead to patients – and staff – feeling it necessary to speak louder than is ideal in order to be heard.

Clearly, there is no "magic wand" to improve this. But practices – and those funding them – need to think more carefully about whether heavy glass screens are the best way to approach patient-practice communication.

The teams would like to thank all staff and patients who were seen during the visits for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to visits carried out during the period May to July 2016 and is representative only of those patients, carers and staff who participated in each visit. It does not seek to be representative of all service users and/or staff.

APPENDIX 1

Individual reports of the visits

The reports of the individual visits follow. They are presented in order of the date of each visit.

GP Hub at Rosewood Surgery – visited 16 May

12 patients were interviewed during the Healthwatch Havering Enter & View visit to Rosewood GP Hub.

The building has a pleasing, modern appearance, with parking for about six cars, including disabled car users. It is shared with the regular Rosewood GP practice. There is a wide entrance leading to the main reception desk, which is shared by the GP practice and the Hub. The GP practice receptionist sits at the first position (on the left) on entering and the Hub receptionist sits in the second position (on the right). To the right of the reception desk is a large nicely decorated waiting room seating area with low tables.

The practice appeared clean and tidy. There were magazines on low tables and children's toys. Several notices were displayed on walls. It is easily accessible for wheelchairs and pushchairs.

On arrival, the team could not see information outside referring to the Hub; the notice displaying opening times was purely for the regular Rosewood GP practice. The team felt this would be confusing for patients and, indeed, were initially not sure they were in the right place. However, having been told beforehand it was in the same building, they entered and were greeted by the reception staff for the GP practice sitting at a long counter, and were then directed to the Hub receptionist sitting alongside. From this point, the Hub receptionist gave clear guidance on what to do.

There was no electronic check-in. It did not appear to be necessary as the receptionist directed the patients to the waiting area, which was in sight of the reception desk. Hub doctors came out of the consulting rooms they were using to call each patient personally and patients were seen ahead of time, on time or only a few minutes after their appointment times. There appeared to be enough privacy at reception, the desk being situated a reasonable distance from the waiting area. Both the GP practice receptionist and the Hub receptionist were friendly and approachable and were very keen to help and to explain things.

The availability of online booking was advertised and a hearing loop had been installed for the benefit of the hard of hearing. Toilets were available near to the waiting room, and appeared clean and presentable, with hand sanitisers available.

The team noted that the notice boards were clear, with up to date information displayed and that a translation service was available. The availability of the patient participation group was also clearly advertised.

A poster advertising the team's visit was on display in both the Hub and the regular GP practice areas. In addition, Healthwatch Havering "Tell Us What You Think" cards were displayed prominently on the reception desk.

During the visit, the team observed the interaction between the receptionist and patients and considered it to be warm, friendly and helpful. The doors were locked during the latter part of the Hub practice time and patients had to press the buzzer at the front door. The receptionist opened the door automatically for the patient after confirming their identity and appointment.

Appointments for the Hub are arranged through a dedicated call centre, which books the appointments and gives patients their appointment times, which are adhered to. Booking can be made either directly to the call centre by patients, or through the NHS 111 system.

Staff told the team that they enjoyed working in the Hub. They would assist disabled patients with mobility problems to access the building, and those with difficulty writing to ensure that what needs to be in writing is properly recorded. Patients who have learning difficulties are dealt with in an appropriate manner.

Staff meetings are held monthly and include colleagues from the Hubs in Havering and Barking & Dagenham.

Patients' views

Eight patients told the team that these were their first appointments at the Hub and four had visited previously - **t**wo of whom had been to the Hub twice before and one had been three times. All patients either knew the out of hours' number or were given the number by a member of staff at their own surgeries.

Many said that they had tried to get an appointment at their own surgeries but were told that they faced waits of 2 to 4 weeks for an appointment within normal practice hours at their own GPs.

Two patients said they found it easy to get appointments but most of the respondents had waited anything from 12 minutes to 45 minutes before being able to get through. Several patients told the team that they had experienced an engaged tone every time they rang and had taken a long time trying to get through. Patients had found the waiting stressful, wondering if the phone would be answered as they had to redial constantly for twenty minutes or more. That said, all patients had eventually been able to get an appointment the same day.

No patient had tried to book online.

Most of the patients were not concerned whether they saw a female or male GP – their main concern was to get an appointment.

Most patients had a good, or very good, impression of the service. Comments included: "really glad to see someone on the same day"; "very happy that there is a surgery to come to out of hours"; "the

experience was good this time and on a previous occasion visiting the surgery".

All 12 patients said that they were aware of the Hub's 'out of hours' opening times. Several qualified their answers by saying the opening hours suited them as they could go to work and still see the doctor. One patient remarked that the opening times shown on the outside of the building did not reflect the actual Hub opening time (they actual reflected the opening times of the regular practice housed in the same building). They found the absence of mention of the Hub on the outside of the building confusing.

Asked whether they were confident that the GP they were to see would have read their medical history, four patients replied that they were; the rest were unsure.

Asked their impression of the staff, the patients' comments included: "polite"; "great"; "pretty good"; "good"; "very kind" (and this helped as the patient said they were stressed); "very good"; "helpful and really nice"; and some added that the call centre had been helpful.

All of the patients said that the Hub's location was helpful. Some qualified their answers because they lived in Hornchurch or Rainham; one patient had experienced some confusion with the address. Another patient who had come from Dagenham criticised the lack of signposting and said that their satnav device had directed them to the end of the road. They also commented that there were no facilities for out of hours in Barking and Dagenham; Rosewood was the only Hub available.

Most patients thought parking was fine as they were able to park outside the building in the small parking area. Some noted there was a disabled bay. Two patients did not require parking places as they lived close by. One patient thought the parking facilities were a "bit minimal".

Rosewood GP Surgery – visited 17 May

Although a team from Healthwatch Havering had previously visited the Rosewood Medical Centre in March 2016, this visit was carried out separately, as part of the review of the GP Hubs.

Nonetheless, prior to this visit, the visiting team was aware that patients had expressed continuing concerns: around the appointment system in use at the medical centre, about delays in collecting prescriptions and/or problems arising when collecting medication from the Pharmacy, that the Practice website is not kept updated and some information is misleading or not included, that some members of staff are unfriendly and that there is insufficient car parking space.

These points were borne in mind in preparing for the visit.

The Visit

On arrival at the Medical Centre, the team was pleased to note that the Healthwatch posters advising of the visit were clearly visible in the entrance area. The reception area appeared clean, tidy and welcoming. The doctors and staff were aware of the planned visit and the team was warmly welcomed by the Practice Manager and the senior partner.

The waiting area was divided in two and patients were directed by the receptionist to the appropriate area, depending on which health professional they were waiting to see. There are two toilets for patients use – one of which was specifically for disabled people. The side entrance is accessible for wheelchair users. There is also a loop system in both waiting areas.

At the time of the visit the seating in both areas was fully occupied and despite having a self-checking in machine, the three receptionists were kept busy dealing with a steady stream of patients' queries.

The patients are notified when it is their turn to be seen, by the practitioner coming into the waiting area and calling out their name. However, the team noted that owing to the number of people in the waiting area, it could be quite noisy at times. Some patients told the team that they were worried they might not hear their name when

called out, which caused them some anxiety as they might miss their slot.

The senior partner's viewpoint

The senior partner was keen to explain that changes had been implemented since on 1 April in the day-to-day running of the practice, including the various options open to patients when booking an appointment. He confirmed that notification posters had been put up around the practice advising patients of the changes.

The practice had reverted to its original appointment system "after listening to what the patients had to say" so that patients can now phone in, come to the practice to book an appointment or book online.

Patients also have the option of a face-to-face consultation at the practice or a telephone consultation with one of the doctors. Patients who choose the latter are then given a time slot, usually within a 2-hour period that same day. However, while every effort is made to meet the time slots, there may be occasions when this is not possible, for example, if the practice is busier than usual or an emergency arises. The decision to telephone will be based on level of priority: each doctor in the practice keeps void slots in their allocation of appointments every day to allow space to fit in urgent appointments if required.

The number of slots available depends on the demands of the practice on any given day, with Monday and Friday being the busiest. There is also a duty rota in place between the doctors. Their responsibility is to offer advice and support to receptionists who may require guidance on medical queries patients may present to them. The duty doctor will also act on the concerns of staff if they receive a call from a patient when it is unclear what would be the most appropriate action required. The duty doctor will decide the best course of action based on the merits of each individual case. This may include calling the patient back to ascertain more in-depth information on the patient's medical condition and, where it has been identified that there is a need to be seen that same day, the patient will be offered an appointment.

Patients' viewpoint

As part of the visiting process, the team spoke to a number of individual patients, to seek their opinions and experience of using the service. When asked their views on the appointment system currently in place, each one expressed the same view that they were unhappy, confused and frustrated and wanted to "revert back to the old system", which was phoning in or turning up at the practice to book an appointment. All but one of the patients spoken to were unaware that the practice had reverted to the original appointment system since 1 April: the sole exception said she had phoned earlier on the morning of the visit and had been given an appointment for herself and her small child that day. The other patients said they had to wait approximately two weeks for an appointment.

The patients interviewed said that, when phoning the practice to book an appointment, they would sometimes be answered straight away but at other times they might have to wait ten minutes or more for an answer.

The patients expressed the view that, while most of the receptionists were helpful, some appeared to be "less friendly". All the patients interviewed agreed that they had sufficient consultation time with the doctor/practitioner they had chosen to see and did not feel rushed.

There was a mixed response when asked if they knew they could book appointments online: the majority said they did not know it was possible, whilst the remainder said they were aware but that they "wouldn't know what to do." When directed to posters displayed advising them of this facility and other relevant information related to practice, one patient said "I cannot read them unless I am up close because the print is too small." Another patient commented that they would have to walk around the room to find them (posters) and said they needed to "stand out more."

Another common view expressed was that, when they rang to make an appointment, the receptionist would ask about the nature of the call

and advise them that a doctor would call them back, but would not commit to a time, which meant that some might be waiting in all day. It was noted that these comments did not appear to match the information provided by the senior partner, who had said that patients were given time slots. One patient said that she had had to wait two days for a call back with regards to a medication query.

Each individual patient was asked if they were aware of the Hub and how to access medical advice/assistance out of hours. None of the patients spoken to had heard of the Hub and – surprisingly – did not know one was actually based at their practice. They all confirmed that they would go to A&E if they needed medical assistance out of hours.

Some of the patients described the problems they faced when requesting a repeat prescription, being advised by the receptionist they may have to wait 72 hours before it is ready for collection, which one patient said "worried him that he would run out of tablets".

Another patient explained her experience when she rang the practice to tell them she had run out of her young child's asthmatic medication and needed an urgent prescription: she was told that it might take 48 hours before it would be ready for collection. She told the team that "I was so distraught that I took him to A&E because I was worried he might have an asthma attack in the meantime, and didn't know what else to do." One patient explained how they had a query on their medication and had rung the practice and was told a doctor would ring them back: they told the team "I received the call back a week later." Other patients described their frustrations when they had gone to pick up their medication from the pharmacy, only to be told that, due to a discrepancy, the medication could not be dispensed until it had been verified by the GP.

All the patients interviewed collectively voiced their frustrations with the lack of parking space at the practice. One patient said "I could do without the added stress of having to find somewhere to park, before I even get in the surgery door." It was noted that the situation had not been helped as the number of parking spaces had been reduced while

building work went on at the practice, which was not expected to be completed before August. Only one disabled parking space was available, which at the time of the visit was not clearly signposted.

The Practice Manger's viewpoint

The Practice Manager (PM) provided a breakdown of the number of staff currently working at the practice, which included four General Practitioner (GP) partners in total, of whom three were employed full time, and one worked Monday and Tuesday; in addition, a salaried GP worked Wednesday, Thursday and Friday. Two Practice nurses and one Health Care Assistant were available, a secretary and nine Receptionists who alternated their roles between covering the phones and interacting with the patients face to face.

The Practice opening times are between 8am and 6.30pm Monday to Friday and 12.30pm Thursday. Extended hours surgeries operate to accommodate working patients most days of the week and some Saturday mornings. These are strictly booked-appointments only and were from 7.30am to 8.30am, 6.30pm to 8pm during weekdays and from 9am to 12noon on Saturday mornings. However, it was noted that the practice website did not reflect the full range of opening hours.

Currently, major renovation work is taking place to extend the premises which appears to be managed well, causing minimum disruption to the patients and staff (although it has led to a temporary loss of parking space, as noted above). The new extension will provide 3 clinical rooms and a room for the Health Care Assistant. It is expected the work will be completed by August at the latest.

Minor surgery is carried out fortnightly, such as removing sutures, contraception implants, sexual health checks and awareness/advice, and travel vaccinations. There are also clinics to monitor chronic/long term conditions such as diabetes, blood pressure and chronic breathing problems. Palliative nurses visit every three months to discuss cancer patients' care.

Currently staff meetings take place monthly, but the PM plans to change this to weekly meetings. Sickness absences are covered from the existing pool of staff.

The PM said there was a robust programme of staff training, done in - house, for all front line staff, including telephone training, safeguarding adults and children, customer service and batch prescribing. The PM said she felt supported both by the team and the practitioners; whilst acknowledging there had been some initial problems when she started in the post in 2015, she now felt that she had developed a good working relationship with the team. Instead of structured supervision on a one-to-one basis, the staff receive ongoing supervision whilst preforming their daily tasks, enabling her to identify any shortcomings and arrange training as necessary. The PM regularly attends training sessions herself in order to maintain her own continual personal and professional development, and to keep herself updated on the ongoing changes to the statutory and legal requirements, which may apply to her work practices. Practice meetings are conducted on a monthly basis and are attended by the practitioners and all members of staff.

In response to patients' comments about the wait of up to 72 hours for repeat prescriptions, the PM said that it was rare for patients to have to wait more than 48 hours. The team suggested that the practice of stating "up to 72 hours" should be reviewed, as the not only was that misleading but it was causing unnecessary stress to some patients, and that the website should also be updated to reflect these changes.

The PM said she was aware that there had been some problems with prescriptions and has already trained up more staff to deal with these issues, and can already see improvements.

When asked about support for carers, the PM said that carers are identified at registration and are well supported, by being offered counselling and/or signposted to the most appropriate means of support. The PM confirmed that all Learning Disabled and patients with special needs have all had their annual health checks.

In the course of discussion of the reduced parking, the PM advised that she was looking into the possibility of negotiating with a local public house for use of their car park during practice opening time.

Recommendations

That

- The website be updated as a matter of priority as some of the information is misleading or omitted, for example wrongly stating there is a wait of up to 72 hours wait for repeat prescriptions, and inadequately explaining practice opening times
- Staff wear named badges to help patients identify who is attending to them
- When putting up notices in the practice, consideration be given, to the size and style of font used, the colour of paper used, to meet the needs of all patients, particularly those with a visual impairment
- Provision for car parking by disabled people be reviewed: an additional disabled parking space and better signage would be a real benefit to patients with reduced mobility
- Because of the difficulty some patients are experiencing hearing their name being called, consideration be given to introducing a speaker system to alert patients when it is their turn.
- All front line staff be given customer services training
- A list of charges and fees for services not covered by the NHS be prominently displayed and kept updated
- The Patient Participation Group (PPG) be encouraged and assisted to produce a monthly newsletter, with updates on any changes that are currently taking place in the practice, or planned for the future, copies of which should be left in prominent positions (such as next to the self-checking in machine and on the reception desk) for patients to access

- Consideration be given to the use, with patients' agreement, of Information sharing through electronic media such as text, Twitter and emails
- Develop a better relationship with the local pharmacy staff for a more seamless service, which would be mutually beneficially to patients and staff.

[Note – a senior partner at the practice has since advised that the practice has accepted the majority of these recommendations. Healthwatch will be working with the practice in a number of areas in the coming months, not least at the request of NHS England to improve patient-practice engagement]

King's Park Surgery and Harold Wood Polyclinic, including Well Pharmacy – visited 17 May

King's Park Surgery is located within the Harold Wood NHS Polyclinic, a purpose-built NHS building operated by the Hurley Group, which is a NHS GP Partnership that runs a number of practices, Urgent Care and Walk-in Centres across London. The King's Park Practice Manager is a senior member of the group of 16 surgeries and has monthly meetings with other Practice managers.

The Surgery is co-located with, and operates alongside, a Walk-In Centre and is accessed through a housing estate. Premises used for nursing and other training by the London South Bank University and for a number of specialist community clinics by NELFT (the local community health services trust) are nearby.

The Hurley group use the Econsult website and an online platform called webGP for patient self-management, which allows online consultations with over one hundred templates for common conditions. The online consultation service lets registered patients request feedback and medication from GPs by filling out a simple questionnaire. The GP

reviews the answers and the practice responds by **the end of the next working day**. This helps Improve patient experience and frees up the practice for more complex needs. E-consultation is available 24 hours. Being part of a large group enables surgeries to use experiences from all areas of the medical profession. King's Park benefits from the support structure the Hurley Group gives. Views are often discussed and recommendations transferred from one clinic to another.

The practice is open from 8am to 6.30pm Monday to Friday, 9am to 1pm Saturdays.

There is a very large car park, which was very full at the time of the visit as it serves a number of clinics for NELFT as well as the Surgery and the Walk-In Centre at the Polyclinic. There are five parking bays for people with disabilities. In common with most other healthcare facilities, parking is an issue. The car park is operated by an independent specialist company, Parking Eye – the staff at the practice are unable to assist with any parking issues as Parking Eye has sole responsibility for them. Parking is free, provided patients provide their car's registration number using an electronic system – failure to do so can incur a penalty charge.

The Polyclinic is a large, modern purpose-built building in good condition internally and externally, with disabled access. There is a very large waiting area, with a central reception area serving both the practice and polyclinic.

On arrival, the team was met and welcomed by the Practice Manager (PM). She is responsible for both the practice and the polyclinic and was able to answer all the points raised by the team.

During the visit, two reception desks were covered. There was good security on the reception, and all doors to consulting and treatment rooms were locked, with practitioners having to come into the waiting area to call patients. The size of the waiting area, which is not particularly quiet, makes this difficult, especially for those with hearing problems. There are three portable loop systems available for the hard

of hearing patients. Patients may wait in any part of the area and, although there is a designated area for practice patients, it was used by polyclinic patients as well.

Signage in the waiting area was clear and concise, four medium-sized noticeboards giving plenty of information. Various leaflets were available, data protection privacy was advertised (and a chaperone service is available) and the local Patient Participation Group (PPG) was clearly signposted (and appeared to be active, meeting once a month).

There is a café (run by the Royal Voluntary Service – formerly the WRVS) for the use of patients, friends and relatives as the wait for the polyclinic can be quite long (it was up to 5 hours on the day of the visit). Refreshments available include hot and cold drinks and snack foods.

There is a complaints procedure in place. Every complaint is logged and dealt with where possible 'locally'. All complaints are seen by the PPG. There is a carers support group with 173 identified carers. If there is a language problem a translator can be booked. The practice uses the Google translator – The Big Word - when necessary.

Toilets are clearly marked and a non – alcohol hand sanitiser is available.

The Surgery has two full time GPs, one full time registrar and one locum for about 6,500 patients. The practitioners have listed and designated specialisms on set dates. They are supported by a Nurse Practitioner, other nurses and health care assistants. The nurses have been trained to a level where they can prescribe. One doctor performs minor practice for topical conditions and minor injuries. In addition to general practice, there are clinics covering diabetes, babies, skeletal, physiotherapy and long-term chronic conditions.

The practice follows the Everyone Counts and Once for London initiative, which means new patients are not "quizzed" on registration and they are not refused. Everyone is treated equally. No identification is needed to register at the practice.

Appointments can be made or cancelled online or by phone. The EMIS Access allows patients to communicate with the practice via the

internet. Patients can book and manage their appointments online and also request repeat medication. EMIS Access also allows patients to update personal details.

The Surgery piloted a triage system on the last occasion of a strike by junior hospital doctors, which worked so well that the Surgery plans to introduce triage generally at the beginning of June. Patients' feedback had been positive. Regular appointments are allocated in 15 minute slots.

Test results are texted to patients wherever possible but doctors will contact patients by telephone if the news is not good. The aim is to do this within 48 hours. Repeat prescription requests are never accepted by phone. Names, addresses and DOB are checked on collection of results and prescriptions. They have a good response to emergencies with phone call and home visits if necessary. This is monitored at PPG meetings every month.

Most patients are not routinely reviewed annually but patients who are over 75 and those with a learning disability are reviewed. Such patients can be difficult to manage owing to a lack of co-operation but they are offered home visits. The Hurley Group as a whole are looking into this issue.

Training for staff is available and supported by grants. The PM has a training schedule in place; all permanent staff complete one full week's training a year, which could involve either classroom-style or online training.

The team spoke to a member of staff who said he had worked at the practice for two and a half years. He commented that the work could be challenging but felt well supported by a good team. He had completed Fire Marshall training and a NVQ on customer services training, and was in the process of finishing a Management Course. When asked what could improve patient experience, he answered "more doctors: it can be difficult to be accommodate appointments promptly", adding that parking provision for disabled drivers was not adequate

enough. He added that supervision was good – he could not always attend team meetings due to the time and availability. Patients' paper work stops at 3pm, which inevitably leaves work to be carried over. The member of staff in question would like to see that change to 3.30pm or 4pm. ***[Note – the PM has since advised that, subsequent to the visit, the decision was taken to cease having a "cut-off" time for such paperwork]***

Patient interviews: this was quite difficult as practice patients were not sitting in the allocated area.

The team spoke to one patient who had rung the practice at 8am and booked the appointment on the same day. The phone had only rung a few times and she was third in line. She told us that she always had had a good experience booking an appointment. She had been waiting 5 minutes at the time of interview. She felt she was happy with her overall care and treatment and was always involved in discussions about her care. The patient was aware of practice opening times and said that they suited her needs. She felt the staff were welcoming and friendly.

One patient was distressed: she had been waiting for 4 hours for a dressing to be changed after a major abdominal operation, and stated that she had been told to wait each time she reminded the reception staff she was there (this was mentioned to the PM in the end). There did not seem to be any evidence of patient/reception interaction.

It was noted that the water station was without cups.

Pharmacy

The team returned on the 19 May but there were no patients waiting to be seen in the practice, so they spoke to some people waiting at the Chemist. There were still no cups at the water station.

Of the five people questioned at the pharmacy, only two were there to pick up a prescription for themselves; the remainder were there to pick up a prescription for someone else.

Two respondents were 'very satisfied' with the advice and information provided to them by the pharmacy team during their visit and one was 'satisfied'. Two said they were very dissatisfied.

Four respondents reported being able to collect their prescriptions within five to ten minutes but one had been waiting for over 20 minutes. The majority of people managed to collect their prescriptions within ten minutes. All of the respondents reported being 'very satisfied' or 'satisfied' with the time it took to receive their prescription.

The team asked several questions regarding patient opinion of the pharmacy team, asking them to rate the pharmacy on their politeness and listening skills, answering any queries or concerns, the pharmacist themselves, the service overall.

The responses were that all respondents considered the pharmacist and their staff to be 'very good' in all of **the** above areas.

When asked who they were more likely to consult on a health care issue, three answered their GP, one answered Pharmacy and one answered "other".[6]

The team asked about using the pharmacy and how well do patients think it provided the following services.

- Providing advice on a current health problem or a longer term health condition – four replied they had never used this service but one thought the service was very good.
- Providing general advice on leading a healthier lifestyle – four answered they had never used this service but the other thought the service was very good.
- Providing advice on health services or information available elsewhere - four had never used this service but, again, one thought the service was very good.

There was a good supply of leaflets and sign posting on all the above at the Pharmacy, but the majority of people spoken to were not

[6] It should be noted that these responses, albeit from a very small sample, are broadly consistent with the survey results referred to in Appendix 2

particularly interested in them, simply wanting to collect their prescriptions and leave.

None of the people questioned had ever been given advice on stopping smoking, healthy eating, physical exercise or sexual health.

Of the five people interviewed, one was aged 16-19, one 20-24, one 45-54 and one 55–64.

Recommendations

That

(a) The Water Station be checked regularly for water and cups

(b) The electronic sign in the Polyclinic above the reception area showing adverts would be more useful if the information for the services of the Polyclinic and Surgery could be displayed

(c) More parking bays be provided for use by disabled people.

Petersfield Surgery – visited 24 May

Petersfield Surgery was established after the Second World War when many people had to move from the East End of London to begin a new life on the new Harold Hill Estate. Since then, it has undergone many changes and has expanded to meet the growing need. In 1983 the practice was redeveloped into modern premises when two buildings merged; and two years later a nearby single-handed practice was absorbed. In 1993, the practice became a fund holding practice. There are many different sized rooms, with modern additions to the rear.

The practice relies heavily on computer technology and all notes are made exclusively onto computer records. They receive blood results

electronically from a nearby pathology laboratory. They are proud that they hold beacon status for information technology. For 17 years, the practice has been part of Upminster Primary Care group and they are represented on the board of this organisation, providing clinical governance lead.

The practice has added touch screen booking in and 24-hour telephone appointment booking

Petersfield Surgery has a long tradition of teaching and training. Each year they welcome one or two GP Registrars to join their team for their final year of training. All teaching practices have to go through a rigorous re-approval process every 3 years to ensure that young doctors are taught in the best possible placements. There is a dedicated tutorial room large enough for 8 people with computer technology training equipment. Most training is done in house for all staff, and the Nurse is a qualified trainer.

The practice serves about 6,500 patients, showing an increase of approximately 1,500 due recent housing developments in the area.

Normal appointment times are 10 minutes per patient but, in times of high demand, such as increased referrals owing problems elsewhere or to the 'flu season, a 3-minute consulting service may been operated. Emergency appointments are normally available on the day for people who need to see a doctor and cannot await an appointment. The aim at the practice is to offer first class medical care in a friendly manner.

Because of its origins, the practice has an unusual layout with many stairs. Provision is made for the disabled with a ramp outside to the entrance and 3 surgery rooms on the ground floor. Unfortunately, so far the practice has been unable to provide a dedicated disabled toilet – to do so would require structural alterations. The condition of the practice premises is good and clean internally and the practice is well-advertised outside. There are very limited parking spaces but street parking is available nearby.

The reception desk is immediately inside the entrance. There is privacy for patients, a reasonable sized waiting room with toilets and sanitiser gel. Patients are called by an electronic indicator board and a buzzer - there is no loop system. The reception staff were very approachable and friendly - most are part time. There are clear noticeboards with up to date information, which included information on NHS 111 and the Hub.

Online booking is advertised. Because they have a large team of part-time staff, many languages are covered but interpreters can be called in if necessary. There was a large poster in the front porch advertising the PPG but the Practice Manager (PM) told the team it is very hard to engage patients and more work is needed on the PPG.

Complaints are rare - last year, there were just 5, 4 of which were valid. Complaints are usually resolved by the PM.

There are alarms in every room.

There are two Partners (one of whom now works part-time and is planning to retire in the near future), two Salaried GPs, 5 Registrars (with a further due to start soon), 1 part-time Senior Practice Nurse, 2 Student Nurses, 1 Healthcare Assistant and 8 part-time receptionists.

The practice generally opens at 8am and closes at 6.30pm, but on Tuesdays opens earlier, at 7.45am and closes at 9.30pm and on Thursdays closes at 2pm. The website was updated during the week before the visit.

Patients can call for pathology results but a doctor or nurse calls the patient if the results are not good.

There is a walk-in clinic for blood tests. Clinics are available for Diabetes, Eczema, LD but chlamydia and smoking have ceased due to lack of funding. Contact with patients is by phone, newsletters, posters, emails and texts. Two GPs undertake minor surgery and accept referrals from other surgeries, which is a new project.

There is a carers policy which is advertised with posters. They have 93 known carers. Patients between 40 and 74 can have health

checks. Most of the LD patients live in communal houses so a GP normally visits them

The team was able to meet the Nurse Specialist, who is very enthusiastic and committed, and has worked at the practice for 27 years. She said the best part of the practice was the teamwork and the worst part was the need for more money to increase facilities and pay more staff hours. She is training 2 nurses, one has been there for 4 months and one for 4 weeks. She makes herself available as much as she can and would like to have more hours. She is offered support and supervision from the doctors and Practice Manager and she does attend practice meetings.

The team spoke to an elderly couple of patients (the wife had an appointment) who had been with the practice for over 30 years. They were very happy with all aspects of the practice, making and getting appointments promptly, no long waits at the practice, and were having a same day appointment. Doctors consulted them on treatment options and gave them adequate time. They were just getting to grips with online facilities. The best thing was accessibility and they could not think of any changes they would like. They lived nearby so, although parking was not easy, it was no problem for them.

The team also spoke to a young person who was waiting for a vaccination. He lived in Gidea Park (an area a mile or so distant from the practice) but while he was at University he came home at weekends sometimes and had used the Saturday morning drop in service at Petersfield. He was so impressed that, although he had now graduated and returned to live in Gidea Park again, he had registered with the Petersfield Surgery. He was happy with all aspects of the practice and had only waited 10 minutes on the day of the visit. He liked the accessibility and also could not think of any changes he would like to see: *"It is such a good practice and easy to use"*.

As the team left, they were discussing the outside condition of the practice when one of the GPs joined them as he was leaving, to ask about the work of Healthwatch. He commented that, although the

building was not purpose-built, the quality of the care given was what mattered.

North Street GP Surgery – visited 25 May

North Street Medical Care is a practice spread over two sites, one in North Street, Romford and one in Ashton Gardens, Chadwell Heath (in Barking & Dagenham), providing patients from both areas flexibility to access services at either site. Doctors and staff work at both sites. This report is concerned solely with the premises in North Street, Romford.

The premises have recently received funding from NHS England's Primary Care Infrastructure Fund, enabling improvements to be made including three new consulting rooms, a new reception area, automated front doors and provision of additional storage space for patients' notes. The external and internal building still had ongoing work at the time of the team's visit, although it looked close to completion.

There is ample parking space on site, with parking available also in adjacent residential streets and superstores nearby.

The Surgery has a new disabled access slope at the front and, on the day of the visit, new hand rails were going to be fitted. New electronic automatic doors have been installed at the entrance. There is a disabled persons' toilet as well as baby changing facilities although these were not signposted. All floors and passage ways are suitable for a wheelchair use. Hand sanitiser available.

The opening hours for the regular practice are:

8am – 6.30pm Monday, Tuesday, Thursday and Friday

8am – 1pm Wednesday

9am – 12noon Alternate Saturdays

The Surgery reception is quite small considering there are 17,000 patients across the two sites, but on the day of visit there was plenty of

room for patients to wait. There is clear guidance on arrival of how to check in either electronically (in nine languages) or directly with a receptionist. There was, however, a distinct lack of privacy at reception, but the team sat at the back of the waiting room and could not hear any of the patients. Reception staff seem approachable and friendly. A room behind reception is available for patients to talk in private and there is a poster on the wall advising this. There is a television screen above reception giving plenty of information on a continuous loop; the loop speed is however on the high side and could be slowed down in order to be more easily read. There were clear notice boards with information on and a Healthwatch poster which was, however, out of date. A Chaperone service is advertised as available.

The Patient Participation Group had a large poster behind reception. There are currently 140 members and the practice carries out regular surveys with the group. This is a virtual group online, so a number of patients who would like to get involved may well be unable to. Security was evident, staff on reception had panic buttons direct to the police station and doctors had them to call other members of staff. Consulting rooms not in use were locked.

The waiting room was clean, fit for purpose but in need of redecoration.

A portable loop system for the hard of hearing is available at reception.

Appointments can be obtained by phone or in person, bookable up to 6 weeks in advance and, for more acute problems, a number of appointments are available on the day. Online booking is available for doctors but not for nurse appointments. It is possible to use the online system for cancellations. Appointment times are ten minutes long. Double appointments are available on request.

Home visits are available for housebound patients, bookable on the day before 11am.

Triage consultations are also bookable on the day where a patient simply needs advice from a doctor, who will call back at a set time, and if necessary prescribe medication or book a face-to-face appointment.

Repeat prescriptions can be requested by fax or in person, but not by phone, and require 48 hours' notice. Prescriptions can be sent electronically to local pharmacies for ease. Name, address and DOB are checked when picking up prescriptions and letters.

Test results can be obtained by calling the practice between 3pm and 5pm, weekdays only. If patients need to, they can make an appointment at that time.

Patients are called to see the doctor by an electronic system, a loud buzzer sounds and the patients name, doctor and room number are displayed. Other information was also given on this electronic board such as a certain doctor running late, and the facility to book a double appointment if necessary. Patients told the team they liked to be kept informed. As with the other board, the information passed through quickly and could be slowed down.

The team was met by the Practice Manager, who was very passionate about the practice and the staff. There are four GP partners and one nurse practitioner partner supported by two salaried GPs, two registrars, another nurse practitioner, five practice nurses and one health care assistant. There are also 18-part time receptionists (spread between the two sites). Doctors work on a regular roster between the two sites and take turns to work at the weekend during the two alternate Saturdays that the practice is open. Doctors prioritise when patients are triaged. There is a duty doctor for urgent issues on the day.

The practice offers a wide range of clinics, covering asthma, diabetes, stroke, cancer, epilepsy, heart disease, mental health care, long term condition management, contraception and sexual health, child development and immunisations, foreign travel advice and immunisation and ear, nose and throat. Minor surgery is performed, including skin lesions, in-grown toenails and cortisone injections, but not cosmetic surgery.

The team met a doctor who was particularly proud of the practice website and had recently updated it. The practice is on social media.

The practice is quite successful with annual health checks for people with Learning Disabilities. The practice uses a flag system to highlight patients with communication difficulties. A translator can be booked when the appointment is made.

As at most others, the practice charges for services such as private insurance certificates, medical reports, private immunisations etc.

A senior member of reception staff told the team that she enjoyed working at the practice but as with most front line staff found it stressful at times, although now that the triage system had been scaled back overall things were settling down again. Any issues are addressed promptly through the Practice Manager, whom she said was very approachable, as were all members of the practice. The practice is in the process of recruiting three more people to work within administration and reception.

Overall there was a passionate and enthusiastic atmosphere at the practice: everyone felt very supported and looked forward to the future with great optimism. The practice had taken on board the feedback from the PPG that triage appointments were not working and had scaled the system back to a capable size.

Recommendations

- The Disabled Parking bays should be more clearly marked
- The toilets should be more clearly sign posted
- That the reception/waiting arrangements be reviewed to ensure that patients do not need to queue unnecessarily
- That, in order to increase patient participation, arrangements be made to ensure that patients who do not wish to go online can be involved in PPG activity
- That the speed with which messages scroll on the electronic notice board and TV be adjusted to give patients more time to read the information

Central Park Practice, Harold Hill (Gooshays) Health Centre – visited 1 June

Central Park Surgery was established in 1978 with 200 hundred patients and six staff. Today the practice caters for nearly 8,000 patients and has 19 staff. The Surgery offers a wide range of services, including clinics, minor operations, travel vaccines and well-person check-ups. The practice is also a teaching practice for medical students in conjunction with University College, King's College and St Bartholomew's Hospital. The practice has GP's who specialise in certain areas including Diabetes, Dermatology and Rheumatology. Central Park is one of four practices in the Centre building, sharing a main reception area but otherwise segregated. The practice is spread on two floors with easy lift access to the first floor.

There is a pharmacy adjacent to the Centre, to which many of the patients go. It was not possible on this occasion to extend the visit to the pharmacy but a visit will be carried out there in due course.

The Centre is a modern, purpose-built building, which opened in 2006. There are bus stops outside, so it has good public transport links, and plenty of parking including six disabled bays. The premises are easily accessed with large sliding electronic doors. At the back of the building parking clearly designated for ambulances only. All four practices' receptions are situated in rows by the entrance.

The opening times were not displayed at the entrance to the practice.

The décor inside is clean and some walls are brightly coloured, seats are plentiful and comfortable (apart from one set of chairs which looked as if they had been vandalised). There were ample toilets in reception including two for disabled people.

There appeared to be plenty of room for notice boards and NELFT had two large, very informative notice boards. There were two leaflet stands (but both were empty) and there was a large NHS stand with leaflets about A&E departments.

There was a large sign for the PPG which is online only, so would exclude a large section of the local population.

There did not appear, however to be any information about the Hub or NHS 111.

The reception area for the Central Park's reception area was clearly signposted. There was an electronic check in system for patients, who could also check in with the receptionists. The reception had a low desk with a clear glass screen and was very private. A bottle of hand sanitiser was available.

Opening hours are 8am–6.30pm Monday to Friday, except Wednesday afternoon when the practice closes at 1pm. The GPs are available 8.20am-11am and 16.20pm-18.20pm.

Above the reception area was a large rolling electronic information screen, which informed patients when their doctor was available to see them. There was also information on how to call in to book an appointment. Online booking was advertised on the electronic moving notice. A survey was advertised but the member of staff the team approached about it was unaware of how long the consultation would take and when the results would be published; in fact, the survey had finished and results had been published on the website. Reference to this survey was subsequently removed from the electronic board.

There is a hearing loop at reception, but there was no evidence of one in any of the consulting rooms that were seen in the course of the visit.

There was a small notice board for Central Park. The Hub was mentioned on the notice board.

Patients can book an interpreter; this has to be done 48 hrs in advance.

Doctors and receptionists have panic buttons for internal use.

The website is updated when needed, by the practice manager.

The team was told that the Surgery has six GPs; the number on duty at the practice varies from day to day. On the day of the visit (a Wednesday), there were 3 GPs on duty. The practice has two Practice

Nurses, who advise on long term conditions including asthma and diabetes. There are no health care assistants.

There is a bank of nine receptionists with four on duty at any one time. The receptionists work a 20-hour week. As the main reception area is quite small, two people at a time can work there, so the other two receptionists work upstairs.

There are two telephone lines into the practice one for regular appointments and one for emergencies, but it is arguable that more are needed for a practice serving some 8,000 patients.

Patients who urgently need to speak to a doctor but do not need to be seen can access a telephone consultation.

Urgent appointments are possible, though not necessarily with the doctor of choice. Patients can be seen on the same day, if they provide details that enable a doctor to give them priority. Doctors clear everybody on their list each day. Patients can call at the Centre without appointment if they are prepared to wait for a consultation slot and some appointments are available in the evening before 6pm.

For regular appointments, the doctors expect to see patients within 48 to 72 hours of request; for a nurse the wait is generally 24 to 48 hours. Online booking is available to registered patients for either service.

The doctors see 16 patients in the morning and 12 in the afternoon sessions.

The clinics are all downstairs. Minor operations are performed at the practice, including mole and skin lesion removal, ear suctions, and ingrown toe nails. A wart clinic is held every six weeks.

The team was told that file storage accommodation is at capacity but that, despite applying to NHS England and the landlords for more room, the practice had been unable to obtain more space, even though there are empty rooms upstairs.

For test results, patients are asked to book an appointment. Repeat prescription turnaround is 48 hours, unless in an emergency.

All training for reception and admin staff is completed on line, recent training had included safeguarding and fire safety. Staff are not expected to complete training in their own time. The doctors attend a Protected Training Initiative once a month, on a Tuesday afternoon and the practice closes. Practice meetings are held every six weeks.

Addresses and confirmation of DOB are asked for when picking up prescriptions or letters.

Patients with long term conditions get annual reviews.

When asked whether there was a clear policy on supporting carers, the receptionist was not sure but the Practice Manager later advised that there was a clear policy on how to support carers.

The team was told that the practice had 187 failed appointments as patients "Did Not Attend" (DNAs) in May, for the GP's and 70 for the nurses. Patients that persistently fail to attend appointments are sent a letter after 3 DNA'S in three months.

The Practice has leaflets available for patients for additional services available for their conditions as well. Doctors are kept informed of different services so they can discuss patients' specific needs.

New Patients receive a leaflet welcoming them to the practice.

All annual health checks for LD patients have been completed this year. Patients over the age of 75 are allocated a dedicated GP and have an annual check-up with a nurse or GP, although they can still see any doctor of their choice.

Complaints are dealt with by the Practice Manager; most complaints are associated with the telephone waiting times. All complaints are acknowledged within three days and attended to within ten working days. All complaints are then looked into by the practice manager and then discussed with all the doctors in a weekly meeting. When the practice manager is absent another member of staff will deal with these issues.

The member of staff who was spoken to by the team said she enjoyed working at the practice, and was impressed with the doctors'

commitment and was sure this was why the rest of the team were so committed. She was confident that patients seeking an appointment would be seen within two days.

The Central Park Surgery is well informed and gives plenty of information about the practice. This is ideal for patients online.

Recommendations

Healthwatch recognises that the Practice shares accommodation with several other practices based in the Health Centre, and that all of the practices are "tenants" of the building, which is in the centralised ownership of the NHS. Nonetheless, the following recommendations are made in order to improve the experience of patients attending, or contacting, the practices based there. This report is being provided to the Havering CCG, NHS Properties and the other practices based at the Health Centre so that, collectively, they may consider and act on them together with the Central Park Practice:

- There should be open hours' information at the Centre entrance, giving full details for all of the practices that operate there.
- The team was told that most complaints related to the telephone system; apparently, there are only two lines into the practice, one for appointments and one for emergencies, which means that patients can be waiting up to 40 minutes to be answered. A wait of that length is clearly unacceptable and causes frustration and anger for patients and can lead to unnecessary confrontation with staff. The practice should investigate improvement to its telephone system.
- Staff have to go upstairs to use the photocopier. Ideally a photocopier/printer should be installed downstairs. There were loose wires under the desk. A member of staff had broken her toe tripping over these. These wires should be dealt with professionally.

- The reception area was stiflingly hot even though the temperature outside was only 12º; in the height of summer it could become unbearably hot. The provision of a portable air conditioner for patients' comfort should be considered.
- Consideration needs to be given to ensuring that the electronic notice board is kept up to date.
- More information needs to be provided on Hub and NHS 111 on notice boards
- The Practice leaflet should mention and explain the Hub and NHS 111.
- More practice leaflets should be available to patients.
- A hand sanitiser should be provided at the entrance, with a notice to accompany it

GP Hub at North Street Surgery – visited 23 July

The team arrived for this visit at 12 noon, intending to sit, observe and talk to patients, hoping that at 1pm they would be able to talk to a member of staff. It subsequently became apparent that the receptionist was the only member of staff present, other than the three doctors available to see patients. One of the doctors was leaving at 2pm to be replaced by another. The Hub operates at the premises from 6.30pm-10pm weekdays, from 12pm-5pm on Saturdays and 12pm-4pm on Sundays (the call centre opening to take appointments at 2pm on weekdays and 9am at weekends).

The practice was generally clean and tidy with a very relaxed atmosphere, although some of the seating was damaged or in need of cleaning. The electronic notices etc were switched off, but the air conditioning was on.

The internal and external conditions of the building were fine and acceptable. Parking was good and wheelchair access was excellent.

There was no separate signage for the Hub, but in fact none appeared to be needed.

The receptionist was very welcoming. She told the team that she works at the Hub on Saturdays and at the Havering Health Call Centre in Ashton Gardens, Chadwell Heath on other days. She had been working at the Hub for six months.

Privacy at reception is difficult, but patients can ask to speak to staff in private if necessary. There is no online booking, as appointments are only available by calling the call centre. A hearing loop is installed, and there are toilet facilities; hand cleansing gel is available.

The team's immediate perception on arrival was how efficiently the system was working; and the receptionist reinforced that view, saying that it was best "to keep it simple", as it was working very well. She also offered the view that more Hubs should be opened eventually, as the call centre receives thousands of calls covering all Hub sites in Havering, Barking & Dagenham and Redbridge.

As stated no Hub signage was seen, but posters were displayed about the host practice's service and others.

Some patients were called by a doctor to be seen, while another doctor got the receptionist to call them. The interaction between patients and reception was extremely good. Information about the Hub and 111 systems was clearly displayed.

The patients seen by the doctors had all made same day appointments. Talking to patients they were all being seen within five minutes of their allotted time.

Comments from patients were extremely good, all were very pleased with the service they were getting, although some said that they had experienced problems in getting through on the phone to book their appointment. The team was told by patients that doctors had on-screen access to their medical notes in order to check their history, which they welcomed. Everybody leaving the Hub said their experience was excellent. We also viewed patient surveys that had been filled in: all

were deemed excellent. The receptionist would contact her supervisor at Chadwell Heath about any complaints that arose.

She confirmed that her training was regularly updated. She told the team that the system at the Hub was kept simple and was working very efficiently.

It was noted that the Rosewood Hub Centre was not operational on the day of the visit and patients were being sent from there to North Street. The receptionist did not know why Rosewood was closed.

Patients were asked how they had found out about the Hub and all replied that they had read leaflets in their own GP practice.

The team found the experience of the visit encouraging and supportive of the development of more Hubs in the Borough.

APPENDIX 2

Survey of patients by Healthwatch Havering, March 2016 [7]

In March 2016, Healthwatch Havering and the Healthwatch organisations for Barking & Dagenham and Redbridge were commissioned jointly by the Barking & Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups (CCGs) to carry out a survey of patients' views around urgent and emergency care services. This was part of broader work by the CCGs to find out how best to improve urgent and emergency care in the three BHR boroughs, not least to relieve the immense pressure on the Accident and Emergency (A&E) services provided at the two principal hospitals in the BHR area, Queen's Hospital, Romford and King George Hospital, Goodmayes.

The survey sought to ascertain where patients would seek medical care in urgent or emergency circumstances, and their views on the alternative sources of care and advice to the GP or A&E services. Respondents in the three boroughs were all asked the same questions; the responses varied by borough, although the views of people in Barking & Dagenham and in Redbridge tended to be closer to each other than those of Havering people. Analysis suggests that the reason for this is that the population of Havering is more settled than those of the other two boroughs and less ethnically and age- diverse, with Havering people more familiar with their local services than those of the neighbouring boroughs.

In Havering, 306 people were surveyed, in a variety of settings, including GP practices, workshops and focus groups, with participants of varying ages and backgrounds, both knowledgeable about the National Health Service and those with less knowledge. The sample is believed overall to have been reasonably representative of the population as a whole.

[7] **Note** - the data referred to in this Appendix is derived from responses to the survey now reported. The permission of the BHR CCGs to use the data in this context is gratefully acknowledged.

The survey data seems to indicate that people in Havering are disinclined to use NHS services with which they are unfamiliar – the responses to question 1 show clearly that most respondents are likely to seek urgent or emergency care from their GP, the A&E service or by calling 999 for the ambulance service. Most respondents had made more visits to their GP in the past six months than to any other source of care, with their pharmacy being second most visited and A&E/Walk-in centre joint third (question 2).

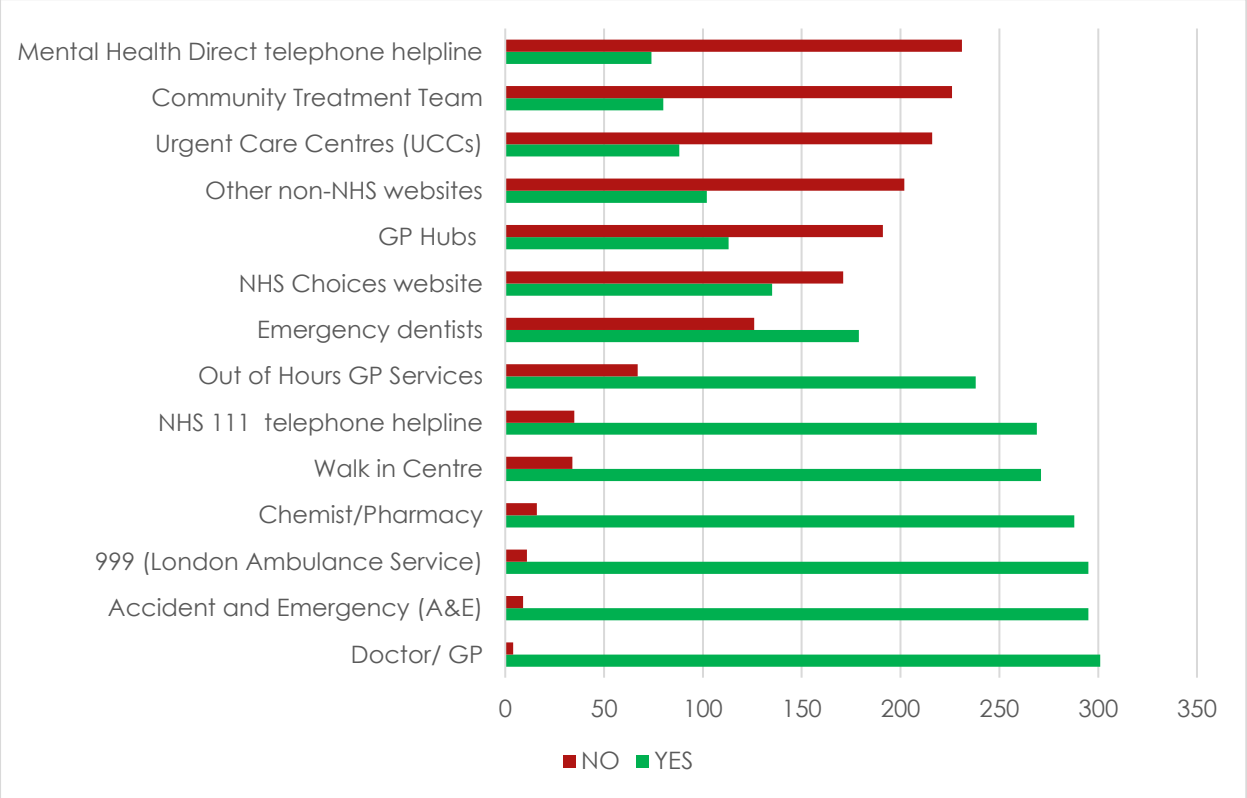
Asked whether they had sought advice before seeking the service(s) they had used, the responses to question 3 indicated that by far the majority had not – they had gone to where they thought they would best received the service they felt they needed.

Question 4 indicates that, of those who had been to A&E, most had gone there urgently or by ambulance, while a significant number had been referred there.

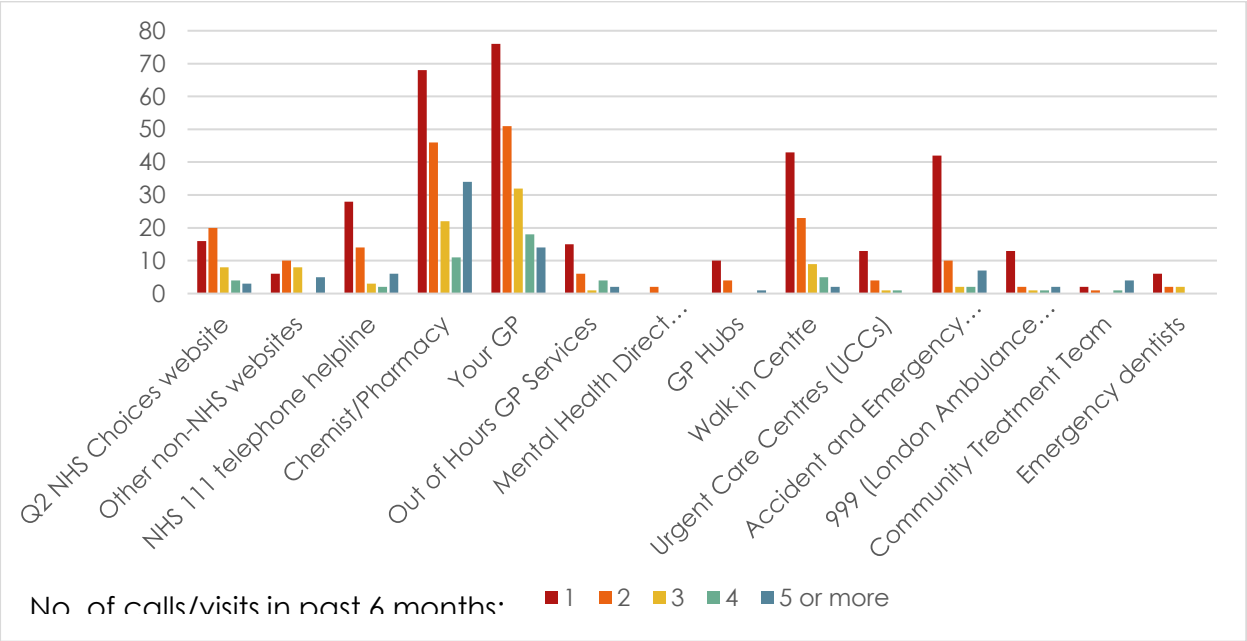
Using online or telephone services is becoming increasingly favoured across government. Many services are only available online. Question 5 suggests, however, that there is a significant proportion of the populace that would prefer not to use online services. This is reinforced by the response to question 7, in which a significant number said they preferred to deal with someone face to face. That said, of those prepared to use online services, most thought that their availability all day, every day, was the main advantage.

This appendix does not set out the survey results in full, but outlines the responses by Havering interviewees to some of the questions.

1 Question: Have you heard of the following services where you can get help with treatment, or advice for urgent and emergency care?

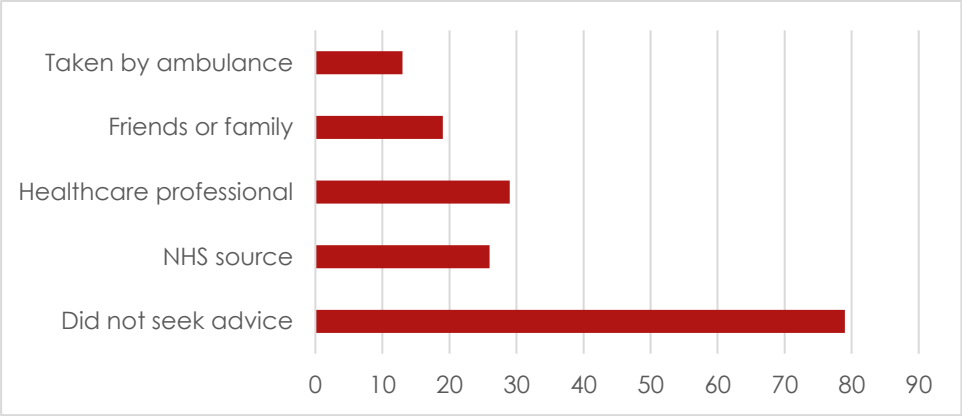


2 Question: How often have you or your household used the following health services for urgent or emergency care the last 6 months?



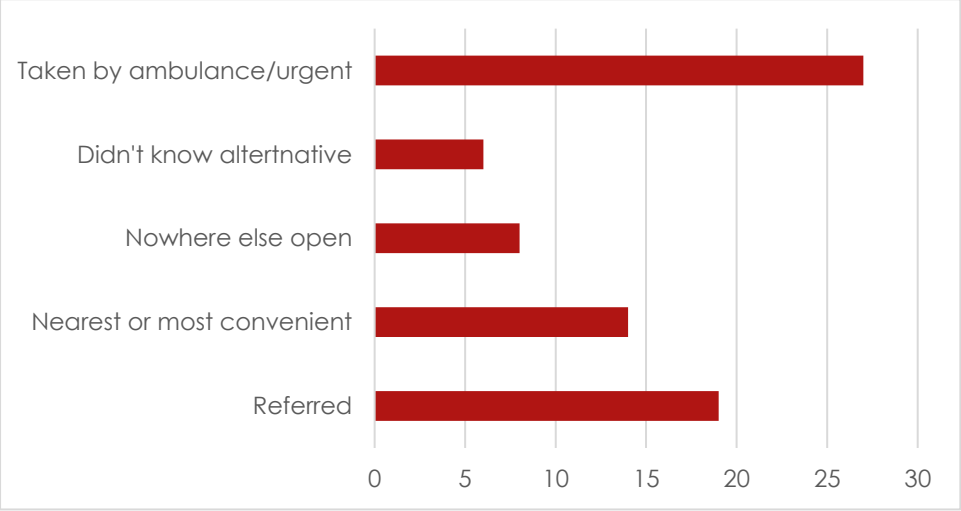
3 Question: Thinking about your last visit to A&E/UCC/Walk in/Hub: did you seek any advice on the best place to go for care and treatment before you went?

1 Yes - from an NHS information source such as 111/ NHS choices
2 Yes – from a healthcare professional such as a doctor, chemist
3 Yes - from a non-NHS source e.g. other website/friends/family
4 No – I did not seek advice
5 No - I was taken to A&E by ambulance

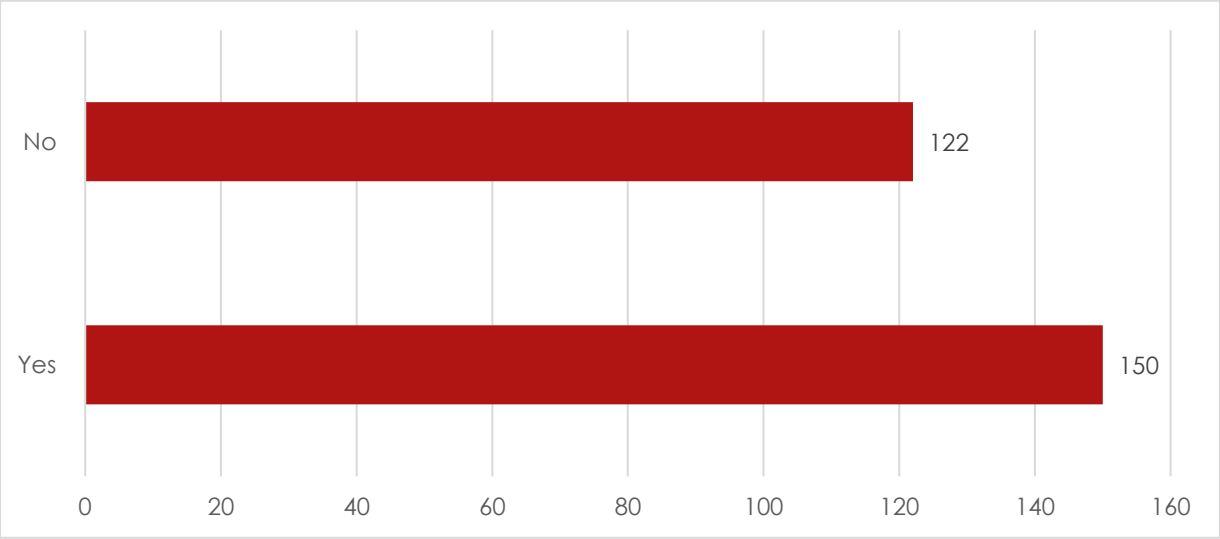


4 Question: Thinking about your last visit to A&E. What was your main reason for going to A&E?

1 Referred by someone
2 Nearest/most convenient place
3 Nowhere else known to be open
4 Didn't know of any alternatives
5 Urgent injury/condition or taken by ambulance

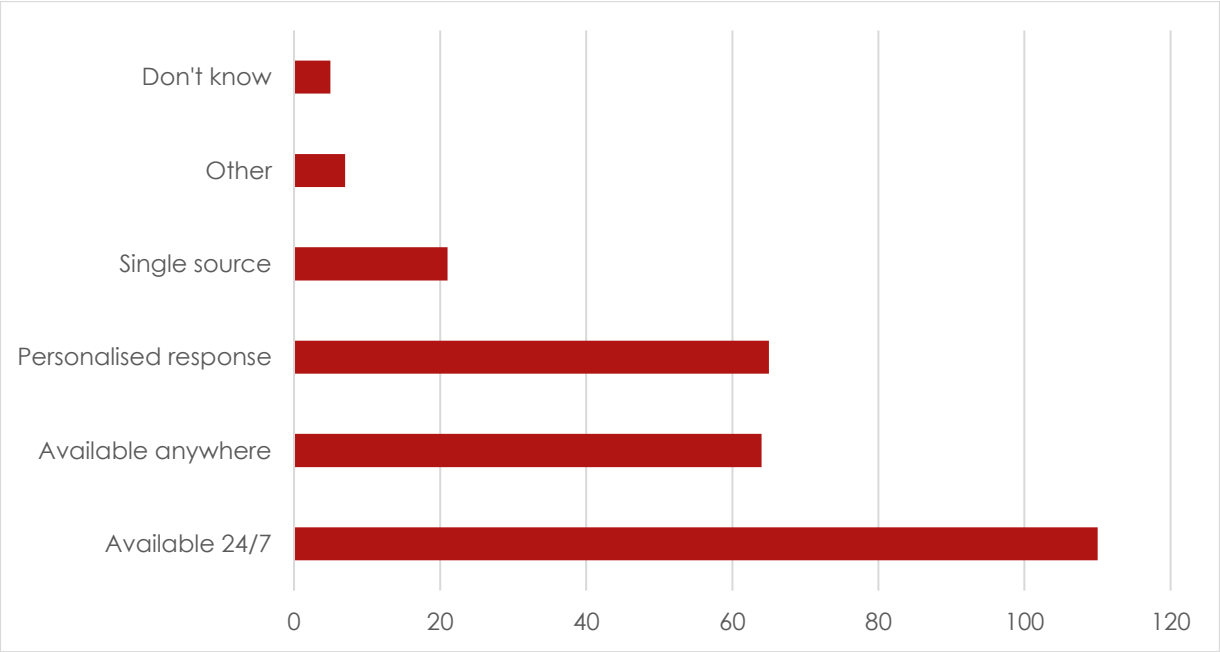


5 Question: If the local NHS had a website or app which held all your health information, where you could get advice, chat with a doctor or nurse if necessary or book yourself into appointments with your GP or a clinic, do you think you would you use it?



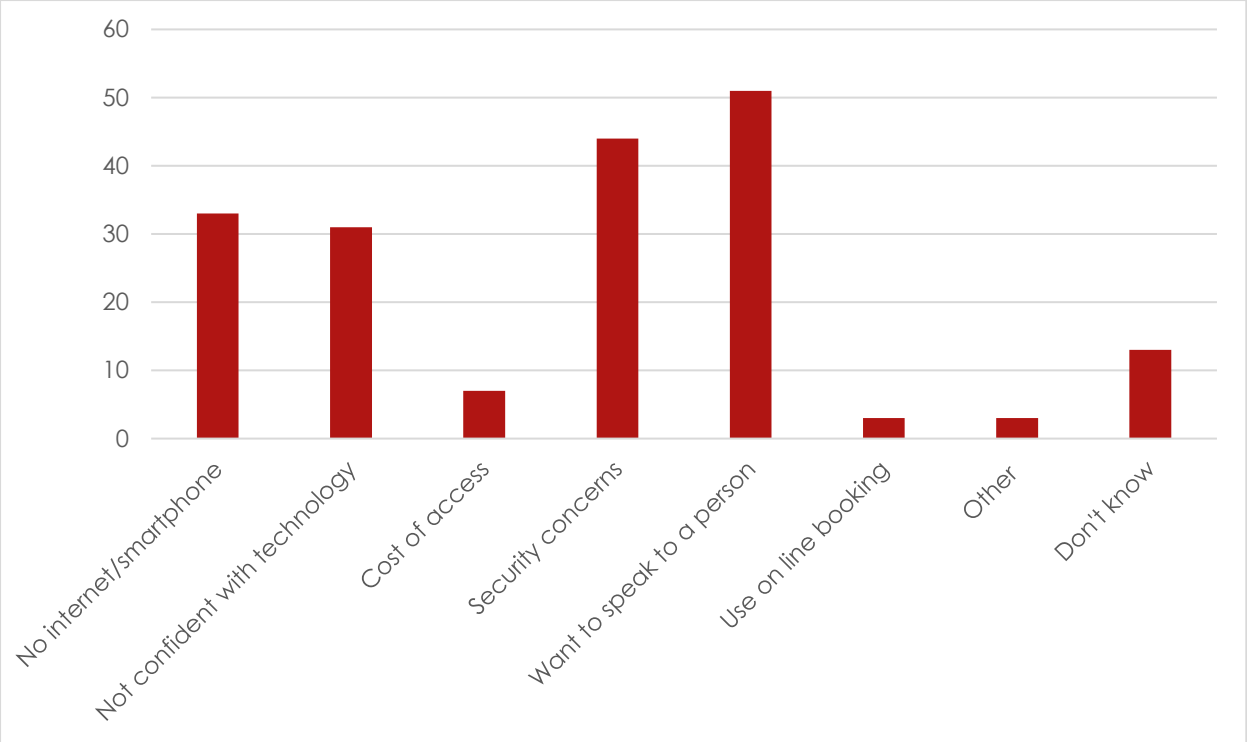
6 Question: What do you think would be the main advantages of such site/app?

1. Available all the time/ outside of working hours (24/7)
2. Can be accessed anywhere
3. Personalised/responses based on my health records
4. Single source of information
5. Other
6. Don't know



7 Question: Can you explain why you would be unlikely to use such a website or mobile phone app?

1. Do not have internet access/computer/ smartphone
2. Do not feel confident with technology/ would not know how to use
3. Data charges/cost to access
4. Concern about security of personal data/ health records
5. Would prefer to speak to someone in person
6. Use existing online GP booking systems
7. Other
8. Don't know



APPENDIX 3

Attendances at the Accident & Emergency Department (A&E) at Queen's Hospital, 2015/16 [8]

1. How many patients attended A&E? –

232,382

2. Of those, how many were actually treated in A&E?

*221,319**

**We have interpreted this question as patients with a recorded outcome. i.e. excluding those who took their own discharge before being seen or patients who arrived deceased (as we only pronounce the death and transfer to the mortuary)*

3. Of those not treated in A&E, how many were referred to the Urgent Care Centre or GP centre "next door"?

41,812

4. Of those who were treated, how many were admitted (overall, no need for breakdown by specialism)?

55,303

5. How many patients were brought in by ambulance? If possible, can you distinguish between those brought in by the LAS and those by other ambulance services (not essential, but useful if you have it)?

LAS Ambulances;	*62,372*
Non-LAS Ambulances;	*3008*
TOTAL:	***65,380***

[8] Source – Barking, Havering and Redbridge University Hospitals Trust: response to Freedom of Information Request, August 2016

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Registered Office:
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Telephone: 01708 303300

Email: enquiries@healthwatchhavering.co.uk

Website: www.healthwatchhavering.co.uk

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Enter & View

Berwick Surgery

17 Berwick Road, Rainham, RM13 9QU

18 November 2016

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Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident, patient or other service-user is not compromised in any way.

The Surgery

The surgery is located in a converted chalet bungalow, with the patient areas on the ground floor and a store room upstairs. The building is clean and tidy but appears to require refurbishment throughout.

The patients' areas comprise a waiting room (which on the day of the visit appeared adequate for the number of patients there), two consulting rooms

(one without natural light) that appeared somewhat cramped, toilets and the reception, which was is bright and had an entrance to the garden.

There are no parking facilities on site and restricted parking in the street.

The building appeared poorly accessible for disabled patients, especially wheelchair users; there was a short ramp and a narrow door that was just about accessible. Only one of the consulting rooms is wheelchair accessible.

The Practice Manager's office was very narrow and has inadequate lighting.

A pram store was provided.

A large blood pressure monitor was located in the waiting area but seemed out of place there, with no privacy, although the team was advised that a screen was on order.

No hand sanitiser gel appeared to be available for patients' use.

The Staff

There were three GPs (Doctors Adur, Kakati and Banarjee), the Practice Manager, a Practice Nurse, a Healthcare Assistant and six staff in the Reception/Admin/Secretarial team.

Mandatory training, including health and safety, fire and infection control had been completed by all staff and all were due to take on-line safeguarding training in the near future.

All staff interviewed were positive about working at the surgery, and they seemed happy working together. The main consensus was that the increase in the number of patients over the years had left the surgery building too small to provide the service now expected.

The patient experience

Two GPs were available for each session, with three emergency appointments in each session but otherwise by appointment. The

surgery was open 8am-12noon and 1pm- 6.30pm, Monday to Friday. There were no weekend sessions but telephone consultations were available. The waiting time for appointments was 4-5 days but if a specific doctor was requested, the wait could be for up to 10 days. A television in the waiting area advertised the GP hubs and walk in centres, and reception staff also advised patients of these facilities. A hearing loop was available in the reception and consulting rooms.

Reception was fairly large, with a small area for patients wanting to speak in confidence. No notice boards were visible, as they had been removed to enable the installation of the TV, but assurance was given that the notice boards would be put back. All reception staff were friendly, and knew a lot of patients by name.

The waiting room was clean and tidy, and patients were called to see the GP by use of an electronic screen.

Repeat prescriptions were arranged using an electronic system, that the team was told works well. Test results were received daily and forwarded to the GP who marks up what Is to be done; those considered urgent were acted upon immediately.

The Practice Manager and the GPs speak a number of languages between them, which reduced the need for interpreters. This has resulted in language line being used once.

The surgery has received very few complaints, all of which were dealt with in house.

Views of patients and the Patient Participation Group (PPG)

There was a very active PPG, three members of which met the team. All three were very positive about the surgery, were aware of no complaints about appointments, felt listened to, and told the team that treatments were explained. They also expressed the view, however, that the building was inadequate.

One patient spoken to in the waiting room told the team that waiting times to see a doctor were often lengthy; she had waited for 50 minutes. When asked if she felt involved in discussions on her care, happy with treatment she received or listened to, she replied that that depended on which doctor was seen.

Conclusions

There appears to be no question that the surgery building is inadequate for its use as a surgery, and may have been for some years. That said, the GPs and staff appear to be making every effort to make it work, but there appears to be no capacity to take on further patients.

The staff are all doing well in difficult circumstances, and are friendly and helpful to all the patients. The patients from the Patient Participation Group expressed frustration that they have been trying to get improved premises for a long time.

Recommendation

It is unusual for Healthwatch to comment on the adequacy of premises used for a surgery; but in this case, it is clear that staff and patients, though happy with the service provided, consider the premises to be inadequate and that they have been so for some time.

Healthwatch's concern is for the patients. It is wrong that patients should be treated in inadequate premises, whatever the reason and regardless of the cost of putting those premises right.

Accordingly, it is recommended that the practice work with the Havering Clinical Commissioning Group to explore what options may be available either to fund improvements to the premises or perhaps to locate and acquire more suitable premises in the vicinity as a replacement.

Healthwatch stands ready to support this process if need be.

The team would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

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Enter & View

The Greenwood Practice

89 Gubbins Lane, Harold Wood

RM3 0DR

7 November 2016

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Background and purpose of the visit:

Healthwatch Havering (HH) is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

The Healthwatch team were met by the Practice Manager who advised that she had worked at the practice, which is provided over two sites (the second being in Ardleigh Green Road), for some 28 years.

The premises

The Gubbins Lane surgery is provided in two converted houses on a very busy road, with only 4 designated parking bays (maximum waiting time 3 hours) – one of which is designated for disabled drivers. There is no parking on Gubbins Lane although it is possible to park in the side street (The Drive) other than during a restricted period, between 10.30am and 11.30am.

The external building appeared to be in good condition. The surgery opening times were displayed at the front door but there was no signposting to the disabled/wheelchair access at the side of the building. This access is via a ramp through a rather narrow door but there is a bell inviting patients to ring if they need assistance in entering, when a member of staff will attend. There appeared to be little or no accommodation for pushchairs etc. There was also a notice displaying details of the GP Hub out-of-hours services and the walk-in Centre at Harold Wood.

The waiting room displayed posters on a wide variety of conditions and available services. There was also a poster indicating that the CQC would be visiting the surgery on Thursday 10 November and there were comment cards and a box on the reception counter.

There did not appear to be any signage towards the reception area but this was obvious once inside the building. Patients reported to reception and were then called to see the doctor/nurse from one of two waiting rooms. The doctors/nurses buzzed reception to indicate when the next patient should be called in and the receptionist called out the patient's name, directing them as necessary. We found that the reception staff were very discreet although there appeared to be little privacy overall in the reception area, which was very wide. The team were advised that there was a panic button installed in the reception office but it was sited at one end of a fairly long reception desk.

There is an on-line booking service for doctors' appointments but not for nurses' appointments.

Internally, the surgery was clean and comfortable, other than three chairs which needed to be removed and replaced/re-covered. The medical records were stored in a number of purpose-made filing cabinets but had overflowed into cabinet top boxes, although they looked neat and tidy. Because the surgery is provided in two converted houses, the pre-existing design presents particular problems.

The nurses' treatment room was well-equipped and well organised. Some minor surgery procedures such as lump removal and joint injections are performed here.

The team did note that there was little space in which to accommodate children away from the mainstream of patients waiting to be seen. Potentially infectious patients are requested to sit in the small clinic room available.

The practice

The opening hours are 9am-11am Monday to Friday, 5pm-6.30pm Monday and Friday and 4pm-5.30pm Tuesday and Wednesday; there are limited weekend surgeries on alternate Saturdays for booked appointments. These times reflect the availability of booked appointments: it is, however, normal practice for all patients to be able to attend and be seen the same day at the end of the booked sessions. The morning nurses' clinics are provided on a walk-in basis but evening appointments are bookable and it may be up to two weeks' wait for a booked appointment.

There are 6 doctors providing cover over the two sites: 3 full time partners, 1 full time salaried GP and 2 part-time salaried GPs. Additionally, there are 2 Practice Nurses on each site. There are 6 part-time reception staff who, between them, cover annual leave and sickness.

The practice website is updated every month or so.

When patients are referred for tests, they are asked to ring for results at a time appropriate for the tests to be processed. GPs/nurses review results as they come back and an action box is completed daily. Where action is required, every effort is made to contact the patient by telephone but if this fails, a letter is sent out. Non-response from 3 letters instigates a further phone call and, if the patient is unable to attend the surgery, a visit to the patient's home.

The only service charges made are for Hepatitis B injections. Details of this are displayed within the waiting room.

According to the website, requests for repeat prescriptions are dealt with within 48 hours but the team was advised that all prescription requests received by 11.30am were written up on the same day. The practice has electronic links with several local pharmacies.

Additional support is provided, by nurses, to patients with long-term conditions. Regular warfarin tests are carried out in patients' homes if necessary and nurses promote additional/ancillary services such Alcoholics Anonymous, drug rehabilitation etc. Regret was noted about the withdrawal of the Weight Watchers free service.

There did not appear to be any annual reviews of patients over 70 and there was no doctor allocated specifically for older patients, but patients with long-term conditions were monitored and tests were carried where these were indicated.

The team noted that the Patient Participation Group (PPG) is managed online, which is less than satisfactory; direct, personal contact with PPG members through meetings is preferable.

Staff training appeared to be carried out on an ad hoc basis and most had undertaken Life Support training, Fire training and Safeguarding. Doctors and Nurses were trained to a higher level in courses appropriate to their duties.

It was noted that the practice did not make use of telephone triaging of appointment requests. This is something that, after a period of consultation with patients and preparation, might usefully be introduced.

Patients' views

During the visit, the team talked to a few patients, whose views about the practice were mixed. Some felt that it was "brilliant" but others – possibly those who would be going to work after their consultation – felt that the wait for an immediate consultation was unacceptably long. There were comments about the length of wait for nurses' booked appointments.

Recommendations

The team recommend that:

- Consideration be given to managing the PPG by direct contact and meetings rather than simply online.
- All soft furnishings be examined for damage and repaired or replaced as required.
- The arrangements for storing medical records be reviewed to provide a more user-friendly, logical way of storage.
- A notice indicating the location of the wheelchair access be fitted to the main surgery sign.
- Consideration be given to providing some early morning appointments specifically for patients who must proceed to work.
- Consideration be given to consulting patients on the possibility of providing some telephone triage/consultations to help reduce the high attendance at the surgery.

The team would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

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Website: www.healthwatchhavering.co.uk

Enter & View
Rosewood Medical Centre

March 2016

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

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Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

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What is an Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP Medical Centres, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

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Background and purpose of the visit:

Healthwatch Havering (HH) is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

In January 2016, a number of patients of the Rosewood Medical Centre contacted their local Councillors to express concerns about what they considered to be poor service from the Medical Centre. Those concerns came to the attention of the Chairman of Havering Council's Health Overview & Scrutiny Sub-Committee, who then sought assistance from Healthwatch Havering and the Havering Clinical Commissioning Group. In a survey of patients' views carried out by the Care Quality Commission in November 2014, nearly 70% of the Medical Centre's patients at the time had

expressed themselves at least satisfied with its services, so the expressions of concerns made to the Councillors indicated that there might be issues that required to be addressed.

After consultation, therefore, it was agreed that the most appropriate way forward at that stage would be for Healthwatch to carry out an Enter & View visit to the Medical Centre in order to assess how patients, staff and partners in the Medical Centre felt about the service at the Medical Centre.

The Medical Centre was accordingly contacted and advised that Healthwatch would like to undertake a visit at short notice because of the concerns expressed by patients. The Medical Centre was aware of the concerns and was keen to co-operate and support the visit. In preparation for the visit the Medical Centre was asked to display posters advising patients that they had the opportunity to share any aspects of the care provided at the Medical Centre with Healthwatch on the day of the visit.

The visit

On arrival at the Medical Centre, the Healthwatch posters were clearly visible in the entrance area. The overall ambience of the entrance and waiting area was clean, tidy and welcoming. It was noted that the opening times displayed in the Medical Centre did not correspond with the information provided on NHS Choices website, which indicated the availability of a much more comprehensive set of clinic times.

Overall, the visiting team considered that there was a lack of patient information, ranging from clinical conditions, help and advice services and how to make the best use of the services available in the Medical Centre. An example of this was that the Medical Centre offers patients a facility to book on-line for appointments, a service particularly aimed at the working patient, but the team was told that this service was rarely used.

Two members of Healthwatch team interviewed the Practice Manager and (at their request) the Medical Centre Partners while the third member of the team interviewed patients in the waiting room – a summary of the comments made by those patients is set out in the Appendix to this report. It was

noticeable that, of those interviewed, 70 % had not heard of the Hub system for out-of-hours GP appointments, 20% had heard of the Hub but had not used it as appointments were too late for children and 10% had heard of the Hub but did not realise that one of the Hub bases was at the Medical Centre. The triage system was mentioned negatively by a significant number of those interviewed as well as by those whose expressions of concern had triggered the visit now reported.

Management of the Medical Centre

The team was informed that, during the past year a significant number of important changes had occurred within the Medical Centre:

1) A change of employees in the Practice Manager and the Business Manager roles
2) Bold steps had been taken to improve the waiting time for appointments, which on occasions had previously been over three weeks.
3) There had been little opportunity for a robust handover of the detail associated with both the Practice Manager and the Business Manager roles
4) The new Practice Manager had joined the Medical Centre as the changes to the appointment systems were being implemented
5) Senior clinical staff had been long-term absent through ill-health
6) During this time the Medical Centre also became the site chosen to provide the accommodation for the second GP Hub.

The appointment system

The Medical Centre Partners were aware that the waiting times for an appointment were excessive and had sought the advice of the CCG and other national bodies as to the best way to address this. They were keen to introduce new ideas and new ways of improving the service.

They had learned that, across the country, many GP practices were using telephone triage as a way of providing patients with an opportunity to speak to a GP without the necessity of attending the practice premises, and at the same time enabling the GP to make decisions with the patient on the most appropriate care e.g. a further appointment, prescription to be collected etc. The aim was that only the patients who had a clinical need for a face to face discussion with a GP would be offered an appointment. This system has been shown to reduce the length of time patients wait for an appointment and could also provide a faster and simpler service for some conditions.

The Partners decided to trial the triage system, accepting that they would have to adjust it as they got feedback from patients and staff. At that stage, they had not appreciated the enormity of the culture change for patients and staff and, although there were staff training sessions and information was provided to patients, it had soon become clear that the preparation had not been sufficiently comprehensive.

According to the feedback provided by patients, this lack of understanding about the new triage system appeared to have led to a lack of confidence in the administration of the appointment systems, concerns that the Medical Centre was not sufficiently supportive to patients and carers using the new system and a feeling that complaints raised with the Medical Centre were being ignored. The team were also told that patients had started to leave the Medical Centre, citing a lack of confidence in how the Medical Centre worked and supported its patients and their carers.

An early problem the Medical Centre had encountered was that there were insufficient telephone lines to enable the triage system to work effectively. This had resulted in patients having to wait a long time to get through to the Medical Centre in order to book a call with the GP. However, for patients there was a further increased concern when they waited at home, often for much longer than had been the promised time, for the return call from the GP. Some patients, in their anxiety that they were not going to receive a call, had then resorted to coming into the Medical Centre to try and book an appointment; other patients had stated that they chose to go to the Walk-in

Centre at Harold Wood instead. The Medical Centre had now increased the number of telephone lines to 20.

When it launched the triage system, the Medical Centre had also kept a half hour slot at the beginning of the day (8 – 8.30am) for re-bookable appointments. However, there appears to have been some confusion within the Medical Centre's administration on the eligibility of patients for this time slot and those patients being asked to use the triage system. In addition, Saturday morning had been identified as a non-urgent pre-bookable service but it was not clear what type of health conditions could be booked into this service.

Responding to patient feedback

The Medical Centre would be launching a new timetable of services based on the feedback and expressions of concern from patients, who wanted in particular to be able to book a face-to-face appointment with a GP without first having to go through a telephone consultation. The aim therefore was to increase the availability of per-bookable face-to-face appointments and to reduce the telephone consultations; although a comprehensive timetable, it would also be a complex mix of time slots, pre-bookable, face-to-face and telephone triage, which could prove a challenge to administer.

If not administered effectively by supporting patients to receive the best possible opportunity to access GP advice, then it is possible that patients would continue to leave the Medical Centre. The team was also told by patients that they were now booking appointments directly with the out-of-hours Hub service which is co-located on the site, where a face to face consultation would be available.

The GP Hub

There had been some concern and speculation by patients that the arrival of the GP Hub at the Rosewood Medical Centre had in some way had a

detrimental effect on the Medical Centre proper, such as taking up GPs' and reception staff time.

The team learned, however, that the GP Hub was a completely separate Primary Care service that did not rely on any staff within the Rosewood Medical Centre. The only support provided to the GP Hub by the Medical Centre related to the provision of the premises and of clinical supplies.

Although many patients had expressed concern that the Hub activities were affecting the Medical Centre, the team could find no evidence for that. Healthwatch Havering intends to review the operation of the Hub system in May 2016 and the allegation that the practices at which the Hubs are based are being affected will be more closely examined at that time.

Conclusions and recommendations

The team's view is that a combination of factors has brought about the high levels of patients' concerns. It is clear that the cultural and systems changes within the Medical Centre and their potential impact were not sufficiently recognised or planned for prior to implementing the triage system, and that this had adversely impacted upon both the delivery of services and the Medical Centre's reputation.

It was also clear from the discussions with the Partners and the Practice Manager that they now understood the concerns of their patients and were very keen to design an improved system which provided the patients with confidence and a range of access opportunities to GPs.

The following recommendations are aimed at supporting the patients and the staff in the Medical Centre to improve its service model.

1) Develop a service which is easy for patients to navigate

The better informed the patients, the better they will make the best use of the service available to them. The vast majority of patients do not want to waste their time or that of the Medical Centre, so helping by providing

straight-forward, clear and simple information in an accessible format for all patients will facilitate the reduction of time-wasting and unnecessary cost.

Accordingly, the Medical Centre will benefit from devising and supplying clear, simply explained information leaflets about

- Opening times and what services are available during this time
- The days and times when the GPs are running clinics
- The triage system times and what the triage system aims to achieve
- What constitutes a “bookable appointment”
- What constitutes a “non-urgent appointment”
- Improved repeat prescription times (aiming for a maximum turnaround of to 48 hours) and a robust on-line repeat prescribing request system
- How to use the on-line booking system

In addition, it is essential to update the Medical Centre website to provide current, consistent and, above all, accurate information.

2) Invest in front line staff to improve the service

The Medical Centre needs to develop a programme of regular staff meetings to provide a forum for collaborative and open dialogue enabling the Medical Centre to achieve a patient-centred approach to delivering care.

A comprehensive training programme, embracing all aspects of the Medical Centre’s services and which ensures that all members of staff are able to provide consistent and supportive advice to patients and carers, should be designed and implemented.

In addition, there is need to ensure the staff are knowledgeable about other services available to support patients, sufficiently so that they can provide details and times for services such as NHS 111 and the GP Hub when the Medical Centre is not able to provide an appointment.

All recorded verbal and written complaints from patients should be reviewed and responded to as quickly as possible.

The need to reduce the turn round time for repeat prescriptions: the local chemist has reported that the advertised turnaround time is sometimes exceeded and is at variance with information given on the Medical Centre website, which itself is in urgent need of updating.

For patients who require blood tests, details of the locations at which that is available should be provided when a blood test request is issued, and a poster displayed in the waiting areas.

3) Patient engagement

GP practices are a very important part of people's communities so the Medical Centre should now consider ways in which it could widen its engagement to get new voices heard.

The following recommendation is referred to the Havering Clinical Commissioning Group (CCG)

The patients' expressions of concern that gave rise to the visit now reported were primarily the result of inadequate preparation for the implementation of the triage system. It has become clear that a particular issue was a failure to explain the principles or operational requirements of the system to both staff and patients, leaving staff in particular with difficulty understanding what was required of them and how to explain it to patients.

But these difficulties revealed a further issue. Reception and administrative staff in GP practices have traditionally been treated as employees of independent, small enterprises whose training is a matter for the GPs as their employers.

The evidence of a recent survey commissioned by the CCG and carried out by the local Healthwatches in Barking & Dagenham, Havering and Redbridge[1] is that many people are unaware of the alternative services to GPs and hospital A&E departments. GP staff need to be able with confidence to refer

[1] Urgent Care Services Survey, BHR CCGs, March 2016

patients to alternative sources of medical support when appointments at their practice are unavailable immediately; the evidence suggests that many staff lack the confidence or knowledge to do that authoritatively.

As more and more functions are shared across the health economy, however, GP practice staff are likely to find themselves having to respond to patients' questions across a range of health activities of which they have scant knowledge. It is vital that patients across the whole of the local health economy get similar, if not the same, access to authoritative and consistent advice about GP services from practices' staff; this can only be achieved by ensuring that all of those staff members, administrative and clinical, are trained to the same – high – standard and receive regular and accurate updates. In this way, it is likely that patients will have greater confidence in, and understanding of the limitations of, GP services and be more likely to await an appointment than refer themselves inappropriately to alternatives such as A&E services. Healthwatch Havering believes that the CCG is best placed to arrange this centrally, either by providing suitable training itself or by commissioning an appropriate training provider to do so.

Healthwatch Havering, therefore, recommends that the CCG consider what might be done to provide all GP practice staff with training and up-to-date information in general issues relating to the health economy.

While this may be costly in the first instance, in the longer term it should result in a more effective use of resources by avoiding unnecessary expenditure resulting from patients failing to understand where best they can obtain services, not least by reducing (if not eliminating) unnecessary attendance at hospital A&E departments.

The team would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit in March 2016 and is representative only of those patients, carers and staff who participated. It does not seek to be representative of all service users and/or staff.

Appendix

Patient interviews

Note: to preserve patient confidentiality, as much identifying information as possible has been redacted from these summaries.

Patient 1

Patient had walked into the Medical Centre and made an appointment approximately three weeks ago, and had to wait two weeks for results of blood tests. Patient saw available GP as the Diabetic GP had left the Medical Centre. Patient had been able to see a female GP without too much of a wait.

Patient said reception staff have a mixed attitude but, because of hearing problems making telephone use difficult, always makes an appointment in person; most staff are very accommodating to this problem. It depended on which GP the patient sees as to whether they felt they were being listened to regarding their symptoms.

When asked if they felt they were able to ask questions to the GP, patient replied they felt under pressure of time especially if something complicated and they don't really think enough time is given with the GP.

Patient said they had never felt they needed to make a complaint.

Patient 2

Patient phoned Medical Centre and GP called back 25 minutes later, got an appointment the same day; when calling, the phone was answered promptly; they were third in line when calling. Patient was not offered a choice of GP but was grateful to get the appointment on the same day.

Patient said reception staff are mostly friendly and helpful. Patient thought the GP listened to their symptoms and they were given plenty of time usually with the GP, they felt able to ask questions and had never felt the need to complain.

Historically the patient had had an accident – attended the walk-in centre. Then made two appointments at the Medical Centre in person, one for an injection and one to have the dressing changed one week after the first appointment with no problems.

Patient 3

Patient phoned Medical Centre, did not have to wait too long to be answered and the GP called back approximately one hour later. GP made an appointment for the same day. Patient was happy to see any GP available and saw a regular GP at the Medical Centre. Patient said some staff were really helpful, and one member of staff in particular would

go out of her way to help. Patient felt sometimes the GP became a bit 'cross' when they ask "too many" questions. They felt at ease asking questions at the reception, but thought it a bit more difficult to ask GPs questions. They also felt there was not always enough time spent with the GP. The patient had complained at the Medical Centre and felt they had been dealt with 'averagely' by the Medical Centre

Patient 4

Patient had made an appointment at 8.30am as had to go to work, walked out at 9am. This had been approximately 8 months ago.

Patient 5

Patient was a parent who had arrived at the Medical Centre for an 8.30am appointment, having taken time off work and children off school, to be told appointment had been cancelled. Parent had not received a phone call or message on answer machine referring to cancellation. The GP, who had made the appointment with the parent himself, was at a Nursing home carrying out routine checks. Parent said this was unacceptable and asked reception to ask another GP to see child, but the other GP refused. Whilst the parent was at the Medical Centre another two patients arrived for 'cancelled' appointments. Patient's appointment was re-booked for the following week, making a three-week gap instead of two. Child has an ongoing ENT problem; parent has been asking to be referred to a specialist for approximately a year, to no avail, and is now having to a seek private medical advice.

Patient 6

Patient was a parent, who had phoned the Medical Centre at 8.30am waiting for returned triage call, called at 11.30am because anxious about child. As it was a Thursday and the Medical Centre closes in the afternoon, parent was told to call the out of hours' number (Hub) and was offered a 10.30pm appointment, which they considered far too late in the evening for a pre-teenage child. Patient took child to see a relative who had some medical background.

Patient 7

Child was put on a nebuliser and left unattended by GP.

Patient 8

Patient was a parent who works at a special needs school, and uses a child minder who has had shingles, suspected child of infant school age had chicken pox, phoned the Medical Centre at 8.30am and waited for triage call. Worried the parent called the Medical Centre again and the receptionist had the wrong number. The GP never called back, the parent called the Medical Centre again and the GP said they had been trying to call the parent,

but the patient had no missed calls. There were no appointments left and by now the child had a high temperature. Parent phoned the Hub and was offered an appointment at 9.45pm. They refused this appointment and made one at the Medical Centre for the next day to confirm the child had chicken pox.

Patient 9

Patient was a parent had been advised by Public Health England to attend the Medical Centre on the day of the visit as son had a serious infection. Patient was advised by PHE that they would ring the Medical Centre to tell the GP the patient would be attending. Patient phoned the Medical Centre to be told there were no appointments and the receptionist very unhelpful. The patient (who is a senior health care professional (HCP) working in a GP practice elsewhere) insisted that an appointment be made available as per PHE's instructions. They felt the message had not been passed on by the receptionists to the GP. The parent really felt that if they had not been so insistent they would not have got an appointment.

Patient felt the staff's attitude was OK, and they were welcoming and friendly at times. She felt that it depended on which GP you saw as to whether you were listened to regarding symptoms. As a senior HCP, they felt they could not use the triage system as 'you have to see a patient to evaluate properly'.

Patient 10

Patient called Medical Centre, waited for two hours to be called back, were prescribed medication which they thought was unsatisfactory.

Patient 11

Patient waited on phone for 45 minutes, then gave up. Patient had just wanted to talk to the nurse, who said she would call back after consulting the GP. Patient waited for call but it never came, which is why they called the Medical Centre. Patient decided to go to the Medical Centre to talk to the nurse. Receptionist told patient that the nurse does not call patients. Patient asked for an appointment to see nurse but was told it was a four-week wait, but the patient could wait until after Medical Centre closed to see the nurse. Patient waited from 10.45am to 12.30pm to see nurse for a two-minute consultation.

Patient 12

Patient had an appointment at 10am, checked in with receptionist as automated check-in not working. GP was due to finish his triage phone calls at 10.30am. Other patients arrived, one patient that had arrived after original patient saw the GP before, but as they had a scan booked at hospital, original patient did not mind. Other patients seemed to be 'queue

jumping' so patient complained only to be told GP was trying to call her at home because they were on the triage list.

Patient 13

Patient who had been at the Medical Centre 38 years, had recently been diagnosed with Parkinson's disease. Patient's carer asked GP for any guidance, support or signposting. Carer was told there was no support in Havering. After searching, the carer found support locally, they told the clinic what had happened and the clinic said that they were 'fed up' with the Medical Centre as they were continually sending information to the Medical Centre for referrals. The patient and carer left the Medical Centre after 38 years.

Patient 14

Patient is a teacher so unable to be triaged, because cannot wait at home to receive a phone call. Reception have given patient early face to face appointments. Patient had to wait three weeks, but was happy with this as they got an early morning appointment with GP of their choice.

Patient 15

Patient received a message on phone from the Medical Centre requesting they make an appointment at the Medical Centre. Patient phoned the Medical Centre to ask who the message was for and receptionist did not know. Patient asked which GP the message mentioned and receptionist did not know. Becoming concerned, the Patient asked to speak to the Practice Manager, but was told the Practice Manager "does not talk to patients". The Patient had recently had a diagnostic procedure at a hospital, but had been given the 'all clear'. Becoming increasingly distressed, the patient went to the Medical Centre to try and find out who the message was for. The Practice Manager still refused to talk to her. All this could have been avoided if the receptionist who made the phone call had said who it was for and for which GP.

Conclusions

In the time available, it was practicable only to interview a very small sample of patients, so it is not possible to draw the specific conclusions that a larger sampling would permit. The random nature of the sample seen, however, enables some inferences to be drawn on which comment is possible.

Most patients appear to have been relatively happy with the service provided by the Medical Centre, though there are clear reservations about how the triage system operates, which cannot simply be dismissed as "teething troubles" or lack of familiarity with it. It is telling that one patient, who is a GP in another practice, had professional reservations

about triaging this way. There appears also to have been a lack of good administration, with several patients reporting what amount to unnecessary confusion on the part of both GPs and staff – for example, a GP was attempting telephone triage while the patient was actually in the waiting room, and in another case an already, understandably-anxious patient was caused unnecessary additional anxiety when no one was able to explain to her why she had been called to make an appointment to see a GP.

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**; or email
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Telephone: 01708 303300

Email: enquiries@healthwatchhavering.co.uk

Website: www.healthwatchhavering.co.uk

Enter & View

Straight Road Doctors Surgery
(Dr Gupta and Dr Prasad)

137 Straight Road, Harold Hill

RM3 7JJ

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Background and purpose of the visit:

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The premises

The Surgery is in a house that has been converted, with the ground floor providing the reception area, waiting room, toilet and clinical rooms, and the upper floor offices and mini-kitchen. The premises appeared to need redecoration and the carpeting appeared to require replacement. There is a ramp into the building and restricted parking is available.

The reception area is in a small room, housing three staff, adjoining the waiting room, with little or no privacy available for patients who wish to discuss confidential matters. The **waiting room is also** small, with notices advertising support groups and how to access them. Information about the GP out-of-hours Hubs and Walk in Centres is advertised on the main entrance door, and the Healthwatch team noted that staff also inform patients about the Hubs and Walk-in centres if no appointments are available. A loop system for the hard of hearing is being arranged.

The Doctor buzzes when available to see a patient, who is then called to see the Doctor by the receptionist.

The premises adjoin another GP practice, the Ingrebourne Medical Centre, at 135 Straight Road (which Healthwatch has yet to visit). There is some co-operation between the two practices.

The Staff and services

The staff of the practice comprise 2 part-time GPs (Dr Gupta (lead) and Dr Prasad) but the practice works as single-handed. In addition, there are:

3 Nurses (2 prescribing), all part time;

2 Practice Managers (both part time);

1 Business Manager (also part time)

The reception staff are all very friendly, and seemed to know a lot of patients by name

The practice provides medical cover for two nearby care homes: Romford Care Home and Farringdon Lodge Nursing Home.

All staff are signed up for website training and have undergone mandatory training in Fire/CPR/Safeguarding and Health and Safety.

Minor surgery is carried out, including cauterisation, steroid injections and wart removals. There is a list of priorities for long-term condition patients including preferential treatment and telephone consultations. Test results are checked by GP and patients are contacted by phone or letter if necessary.

The patient experience

Surgery opening times are 8.30am-6.30pm and it remains open until 8pm one day per week. Patients are asked to phone at 8am for morning appointments and 4pm for the evening session. 10 emergency appointments are available per day, 5 morning and 5 evening, and there is capacity for some walk-in patients to be seen on the day if necessary. According to a patient in the waiting room with whom the team spoke, the phone is answered within 2-3 rings. There is usually 2 weeks' wait for an appointment.

Repeat prescriptions are dealt with in 24 hours and an on-line service is available.

The practice is developing a patient Participation Group (PPG) but in the meantime a suggestion box is available for patients who wish to make comments. The team was told that the very few complaints received at the Surgery are dealt with in-house, immediately and discussed at practice meetings; only one or two patients complain to NHS England per annum.

The Healthwatch team's observations

The building in which the Surgery is located does not have the capacity to offer patients a full range of services and is in need of refurbishment, which staff and patients recognise. The CCG is understood also to be aware of this. Despite that, the staff are all very helpful and friendly and appear to

"go the extra mile" for the patients; for example, they deliver letters to the patients' homes by hand and offer them help in crossing Straight Road, which is a very busy highway, when required.

There is, however, virtually no parking for patients and the adjacent side road is a bus route, which reduces its usefulness for on-street parking. The premises are too small to provide space for prams and pushchairs inside the surgery, and the ramp for wheelchair users is rather steep – consideration could usefully be given to installing a bell so that patients who find it difficult to negotiate the ramp on their own can call for assistance.

Recommendation

This is a small practice, operating from premises that are too small to offer the range of services that patients expect of GPs. Bearing in mind that there is another, similar practice (which Healthwatch have yet to visit) with which there is already some co-operation, patients might well benefit from closer joint working of the two practices or even their formal merger.

The team would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

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We are looking for:

Members

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Interested? Want to know more?

Call us on **01708 303 300**; or email
enquiries@healthwatchhavering.co.uk

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

Registered Office:
Queen's Court, 9-17 Eastern Road, Romford RM1 3NH
Telephone: 01708 303300

Email: enquiries@healthwatchhavering.co.uk

Website: www.healthwatchhavering.co.uk

Enter & View

High Street Surgery (Hornchurch)

219 High Street, Hornchurch, RM11 3XT

14 November 2016

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A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident, patient or other service-user is not compromised in any way.

The Practice

The practice is in a converted house; previously, there had been two houses but it is now reduced in size to one as the other house has been sold back into residential use.

The condition of the building is good and it appears to be well maintained. There is good signage and easy access, including disabled. The practice is

situated on a bus route which is convenient for patients. There is parking space for only one car, and on-street parking is difficult owing to parking restrictions in surrounding streets. Public parking facilities are available, however, both nearby adjoining the St Andrew's Church and a little further away (but within walking distance for most patients) in Hornchurch Town Centre, and there may be opportunities to negotiate with the owners of private parking facilities nearby.

There is one full time doctor (Dr. Pervez) plus a locum when necessary. The practice is open from 8.30am to 6.30pm, with one practice nurse available Monday and Wednesday from 8.30am until 2pm. There are no additional healthcare assistants. There is clear guidance on how to contact the practice for appointments.

There are currently approximately 3,000 patients on the practice's list. The team was told that no need was seen for further expansion of patients as the current workload was manageable and there are other practices nearby.

The team was met by the Practice Manager and a colleague, who were happy to spend time discussing the practice. The discussion took place in a small room adjoining the reception area, which was well presented, clean and welcoming. The two receptionists appeared very friendly and welcoming to the patients. A pool of four receptionists is available, most of whom have been with the practice for a long time. There is a hearing loop in the reception area, but not in the doctor's surgery.

There were many posters and items of information on the walls of the waiting room, local emergency contacts such as the GP Hub and NHS 111, and other organisations; the poster notifying the visit was also on display.

The team was told that the Patient Participation Group (PPG) met quarterly, and was active and efficient.

The practice aims to deal with patient complaints within two weeks of receipt. A complaint form is available, but at the time of the visit was not clearly visible and the team suggested that it be moved to a more prominent position. Complaints are dealt with by the practice manager by letter, but

staff have details of who to contact if the complainant was not satisfied by the response.

In response to enquiry relating to communication with people who have hearing difficulties, the team was advised that in moist cases a deaf person would have a companion to assist but, where the surgery know in advance that there was a requirement for an unaccompanied patient, a signer would be provided.

Patients are called to their appointments electronically, but on occasions the doctor prefers to go the waiting room and call patients himself.

The practice does not routinely inform patients of the outcome of tests as they are expected to telephone the surgery but, where the result indicates a need for treatment or further testing, the doctor will contact the patient.

Children or elderly patients who do not have an appointment can be seen - on a first come, first served basis - but may have to await a free appointment slot or until the end of surgery hours.

Additional services are provided, such as stitch removal and immunisations.

Staff

The staff were all very happy with the working conditions; most had worked at the practice for a considerable time and thought their working conditions were good.

All staff have regular training, depending on their role. The last training session was fire training three weeks before the visit. Practice meetings were held 3 or 4 times a year, but as the practice is quite small, the staff felt that they could discuss any problems as and when they arise.

Patients

The team spoke to several patients, all of whom were very positive in their opinions of the practice. They said that they felt comfortable with the booking of appointments, that their phone queries were always answered

quickly, that they were happy with their treatment, by both the doctor and nurse; they were normally seen within a short time of their appointment (15 minutes at most), and were always involved in the discussion of their conditions and treatment.

At the end of the visit, the team met Dr Pervez, who was keen to show them his surgery, which appeared welcoming and clean. There was a view of the well-tended garden, which made the room welcoming for concerned patients. Dr. Pervez demonstrated how information was stored on his computer screen and was proud of the service his practice provides.

Recommendation

The team felt that, generally, the practice appeared caring and focussed on its patients. The only recommendation was that further thought be given to finding better parking facilities for those patients who attend by car. As noted earlier in the report, there are privately-owned facilities nearby that might be able to be used; although public parking is available, it is at a distance some patients might find difficult.

The team would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

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