Public Document Pack

City of Westminster

# Committee Agenda

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| Title: | **Adults and Public Health Policy and Scrutiny Committee** |
| Meeting Date: | **Wednesday 28th April, 2021** |
| Time: | **7.00 pm** |
| Venue: | **This will be a virtual meeting** |
| Members: | **Councillors:**<br><br>Iain Bott (Chairman)<br>Margot Bright<br>Ruth Bush<br>Nafsika Butler-Thalassis<br>Maggie Carman<br>Angela Harvey<br>Eoghain Murphy<br>Selina Short |

**Members of the public and press are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda**

**Link to live meeting**

**This meeting will be live streamed and recorded. To access the recording after the meeting, please revisit the link.**

**If you require any further information, please contact the Committee Officer, Artemis Kassi, Senior Committee and Governance Officer.**

**Email: akassi@westminster.gov.uk**
**Corporate Website:** www.westminster.gov.uk

**Note for Members:** Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Head of Committee and Governance Services in advance of the meeting please.

# AGENDA

## PART 1 (IN PUBLIC)

**1. MEMBERSHIP**

To note any changes to the membership.

**2. DECLARATIONS OF INTEREST**

To receive declarations by Members and Officers of the existence and nature of any pecuniary interests or any other significant interest in matters on this agenda.

**3. MINUTES** **(Pages 5 - 10)**

To approve the minutes of the meeting held on 17th February 2021.

**4. CABINET MEMBER FOR ADULT SOCIAL CARE AND PUBLIC HEALTH - PORTFOLIO UPDATE REPORT** **(Pages 11 - 14)**

Councillor Tim Mitchell, the Cabinet Member for Adult Social Care and Public Health, to provide an update to the Committee on current and forthcoming issues in this portfolio and to answer questions from Members.

**5. HEALTHWATCH REPORT** **(Pages 15 - 28)**

To receive a report from Healthwatch, including primary care and the patient's voice.

**6. UPDATE ON THE GORDON HOSPITAL** **(Pages 29 - 32)**

To receive an update on the Gordon Hospital.

**7. UPDATE FROM NHS NORTH WEST LONDON INTEGRATED CARE SYSTEM** **(Pages 33 - 36)**

To receive an update report from the NHS North West London Integrated Care System on elective surgery.

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| **8.** | **UPDATE ON COVID IMPACTS**<br><br>To receive an update on the impacts of Covid in Westminster. | **(Pages 37 - 40)** |
| **9.** | **WORK PROGRAMME**<br><br>To review the work programme for this committee for the remainder of the municipal year. | **(Pages 41 - 44)** |

**Stuart Love**
**Chief Executive**
**19 April 2021**

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CITY OF WESTMINSTER

# MINUTES

**Adults and Public Health Policy & Scrutiny Committee**

**MINUTES OF PROCEEDINGS**

Minutes of a virtual meeting of the **Adults and Public Health Policy & Scrutiny Committee** held on **Wednesday 17 February 2021.**

**Members Present**: Councillors Iain Bott (Chairman), Ruth Bush, Nafsika Butler-Thalassis, Maggie Carman, Angela Harvey, Eoghain Murphy and Selina Short

**Also Present:** Councillor Tim Mitchell (Cabinet Member for Adult Social Care and Public Health)

## 1. MEMBERSHIP

1.1 Nominations for the post of Chairman were invited. One nomination was received and seconded. There were no further nominations.

**RESOLVED:**

That Councillor Iain Bott be appointed Chairman of the Adults and Public Health Policy and Scrutiny Committee.

1.2 Apologies for absence were received from Councillor Margot Bright.

## 2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

## 3. CABINET MEMBER FOR ADULT SOCIAL CARE AND PUBLIC HEALTH – UPDATE

3.1 Councillor Tim Mitchell (Cabinet Member for Adult Social Care and Public Health), provided a briefing on key issues within his portfolio. The Committee also heard from Jeff Lake (Deputy Director of Public Health).

3.2 Councillor Mitchell advised that case rates of Covid-19 had been falling steadily in Westminster since early mid-January following wider restrictions introduced earlier in the month. Based on cases from the previous week, WCC had the sixth lowest rate of infection in London at 331.4 per 100,000 population (which was down by 29% from the previous week). Further information was also provided on the rollout of vaccinations and testing including the vaccinations programme for care homes.

3.2 The Committee received the update and held detailed discussions on the following topics:

- Outbreak Management – In response to questions over how outbreaks of Covid-19 were managed within Westminster the Committee was provided with details on the roll out of local testing sites, and roll out of targeted asymptomatic testing, which had supported an increase in local testing rates. Members were pleased to note that that there was three local testing sites, using PCR laboratory tests for those with symptoms, and mobile testing facilities at Hyde Park. Asymptomatic testing was also available at three other sites within Westminster. For those who were asymptomatic, the focus had been on testing key workers and others who had to leave their home during lockdown. Testing had also been targeted at settings with vulnerable residents, including the homeless and those with supported care.

- Communications and Resident Engagement – The Committee was updated on the Covid-19 communications undertaken to date to ensure residents, businesses and stakeholders were aware of how to stay safe and prevent the spread of the virus. There had been a recent focus on promoting the stay at home message, symptomatic and asymptomatic testing, and encouraging residents to feel confident in taking up the vaccine when they were offered it. The Council was aware of anti-vaccination messaging around the Covid-19 vaccine circulating within communities. Communications and Community Engagement Teams were currently sourcing and producing localised content, with trusted sources sharing factual information about the vaccine and what it meant to them to receive the vaccine. Members were interested to note that the Council was producing its own localised communications to address local vaccination hesitancy in addition to working closely with the NHS to amplify national NHS campaigns.

- Vaccine Uptake - The roll out of Covid-19 vaccinations had commenced in late December with the programme being led by the NHS with support from the Local Authority. Currently, there was no published data available on vaccinations at a Local Authority level. However, regionally, 890,877 first doses and 59,155 second doses of the vaccination had been delivered in London (by 30th January 2021). In the North West London Health and Care Partnership CCG area, which covered Westminster, 158,032 doses had been administered up to the 24th January 2021. The Committee discussed vaccine hesitancy in areas with high deprivation and within BAME communities. Whilst precise data within

Westminster was not currently available for these communities' work was being undertaken on communicating factual information to these groups. Members discussed the importance of working in unison with faith groups, Ward Councillors and individuals who worked within these communities to tailor specific messages in order to break down barriers and help identify areas the NHS should target.

- Adult Social Care Budget – In response to a concern raised over the Adult Social Care budget Councillor Mitchell informed the Committee that the budget proposals had been discussed at the Budget Task Group and Cabinet and were due to go before Council for approval shortly. It was explained that any changes to the Adult Social Care budget were about ensuring the efficient use of resources. As any changes would have a minimal impact on service delivery there was not a requirement to undertake a public consultation exercise.

3.3 The Committee also discussed the development of a mental health task group, transporting residents to vaccination centres and staff working within the care home sector. Finally, the Chair expressed the Committee's thanks to the Cabinet Member and all those staff who were providing valuable assistance in helping respond to the challenges faced by the Covid-19 pandemic.

## 4 HEALTHWATCH REPORT: PEOPLES EXPEREINCES DURING THE COVID-19 PANDEMIC

4.1 Olivia Clymer (CEO, Healthwatch Central West London) presented a report detailing resident experiences of Covid-19 from March 2020 onwards. It was explained that a variety of methods and channels had been used to gather the insights set out within the report with an additional focus on young people and local BAME communities.

4.2 The following key findings from the report were highlighted and discussed by the Committee:

- Digital Exclusion – It was noted that participants often felt frustration that they felt excluded from access to treatment or engagement because of a lack of access to, or understanding of, new technology. Feelings of stress, isolation and uncertainty were frequently reported by participants when asked about their use of technology during this period. The Committee discussed the importance that provision for those who did not or couldn't use technology needed to remain a vital part of all health and social care services.

- Mental Health Concerns – The Committee was advised that nearly all of those people participating in the survey had confirmed that their mental health had been affected during the period of lockdown with many experiencing feelings of loneliness, anxiety, fear and panic. There was a

concern amongst participants that this period would have long-term effects for their mental health and their relationships with others. The Committee discussed the findings and suggested this was an important area which would require further scrutiny in the future.

- Stigma and Alternative Information – The Committee was informed about the stigma often attached to contracting Covid-19, including a social stigma of having family members who had died from Covid-19. It was also recognized that there was a prevalence of alternative information regarding the pandemic shared via social media. This information often suggested false, alternative treatments which had no scientific and empirical background.

4.3 The Committee discussed how the BAME community had been disproportionately affected by the pandemic and what work was being undertaken to address this. Transport was highlighted as a challenge in trying to ensure those residents unable to leave their homes could access vaccination centres. There was a concern over a lack of knowledge about Covid-19 and vaccines and it was explained that different options were being explored to ensure adequate information about services and support was distributed to those areas of the community identified. The importance of disseminating information to local faith groups or community leaders was highlighted to help assist and support those people requiring it. The importance of ensuring these areas of the community were supported was highlighted and noted by the Board.

4.4 Members raised the importance of Patient Participation Groups (PPGs) and the importance of ensuring they played an active role within the community, especially during the pandemic. It was essential that CCGs helped encourage and support PPGs and whilst it was recognised there were difficulties due to the current situation this was an opportunity to discuss local issues and improve the service provided. As part of progressing some of the findings from the report the Committee requested that the local CCGs be written to advising them of the importance of PPGs to ensure these groups remained active during the pandemic. It was also requested that the CCGs be asked to respond to the Committee on the findings contained within the Healthwatch report.

4.5 The Committee thanked Healthwatch for producing a very informative report which highlighted the challenges faced by local people in terms of their social wellbeing and mental health. The report's findings were noted and would greatly assist in the process of engaging and supporting local communities during the Covid-19 pandemic.

## 5 WORK PROGRAMME FOR 2020/21

5.1 Lizzie Barrett, Policy and Scrutiny Officer, presented the Committee's 2020/21 Work Programme.

5.2 The Committee reviewed the draft list of items and suggested the following potential future topics:

- Health inequalities amongst the BAME and disabled communities, including vaccine uptake;
- Obesity and metabolic disease in adults;
- Adult mental health and emotional wellbeing, including how services have adapted during the pandemic; and
- Social isolation and loneliness.

**RESOLVED:**

That the Work Programme be noted.

The Meeting ended at 8:18pm.

CHAIRMAN: _____ DATE: _____

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City of Westminster

# Adult's Social Services & Public Health Policy and Scrutiny Committee

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|---|---|
| **Date:** | **Wednesday 28 April 2021** |
| **Report Of:** | **Councillor Tim Mitchell** |
| **Portfolio:** | **Cabinet Member for Adult Social Care & Public Health** |
| **Report Author and Contact Details:** | **Alexandra Deolinda Severino** **adseverino@westminster.gov.uk** |

## 1 Summary

As per the new agreed Cabinet Member report structure, this update provides highlights on my City for All priorities, and current areas of focus in the Adult's Social Services & Public Health portfolio. Since the last Adult's Social Services & Public Health Policy and Scrutiny Committee, I have formally approved the following key decisions:

- Adoption of the Core Drugs and Alcohol Treatment Service Award

## 2 City for All – Adult's Social Services and Public Health Priorities

**Vibrant Communities**

**2.1** Addressing the Impacts of COVID-19 on Residents

This priority will address identified disparities by creating and developing healthy and sustainable places and communities, which will enable all residents to maximise their capabilities and have control over their lives. This work is currently being scoped. The spotlight will be both on health inequalities and a recovery plan.

**2.2** Providing Services That Enhance Emotional Wellbeing and Support Mental Health

This commitment is in the scoping phase and will require a corporate approach and agreement on focus and priorities. A task and finish group has been set up which also aims to identify gaps in the services and develop a business case for sustainable service development.

**2.3** Supporting People Living with Dementia

There are a number of initiatives underway such as the council facilitating Dementia Friends sessions and bespoke dementia training to the whole community. During COVID-19, internal council training was made available to the wider community.

**Smart City**

**2.4** Trial Smart City Assistive Technologies

Adult Social Care (ASC) has been working with PA Consulting to build on the existing digital offer within ASC to develop a roadmap that will enable WCC to be at the forefront of digital delivery in ASC. Two potential 'quick wins' that can be progressed, alongside the initiatives that are running or planned already, are the Automated Contact Services and Smart Speakers (e.g. Alexa). The approach is designed to expedite delivery whilst simultaneously building local capability to inform the design of a sustainable service model for scaling post pilot.

## 3 COVID-19 Update – Adult Social Care & Public Health

**3.1** Cases / Epidemiology

On March 29th the Stay at Home Order was lifted and national restrictions will slowly ease in England as per the guidance from the National Government. As of the 10th of April Westminster, recorded a 7-day rate of 28.3 cases per 100,000. Compared to 331.4 cases per 100,000 at the time of the last report in early February.

**3.2** Outbreak Management / Local Testing Strategy

Lateral Flow Tests (LFT) are still being made available to support targeted asymptomatic testing and there is still currently capacity at these sites. Local testing sites, using PCR laboratory tests for those with symptoms, are at Lydford Hall, Greenside Community Hall and Grosvenor Hall with mobile testing facilities at Hyde Park. Asymptomatic testing is available at Moberly Sports Centre, Little Venice Sports Centre and Westminster Cathedral.

**3.3** Supporting the CCG with the Rollout of Vaccinations

The roll out of COVID-19 vaccinations commenced in late December. The vaccination programme is being led by colleagues in the NHS with support from the Local Authority. Westminster has multiple vaccination centres: South Westminster, Lord's Cricket Ground, and Hospital Hubs. Since March 3rd two additional vaccination sites have opened at Marble Arch and Westminster Abbey. Residents in all care homes have been offered the vaccine via an initial round of visits from NHS teams. In Priority groups 1 to 9 (adults over 50 and at clinical risk) 51,185 of first doses have been administered as of April 20th, representing 65.05% of that population.

**3.4** Local Contact Tracing

This is supplementary to the national scheme which passes details of those who test positive but have not been contactable within 24 hours to the local authority for intervention. Local teams are phoning or visiting persons at home to encourage self-isolation of cases and of their contacts and offer support for those self-isolating, where this is required. NHS and local teams are now regularly achieving 80% of necessary contacts.

**3.5** Communications and Resident Engagement

Public Health and Communications colleagues continue to work closely in delivering the council's COVID-19 communications, ensuring residents, businesses and stakeholders are aware of how to stay safe with advice on how to prevent the spread of the virus available across our diverse communities. Recent focus has been on promoting the stay at home message, symptomatic and asymptomatic testing, and encouraging residents to feel confident in taking up the vaccine when they are offered it.

**3.6** Recovery Planning

National and regional research to date, including that published by Public Health England, has confirmed that COVID-19 has disproportionately impacted certain people and communities. Local data also suggests that a higher proportion of deaths from COVID-19 are among people from a BAME background.

## 4 Areas of Focus

**4.1** Changes in NHS

North West London (NWL) are moving to an Integrated Care System (ICS) commencing 1st April 2021. Local CLCCG dissolved on the 31st March 2021 and has been replaced by a Borough Committee. Changes in personnel and operating models are likely to cause some distraction during the early part of 2021/22, as the new models bed in. NWL Clinical Commission Group (CCG) reports that in Westminster there has to be a £10M budget reduction within the next 5 years. The Borough Committee will have to reduce spend to deliver the savings. The extent and impact are unknown.

## 5 Performance Updates

**5.1** New Permanent Admissions to Residential/Nursing Care of People Aged 65 Years and Over

Performance continues to remain on track. Our position at Q3 showed 46 admissions. COVID-19 has led to a significant reduction in the numbers of people being admitted to residential and nursing care.

**5.2** Service Users Receiving an Assessment or Review

65% of service users (i.e. anyone over the age of 18 who needs support from ASC in WCC) have received an assessment or review at Q3 compared to 43% at Q2. This target is performing well and is on track.

**5.3** Total Sexual Health Screens Undertaken Through E-Services

Performance continues to exceed targets at 11,529 at the Q2 position. From next quarter, we will be changing this indicator to focus on contraception (which has recently moved to online delivery).

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City of Westminster

# Adult Social Care & Public Health Policy and Scrutiny Committee

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| **Date:** | Wednesday 28th April 2021 |
| **Classification:** | General Release |
| **Title:** | **Residents' experiences of using primary care services – a report from Healthwatch Central West London April 2021** |
| **Report of:** | Healthwatch Westminster |
| **Cabinet Member Portfolio** | Portfolio (as listed at www.westminster.gov.uk/cabinet) |
| **Wards Involved:** | All |
| **Policy Context:** | |
| **Report Author and Contact Details:** | Olivia Clymer **Olivia.clymer@healthwatchcentralwestlondon.org** |

healthwatch Central West London

## Residents' experiences of using primary care services - a report from Healthwatch Central West London April 2021

### Healthwatch Central West London

Healthwatch Central West London (Healthwatch CWL) welcomes the opportunity to report to the Westminster Scrutiny Committee on what residents are telling us about their experiences of using primary care.

As a local Healthwatch our role is to ensure that local people are actively involved in shaping the health and care services that they use, and that they have a say

about the health and care services available to them. We also monitor local provision and hold commissioners and service providers to account for the quality of local publicly funded health and care services.

## 1. Introduction

**1.1**. This document outlines what Healthwatch (CWL) has been hearing from local people through our community engagement in Westminster and RBKC and is focused on primary care.

**1.2**. Since March 2020 we have been carrying out extensive community engagement, hearing from our residents about their experiences of information, support and services subsequent to the first wave of COVID-19. This was initially through a digital survey and more recently through focused discussion groups and a paper survey. As the first port of call for patients, GP practices and Primary Care has been crucial.

**1.3.** With the onset of the Covid 19 Pandemic the provision of Primary Care had to change fast and drastically. Usual ways of accessing services were suspended and new urgent changes were introduced.

**1.4.** The commitment and dedication of our health colleagues during these incredibly challenging times has been unquestionable and admirable. The GPs that we have spoken to often felt tired and overworked but have continued to put in long hours, including now running vaccination clinics during weekends. They have been dedicated to providing the best level of care possible to their patients in incredibly difficult times.

## 2. Overview

**2.1** This paper presents some of our key findings and observations on Primary Care based on what residents told us through our:

- Statutory Healthwatch work
- Your Experience Matters surveys
- Focused discussion groups
- Patient Participation Group discussion forums
- Wider community engagement activity
- Young Healthwatch engagement with young people
- GP Mystery Shopping
- Audit of GP websites

**2.2.** This report is set out in 5 sections:

- Patient Access to Primary Care
- Communication with Patients
- Patient Engagement
- Quality of care offered
- Recommendations

## 3. Patient Access to Primary Care

**3.1.** During the Coronavirus outbreak, GP practices had to change how they offer services to their patients. Since the start of the first COVID-19 lockdown, GP practices have been following official Government guidance to conduct their work remotely where possible, in order to stop the spread of the virus, and to protect the safety of Practice staff and patients who have needed a face-to-face consultation.

### 3.2. Telephone access

**3.2.1.** Early on, GP practices introduced a telephone triage system to screen patients' inquiries and to direct them to the right support. This created additional access difficulties for some patients, including long waiting times to get through to the reception staff by phone. Patients also told us that answer phone messages directed them to alternative sources of help, such as the GP surgery website or online consultations. Both of these experiences left them feeling that they should not be ringing the surgery.

**3.2.2.** Patients told us about their concerns about the costs of contacting their surgery. Long initial answer phone messages (often at least one minute long) followed by menu choices and then further waiting in a queue, meant that patients either needed the right phone contract, or to be to afford to top-up their Pay As You Go phones to be able to meet the cost of the call. They were also worried that video consultations could be more expensive.

**3.2.3.** Patients had concerns about confidentiality and in some cases were reluctant to discuss health matters with non-medical staff on the phone.

**3.2.4.** Some patients with conditions such as hearing or speech difficulties, those who have mental health conditions, arthritis or motor neuron disease had additional difficulties expressing themselves on the phone. This was also true for patients with poor English language skills trying to access their GP by phone or online. It is unclear whether interpreting services are offered for phone triage or telephone consultations.

**3.2.5.** Some patients also told us that they become anxious when waiting for GPs to call back. They are afraid that they will miss the call or that they have been forgotten when the GP does not ring at the allotted time. It was not always clear for patients when to expect the GP to ring; this was further complicated by the time slots for a call back from a GP not being as accurate as face-to-face appointments and unlike being in the surgery, patients are not able to check with the receptionist about how long the wait will be.

### 3.3. GP Mystery Shopper

**3.3.1.** During the first six month of COVID-19 restrictions and lockdown, patients reported that access to their GP became more difficult because of the long waiting

time to get through to the reception on the phone. We were aware that all GP Practices had to adapt to using telephone systems to triage patients and that not all GP Practice telephone systems were set up for that. During this time, some GP Practices installed new telephone systems to deal with the increased number of calls.

**3.3.2.** In response to patient feedback, in December 2020 Healthwatch CWL audited GP Practices by testing how easy it was to contact them by telephone, eight months into pandemic. We made calls to all GP practices in Central London CCG and West London CCG during the month of December 2020. Each Practice received 4 calls at or after 8.00am, 10.00am, 1.00pm and 3.00pm during that time period.

**3.3.3.** Patients reported to us that they had most difficulty contacting a GP at 8.00am, when they were trying to book an appointment. During our Mystery Shopping exercise, the two longest wait times for an 8.00am call for a West London CCG Practice GP were 15 mins, 42 secs and 9 mins, 30 secs. Both of these were outliers, with 25 of the 40 Practices in West London CCG answering within two minutes at this time. The other 14 Practices took between two and seven minutes to answer. Call wait times were similar at the other points that we made scheduled calls through the day.

**3.3.4.** Although we did not experience the length of wait times that patients had reported to us, we did find varying usefulness of answer-phone messages. In many examples, the answer-phone messages were long, with some being up to 3 minutes long, setting out detailed menu options that were hard to follow.

**3.3.5.** There were some instances where the message recording was quiet or muffled, making it hard to follow. The quality of information provided was variable. Some messages were clear and gave concise information about how to access GP services either by staying on the line or through alternative routes such as 111 or online.

**3.3.6.** There were three instances of the phone message informing us that the GP Practice was closed until 8.00am at times later than that. We were uncertain whether that was because no one was answering the phone at that point, or that the surgery had not set up an alternative answering message when the phone was busy. In either case, it leaves patients uncertain about what to do and having to keep trying.

**3.3.7.** In six cases, the choice of menu options was complex and hard to follow. Once a wrong choice had been made there was no return point, and the only option was to ring off and start again.

### 3.4. Online access

**3.4.1.** During the coronavirus outbreak most, if not all, GP Practices suspended their online booking access through SystemOne. Patients were redirected to telephone triage or online consultations such as e-consult, Dr IQ, or the NHS App.

**3.4.2.** Online triage and consultations are useful as simple signposting tools or for ordering repeat prescriptions and for addressing simple health conditions. They helped GP Practices to continue to see patients and to manage demand at a busy time. However, patients' feedback varies. Some patients found it useful and were able to get the help they needed; others tried using it and had to give it up.

**3.4.3.** Patients told us that if they had complex health concerns or their symptoms did not "fit the box", online triage and consultation becomes inaccurate and unusable. Patients told us that they do not find the design of online consultation tools user friendly; some said that they felt that it was a waste of time, others experienced inaccurate signposting. People with mental health conditions found it the most inappropriate and difficult to use.

**3.4.4.** Many patients told us that they managed to fill in and submit the online form, but that then they did not get the answer they needed or the correct diagnosis due to the limitations of the online form. Following that they had to speak to a GP anyway.

**3.4.5.** At a time when Primary Care services are changing it is important to have clear information for patients, that they can trust and that is clinically robust, so that they can get the health care they need, when they need it.

**3.4.6.** It is also important for monitoring quality and provision of Primary Care services and understanding whether patients have the same access to services as previously, despite being delivered differently. At the moment, it is unclear how numbers of patient consultations or appointments are accounted for by GP Practices. For example, if a patient has used the online consultation but not received the help they need and subsequently had to also speak to a GP, does that count as two consultations? Likewise, does ordering a repeat prescription through online consultation count as a consultation? If this is the case it could mask a reduction in access to GP services, whilst making it appear that numbers of GP consultations offered have remained the same or increased.

**3.4.7.** Another difficulty with online consultation tools is how they have been promoted to patients. This was especially noticeable during the summer and autumn 2020. Patients were encouraged to use online consultations through lengthy answer-phone messages, on GP websites using pop-up windows, and through text messages. For example, one GP Practice sent 20 text messages during the summer months asking patients to use the online consultation tool; no alternative was offered.

> *"Patients who had not signed up [for the app] were bombarded with text messages… I have counted more than 20 such messages urging me to download [the app]*
>
> *Dear [X]- Our doors may need to close in the next few days due to critical staffing levels. If you need to contact the practice Mon-Fri 8am-6.30pm, please download [the app] This is the fastest way to contact the practice and the only way to contact us on the weekend."*
>
> *Patient response to our 'Your Experience Matters' survey*

**3.4.8.** Our audit of GP Practice websites shows that some Practices have now improved their websites by removing pop-up windows encouraging patients to use online consultation tools. However, most still have long telephone messages directing people to online consultation. It is unclear whether this is still necessary or whether it is best meeting the needs of patients.

**3.4.9.** Online consultation tools like E-consult or Dr IQ can have a place in GP Practice services. However, much more needs to be done to ensure that it works for patients. And more needs to be done to address its limitations, or to be clear when alternative offers need to be in place, for example for patients with low literacy or English language skills or with mental health conditions. We heard that some older people whose first language is not English find it difficult to use Dr IQ or E-consult; they rely on family members which can impact on their ability to access Primary Care. Patients are often not aware that translation service are available for appointments and do not know how to access this on GP Practice websites.

**3.4.10.** In addition, patients need to understand the difference, and the benefits and limitations of SystemOne, E-consult, Dr IQ and the NHS App. They all offer different ways to access Primary Care and patients need to understand when to use them and why, including which best meet accessibility needs such as translation services.

> *"I feel that when ringing the surgery and you first get the automated message about[online consultation app] there is a degree of pressure to use it. I tried to use it for repeat medication but got fed up with the process of having to list all the medication. So, I have used the website and email which have worked OK."*
>
> *Patient response to our 'Your Experience Matters' survey*

**3.4.11.** The NHS is offering more digital options, which can provide increased accessible choices for patients. However, from listening to what patients are saying, it seems that they feel that the choice aspect has been reduced and digital NHS has become a barrier to access and not a gateway for some patients.

**3.4.12.** We were pleased that the NWLCCG Digital First team organised a session to discuss patients' experiences and feedback using E-consult and to look at ways of improving online consultation tool. We would like to see this approach replicated by for GP Practices that are using Dr IQ.

### 3.5. Face to face appointments

**3.5.1.** The most common question patients ask is when GP Practice services will return to normal. They want to know when they can expect to walk into a GP Practice and speak to reception staff or have a face-to-face appointment.

**3.5.2.** Patients told us that during the last 12 months they have struggled to get a face to face appointment when they considered it necessary for their medical inquiry. Often, they would be offered a phone consultation instead, which sometimes led to a follow up face to face appointment. Those patients felt that

time and appointments were wasted because of these strict new policies. Patients also felt that photos they took on their phones were not of a high enough quality to be accurate representations of their condition and did not replace the doctor physically examining the affected area.

**3.5.3.** Patients with mental health conditions, with poor English language skills, hearing or speech difficulties felt disadvantaged by telephone consultations. Some patients said that they would delay or not seek health care at all because they found communication on the phone very difficult. Patients felt that in some cases, they should have been offered a face-to-face appointment without telephone consultation first.

**3.5.4.** As lockdown measures begin to be eased, it remains hard to see how the restrictions that were put in place to ensure patient and NHS staff safety will influence how Primary Care will be offered in the future. Going forward, it is important that the NHS engages with patients to hear their experiences and better understand the positives of the new ways of working and the shortcomings in the ways that Primary Care services were provided during the last 12 months. This needs to be a central part of the planning for future Primary Care provision, that works for patients and for Primary Care services providers.

**3.5.5.** In addition, care needs to be taken to ensure that on-going concerns about COVID-19 do not drown out other health concerns that patients have. Some patients have told us that they feel that the only thing that doctors and other medical professionals want to talk to them about is the vaccine. This is particularly true for patients from minority ethnic backgrounds.

## 4. Communication

**4.1.** Primary Care has changed considerably since the beginning of the COVID-19 pandemic. The usual ways that patients accessed services were suspended and new urgent changes were introduced. Patients told us that they no longer knew how to get the health care they needed. They found national and local health messages confusing, and some patients thought that GP practices were shut. Some patients still believe that they cannot access their GP services.

### 4.2. Patient Participation Groups (PPGs)

**4.2.1.** Communication with patients during COVID-19 restrictions and lockdown became more important than ever. However, during that time a significant majority of GP Practices suspended their PPG activities. NHS England issued an update to GP contracts in July 2020 asking Practices to resume PPG activities; despite this, there are still many practices who have had no PPG meetings for over a year.

### 4.3. GP Practice websites

**4.3.1.** GP Practice websites became a very important tool for communicating and keeping patients up to date with how they could access Primary Care services. Many GP Practice websites were revamped before the COVID-19 pandemic by the

GP Federation. Unfortunately, it appears that neither patients nor PPGs were involved in the design of the refreshed GP Practice websites and it seems that they were designed to meet the needs of the GP Practices rather than patients. PPG members told us that they had to work hard change them and to ensure that their Practice websites were patient friendly, and that information is accessible.

### 4.4. GP Practice Website Audit

**4.4.1.** Healthwatch CWL undertook a review of GP websites between 29th March and 7th April 2021. We looked specifically for content around accessibility and general information, service access and support, and engagement and involvement. Highlights from the review can be found in the table below.

| WLCCG GP practices | CLCCG GP practices |
|---|---|
| 18% of websites do not clearly display the CQC rating. | 10% of websites do not clearly display the CQC rating. |
| 92% of websites give clear information on booking appointments. | 87% of websites give clear information on booking appointments. |
| Just over half (56%) suggest a level of flexibility on consultation method. | Just a third (37%) suggest a level of flexibility on consultation method. |
| Fewer than half (49%) clearly describe the online systems. | Fewer than a quarter (23%) clearly describe the online systems. |
| Two thirds (67%) reference Primary Care Networks | Just 1 website references Primary Care Networks. |
| The PPG is visible on all but one website, however just 15% encourage patients to participate in a way that best suits them, and only 10% have documents (such as minutes) dated within the last 18 months. | The PPG is visible on all websites, however just 10% encourage patients to participate in a way that best suits them, and only 13% have documents (such as minutes) dated within the last 18 months. |
| While the complaints process is visible on the vast majority of sites (95%) just 23% offer clear guidance on the process itself, and what to expect. | While the complaints process is visible on the vast majority of sites (90%) just 27% offer clear guidance on the process itself, and what to expect. |

**4.4.2.** The final report will offer suggestions on how GP practice websites could be improved and with a check list exercise to help review their websites.

### 4.5. Patient feedback

**4.5.1.** How patients submit their feedback or log a complaint can vary from GP Practice to Practice. Most GP Practices now use online forms for patient

complaints. Alternative options for providing feedback or making a complaint are not always explained or offered.

**4.5.2.** It is unclear how many GP Practice web systems, are set up to send an automated confirmation and copy of the submitted complaint, to the patient making a submission. Patients have reported that this is a problem for them because they then do not have any proof of their complaint or the date that it was made. With no confirmation or acknowledgement of a concern or complaint being made, no named contact person, timescale, or route to follow up, patients are left with their concerns comments and compliments being potentially lost.

**4.5.3.** GP Practice and Practice Managers' emails are seldom displayed or shared with patients. This makes it harder for patients to track their feedback or complaint. Providing phone or email contact details for the Practice Manager or the named professional who is responsible for running the Practice would improve the feedback and complaints process for patients and practices.

## 5. Engagement

**5.1.** Over the last year, Healthwatch CWL continued to listen to PPG members, gathered patients' experiences, provided clear information for patients on services, information and promoted national and local health messages. Our Coronavirus: Your Experience Matter patients survey and PPG Forum discussions showed that accurate, consistent, local information is needed to help patients access and navigate Primary Care in a new environment. We worked closely with Central London CCG to share patients' feedback to improve communications with GP Practice patients.

### 5.2. Patient Participation Groups (PPGs)

**5.2.1.** Following the NHS England guidance to GP Practices to resume PPG activities, Healthwatch CWL offered support to GP Practices with moving their PPG activities and wider patient engagement online. We received calls from PPG members asking for help to restart their PPG activities and to support them to contact their Practice Managers. Unfortunately, this was not always possible as many GP Practices have not had any PPG meetings for over a year.

**5.2.2.** However, some good examples of patients' engagement took place during the coronavirus pandemic in practices with well-established PPGs.

> *"We have weekly Zoom meetings where the principal doctor gives updates and answers questions. We have a good practice website as well."*
>
> *Patient response to 'Your Experience Matters' survey (WLCCG)*

> *"I am chairman of the patients' group and I am responsible for writing and disseminating information about GP services. During the lockdown, PPG and Practice made a video which was emailed to over 1,000 patients, followed by a number of newsletters."*

**5.3. Primary Care Networks (PCNs)**

**5.3.1.** It is apparent that PCNs play an important role in ensuring integration and equality of care for GP practice patients. They played an active and important role in successful roll out of Covid-19 vaccination to their local community.

**5.3.2.** For example, NeoHealth PCN was actively involved with local community, NWLCCG, BME Forum and local faith groups in reassuring residents and encouraging the uptake of Covid-19 vaccinations. However, there was little or no engagement with patients about PCN development and involvement in decisions around PCN priorities and new PCN roles.

**5.3.3.** Lack of even basic engagement is demonstrated by GP practice website audit:

- Amongst Central London CCG GP practice websites, information on PCNs was found on just one website. Additionally, none mention the wider primary care roles.
- Amongst West London CCG GP practice websites, around two thirds of websites (67%) contain information about PCNs, with varying degree of detail (in some cases a paragraph, in others a line). Very few websites – if any, go on to mention the evolving primary care roles.

## 6. Quality of service

**6.1.** As Primary Care services have moved more towards being provided online, this has impacted patients' experiences and their perception of the quality of care they are receiving. Different groups have experienced this in diverse ways.

**6.2. Impact of quality on people from minority ethnic backgrounds**

**6.2.1.** We heard from patients from African and Asian ethnic backgrounds that the levels of pain that they describe to their GP or other health professional is not always believed until it becomes critical. We also heard of a lack of trust in GPs:

> *"Since COVID-19, if my children or I become ill, I am scared to go to my GP or A&E and that's just me being honest. What I try to do is use natural remedies. This is because, before COVID-19 my GP made a couple of serious mistakes regarding prescriptions that severely affected me. From all that has happened to me I don't feel that I can trust my GP."*
>
> *Focus group patient from an East African background*

**6.2.2.** We also heard of the importance of translation services and how this can affect the quality of Primary Care services for people from minority backgrounds:

*"Translation services need to be improved."*

*Focus group Arabic speaking patient*

### 6.3. Young people

**6.3.1.** Young people know very little about how to navigate the health system. They are less likely to go to a GP when they have health concerns because they often feel that they are not listened to or that their queries are taken seriously. It seems that the general health advice of 'eat an apple a day' is just going through the motions. Young people feel that GPs need to get back to interacting with young people on a personal level. Our Healthwatch CWL report on Young People and Digital Health highlighted that, contrary to our perception that young people prefer digital interaction, they in fact prefer face to face consultations with a health professional, especially if it is about a new health concern.

**6.3.2.** Mental Health issues are a great concern for young people. Young Healthwatch asked young people (aged 11 to 25), where they would go for help if they had mental health concerns. Only 25% of young people surveyed would go to their GP for support with their mental health, even though it is the gateway to a multitude of support. Most respondents would go to their family (58%) or friends (61%) for mental health support.

**6.3.3.** Respondents explained that GPs are very quick at giving "labels" and they are afraid that with a diagnosis, things can escalate very quickly.

*"Because I'd be nervous to seek help from GP"*

*"I could get help but I'm not bothered to because adults tend to belittle mental health and say it's a phase"*

*"I have been seen by CAMHS for an early disorder and OCD. They were utterly useless and I came out worse than I'd been when I went in. They didn't listen to me, refused to see me without my parents, constantly said triggering things to me and made me feel like my problems were invalid and I was faking them"*

*Young Healthwatch Mental Health survey*

**6.3.4.** It is hard for young people to find reliable information. GP practice websites do not have information services specific to young people. Only 1% of surveyed young people heard about mental health support services from their GP.

*I honestly don't know how to seek professional help, from, for example, a therapist or such. I could probably look it up but as of now I have no idea.*

*Young Healthwatch Mental Health survey*

### 6.4. Continuity of care

**6.4.1.** Many patients told us that they feel concerned when they did not know which health professional will ring them back to conduct their telephone or online consultation or who is looking at their online consultation data. In some cases, this

resulted in patients not feeling confident in the decision making as they felt that the professional did not know their medical history, or that a decision had been made by an algorithm.

> *"Although the doctor in question was perfectly polite and not unduly impatient, the overall attitude conveyed was one of simply getting problems out of the way instead of actually addressing them in a constructive way. The doctor appears not to have looked at my medical history nor at the background of any of the three requests submitted."*
>
> *Patient response to our 'Your Experience Matters' survey*

**6.4.2.** Patients told us that they prefer to speak to the team of health professionals that they know, including their regular GPs, nurses or receptionists. Anonymity of health professionals is a concern to many patients.

> *"My concern was that, by using the app, I was going to be referred for my consultation to a virtual call centre. I would not know whether the doctor I was speaking to was in London or Delhi. Continuity of care is very important to me; I like to know, and to trust, the doctor that I am talking to."*
>
> *Patient response to our 'Your Experience Matters' survey*

Issues of continuity of care, turn over or reduction of GP provision in practices and a lack of engagement with patients has been a particular challenge with AT Medics practices. Healthwatch has raised its concerns with the NW London lead inspector for Primary Care at CQC and the CQCs relationship lead for AT Medics.

## 7. Recommendations

### GP Practices

1. GP Practices should review their websites using Healthwatch CWL recommendations and the check list included in our GP Practice website audit. **PPG members should be involved in this process**.
2. GP Practices should review their phone messages, check for accuracy of information, clarity of the message, time length of the message and how easy to follow the instructions. **PPG members should be involved in this process**.
3. GP Practices should agree a clear policy **with their PPG members** on how to communicate changes and health information to reach all Practice patients.
4. GP Practices should publicise services specific to young people on their websites.
5. NWLCCG should provide clear information for patients in a variety of formats about the benefits, limitations and differences of online access tools such as SystemOne and NHS App, as well as online consultation tools like eConsult or DrIQ.

6. GP Practices should address patients' concerns related confidentially for online inquiries and consultations by providing clear information about who has access to patients' data, who is looking and responding to online inquiries, what their qualifications are, state whether they are members of the Practice team and list them on the GP Practice website.
7. GP Practices should ensure that patients know that they can, and feel welcome to, choose alternative options to digital access and online consultations.
8. GP Practices should promote interpreting and translating services available to patients when booking appointment whether it is online, on the phone or in person and during consultations (online, on the phone or in person).
9. GP Practices should ensure that patient's choice of having a face to face, telephone or online consultation is reinstated as soon as covid restrictions allow.
10. GP Practices should review patients' feedback and complaints protocols **with their Practice PPG** to ensure that patients:
    - can easily find information about how to raise a complaint and what to expect afterwards
    - have multiple routes to making a complaint such as in writing, in person and online
    - online forms are providing confirmation including the date and the context of the complaint.
11. GP Practices should make Practice email addresses and practice managers contact details easily accessible so that patients have ways to communicate with the person in charge of the practice.

**Primary Care Networks**

1. Primary Care Networks should engage with GP member's Practice PPGs and wider community to discuss and identify:
    - When digital tools become a barrier to accessing help?
    - What is the right balance between digital and traditional health?
    - How access to GP services should look like after the Covid-19 pandemic?
    - What coming "back to normal" should look like?

2. Primary Care Networks should improve their communications about the PCN structure, PCN role and services.

3. Primary Care Networks should engage with member GP Practice PPGs and wider community on PCN priorities and workforce planning.

4. Primary Care Networks should engage with schools and young people to understand how GP practice can support children's and young people wellbeing.

**Integrated Care Partnerships**

1. Integrated Care Partnerships should engage with patients to hear their experiences to better understand the positives of the new ways of working and the shortcomings in the ways that Primary Care services were provided during the last 12 months. This needs to be a central part of the planning for future Primary Care provision, that works for patients and for Primary Care services providers

# Westminster Policy & Scrutiny Committee: CNWL Update on the Gordon Hospital April 2021

**Lead Director:** Robyn Doran **Author:** Christina Santana-Smith

## Purpose:

To provide a written update on the Gordon Hospital inpatient wards and CNWL's mental health provision for Westminster. This updates the paper presented to the Committee in October 2020.

## Current Position:

In March 2020, the inpatient wards at the Gordon Hospital were temporarily closed as part of CNWL's COVID-19 response. Due to the level 4 emergency status caused by COVID-19 and its impact, CNWL was not able to consult, only inform local partners at the time. CNWL plans to formally consult on the future of the Gordon hospital this summer, provided National Emergency regulations allow.

## Stakeholder Engagement:

The temporary ward closures have inevitably raised challenges, and while National Emergency regulations have not allowed us to formally consult, we are keen to inform, listen to, and respond to concerns. We are committed to working with our patients, families, communities, and partners to work collaboratively to plan for the right inpatient service to meet the mental health needs of Westminster residents. To enable this, we have taken the following actions:

- We have appointed a **Community & Partnerships Lead** to support partnering with and championing local VCSEs providing services/support to vulnerable and at-risk groups, and partnering with voluntary sector and local authorities to increase alternative forms of provision for those in crisis.
- We hosted a series of **Stakeholder Engagement Forums** open to the public in early 2021 to provide space for discussion, open dialogue, and supportive enquiry.
- We have commissioned Healthwatch to set up a citizen's advisory panel called **The Voice Exchange** to help us deliver our inpatient strategy in Westminster, with local engagement, meaningful consultation, and true co-production.
    - The Voice Exchange launched in January 2021 to advise on the future of inpatient mental health provision in Westminster. The project is made up of a Citizen's Advisory panel, a Deliberation Group, and regular drop-in sessions open to the public to maximise opportunities for inclusion and input.
    - The Voice Exchange has held the first 3 monthly meetings for each of these groups, for what will be a 9-month project where they have so far agreed aims, norms, outcomes & outputs for the group.
- Completed and shared **Equality and Human Rights Impact Assessment** to assess the temporary inpatient ward closures and ensure no adverse impact on persons having a protected characteristic.

**Initial themes** emerging from these stakeholder engagement activities include:

- Westminster residents want appropriate provision & access to inpatient beds close to home *when clinically appropriate,* and consensus that the Gordon inpatient wards are not fit-for-purpose for therapeutic inpatient care.
- There is a strong desire for a continued CNWL presence and provision in the South of the borough, though not necessarily in the form of inpatient beds.
- There is strong support for a non-medicalised and holistic provision, supporting recovery in the community and integrated approaches to care.
- CNWL can continue to improve its communication to ensure effective engagement and that information about existing and future transformation is reaching local partners and residents.

## Key Metrics Update* :

- 560 Westminster **inpatient admissions** have occurred over the last year, with the majority (62%) admitted to St Charles. 91% of Westminster admissions are placed within the NWL system, which is consistent with pre-Gordon inpatient ward closure (90% in 2019-2020).
- Westminster has reduced its **Length of stay (LoS)** to an average of 31 days over the last 6 months (September to February 20/21) compared to 35 days for the same period last year (March excluded due to COVID bias). This means each care episode is shorter, patients are being supported at home earlier, and fewer beds are required to serve the same number of patients.
- There has been a slight rise in **readmission rates** (11% for the last 3 months compared to 10% FY19/20) which we are monitoring to assess the impact of newly live & embedding transformation (see points 3-6 below), and to identify additional actions needed to prevent relapse in the community. We know the answer is not longer stay in hospital, but more support in the community to aid recovery.
- We have managed our use of **beds outside CNWL** by block contracting beds in Farmfield and Potters Bar, in recognition of the impact of the pandemic on demand and in line with a pan-London approach. Since January 2021, most Westminster patients (79%) requiring this type of bed have been placed within that block contract. There have been some occasions where patients were placed further (furthest was one patient in Bristol), but all patients in these beds are monitored daily by our Home Treatment Teams.
- We continue to see patients waiting in St Mary's **A&E** and have agreed an improvement trajectory with Imperial to reduce our >12-hour breaches (21 A&E breeches Jan-Feb 2021 compared to 29 breaches over the same period in 2020 pre-Gordon ward closures).
  *NB This is all 12-hour breaches at St Mary's, not just Westminster patients*

## Transformation Update:

1. **Step-Down Beds [Now Live]:** 5 new beds within a house in Westminster provide short stays (up to 12 weeks) for medically optimised patients to "step down" from wards to

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***Data Definitions:**
Responsible Borough: As entered in SystmOne. *Used for data past April 2020.*
Assumed RB: As Implied by Local Authority of SU, or CCG if LA not known. *Used for data before April 2020.*

the community. This option for patients, who no longer require the clinical input of an inpatient ward but who are not yet ready for discharge to the community, provides an important opportunity for transition from inpatient care to being back home- a period of care that we know is when service users are most often vulnerable. It is an additional tool support the new CAS team (see below) facilitating discharge, and promotes the principles of care in the least restrictive setting and moving care closer to home.

2. **Community Access Service (CAS) [Now Live]:** New service now live across KCW to ensure our patients do not stay longer than clinically required on wards and are supported through re-enablement to live as independently as possible. The team is comprised of an occupational therapist, a social worker and some peer support workers who will facilitate discharge at St Charles Hospital, supporting specifically Kensington, Chelsea and Westminster patients. We have also partnered with Single Homeless Project and Citizens Advice Kensington and Chelsea to provide a part time peer support worker into the CAS team, to provide floating housing support to enable service users to live independently within their own home.
3. **Re-ablement Team [Mobilising]:** A new service in partnership with Westminster City Council focused on support for the social care needs of service users, currently being developed for mobilisation in the coming year. The service will be made up of support workers, working alongside CNWL services to provide intensive support to service users for up to six months to prevent readmission so they are able to manage the transition back into the community
4. **High-Intensity Users [Live end of April]:** CNWL have commissioned British Red Cross (BRC) to develop a bespoke high-intensity user offer to support people who use services repeatedly over a short period of time, which will be the first of its kind for mental health and launching in Westminster by the end of April. We know that frequent attendances can be an indication of unmet social needs which traditional services cannot address. BRC will be taking a person-centred, non-stigmatising approach, working closely with the individual and people involved in their care. They will be mentored by the RightCare HIU lead, who has implemented the RightCare HIU programme across more than 130 CCGs.
5. **VCSE Projects [Now Live]:** New community offers provided by the third sector (VCSE) have now launched, which for Westminster residents includes specific support to people with coexisting MH and substance use problems, specialised Arabic outreach workers through the Oremi centre, and additional BAME support workers in the community. The specific remit of these workers is to engage with service users from BAME communities particularly vulnerable to exploitation by gangs and drug dealers, radicalisation by extremist groups, and/or with alcohol and substance misuse issues
6. **The Coves [Live]:** Service provides 1:1 support, signposting, practical advice and coping techniques, with each Cove staffed by 1 team manager, 2 recovery workers or peer support workers, and 2 volunteers depending on the shift. The Coves are seeing good usage levels, and feedback from Westminster service users is positive:
    - *"Sometimes I can't find enough words to express how thankful I am; thank you very much, your work is to bring life back to people innerly dying, and you do it effectively, thank you so much*."- Westminster resident (10/02/2021)
    - *"I really needed this. Thank you so much for your support today. Thank you for your time and listening without any judgement"*- Westminster resident (08/04/2021)

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City of Westminster

# Policy and Scrutiny Committee

| | |
|---|---|
| **Date:** | 19 April 2021 |
| **Classification:** | General release |
| **Title:** | NHS NW London ICS update on elective surgery |
| **Report of:** | Senior Accountable Officer |
| **Cabinet Member Portfolio** | Portfolio (as listed at www.westminster.gov.uk/cabinet) |
| **Wards Involved:** | All |
| **Policy Context:** | NHS NWL covid-19 acute recovery |
| **Report Author and Contact Details:** | Xiao Cai |

## 1. Executive Summary

Overall, NW London has maintained a greater level of elective activity in Wave 2 compared with Wave 1 thanks largely to the hard work and dedication of NHS staff and improved Covid-19 protected pathways, which have enabled many more planned procedures to continue.

We have been able to care for Covid-19 patients whilst also treating the more clinically urgent elective patients (those who are clinically assessed as needing treatment within 4 weeks, including patients on cancer pathways).

Although waiting times for elective care did not increase at the same rate in wave 2 as wave 1, in line with the national picture in the NHS, we do still have a significant number of patients waiting for planned care, some over 52 weeks.

To address this, we have established a joint acute care board and programme to guide and coordinate developments across all key areas, including: planned surgery.

Our immediate focus is on making sure we step services back up in a way that prioritises clinical need and minimises the risk of Covid-19 infection, whilst we also maintain more intensive care capacity than pre-pandemic to ensure we are able to respond quickly to a possible third wave. And we want to do that while also ensuring

our staff get the space and support to fully recuperate, the needs and views of our patients are at the core of our plans and we actively address health inequalities.

We have developed a huge amount of learning from our response and improved collaboration with our partners across our integrated care system to take this programme forward.

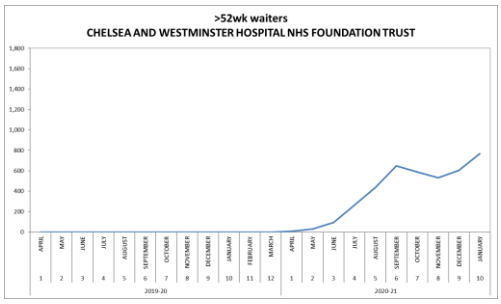
## 2. Background

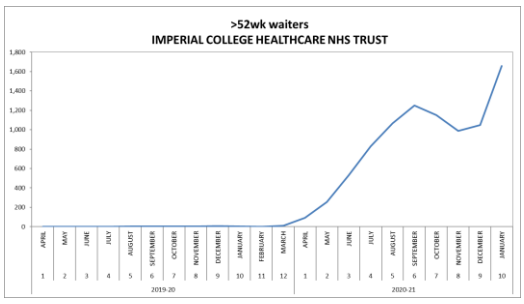
Our staff have provided the best possible care for thousands of patients with Covid-19 as well as thousands more with other urgent or emergency conditions over the past year. However, like the rest of the NHS, this has meant we have had to postpone planned operations, procedures and outpatient appointments for patients with less urgent needs. Many staff have been redeployed to help care for patients with Covid-19 and we have had to introduce additional infection prevention and control measures that have limited the number of patients we can treat on site.

We have learnt a lot between waves one and two of Covid-19 and we managed to safely maintain more planned care during the second wave, while also successfully treating more Covid-19 patients. But many patients with non-urgent conditions have now been waiting for treatment or advice for a long time and this situation will get worse before it gets better as we continue to prioritise patients with the greatest clinical need and as more people are likely to seek care as we move out of the pandemic. The NW London ICS is the largest system in London, currently we have the second lowest number of patients waiting over 52 weeks.

Waiting times for patients awaiting routine care have increased across the NHS, including at both Chelsea & Westminster Hospital Foundation Trust and Imperial Hospital Foundation Trust. In particular, we now have a significant number of patients who have been waiting over 52 weeks.

Referral to Treatment Time over 52wks for Chelsea & Westminster Foundation Trust and Imperial College Hospital Trust:




*Data Source: Consultant-led Referral to Treatment Waiting Times, NHSE Statistics*
*Caveats: Provider-level data only, site-level data not available in national dataset*

Our clinicians are undertaking a systematic 'harm review' to understand whether anyone waiting for care is likely to be suffering – or has suffered - any harm as a result of the delay to their treatment and to identify remedial action. Our clinicians are also continuing to review each of their patients to be clear about how urgently treatment is needed. We have continued to provide planned operations and other treatment for patients who we know need treatment within two weeks, either within

our own hospitals or in the independent sector. This has allowed us to maintain our urgent cancer care pathways.

## 3. Going forward

We have developed a huge amount of learning from our response to the pandemic as well as much better ways of collaborating across our integrated care system. We think we can do more to harness our collective resources, join-up our care and reduce unwarranted variations in access and outcomes.

We have established a joint acute care board and programme to guide and coordinate developments across all key operational areas, including: planned surgery, cancer care, outpatients, intensive care, urgent and emergency care and diagnostics and imaging. The board includes the chief executives, medical directors, nursing directors and chief operating officers of the acute trusts and the chief executive and chief of staff of the integrated care system as well as two lay partners and lead directors for finance, human resources, digital and communications and engagement

**The initial phase of the acute care programme relating to elective care, guided and co-ordinated by the acute care board, therefore includes:**

- **Fairer waiting times**: There are differences in waiting times and waiting list management across different specialties and hospitals and so we are exploring the development of a single view of waits across our hospitals. This will help us develop more consistent approaches to how waiting lists are managed and, potentially, to offer patients who have been waiting a while for treatment the opportunity to transfer to a hospital with more capacity, helping to create a fairer approach to access.

- **Re-starting 'fast-track surgical hubs'**: Last September, as part of a wider NHS initiative, we identified 14 surgical facilities across our hospitals that could have a good degree of separation from other facilities. These facilities were then dedicated to one or more of 29 specific, routine operations (across six specialties) where evidence has demonstrated improved quality and efficiency if a surgical team undertakes high numbers of these procedures following the same process, systematically. We were then able to offer these procedures at one of the corresponding facilities – sometimes called 'fast-track surgical hubs' - to patients from across our hospitals' waiting lists, in order of clinical priority. These services had to be suspended through wave two but have now begun to restart them, with the aim to have them all running at full capacity again by the end of April.

**Outpatient services**

- **Faster access to acute and specialist advice**: We're putting in place processes to enable GPs to get advice and guidance quickly and easily from specialist colleagues in the acute trusts when needed. Evidence from our pilots indicates that up to a third of patients referred to hospital can get the

care and support they need in primary care if specialist advice and guidance is available, avoiding unnecessary waits for an outpatient appointment. Improved processes are also ensuring any blood tests, imaging and other diagnostics needed to inform outpatient consultations are booked and undertaken in advance of the outpatient appointment.

- **Telephone and video consultations**: We had to quickly move as many outpatient consultations as possible to telephone or video during the pandemic to minimise the risk of Covid-19 infections. They have not always worked smoothly but we are continuing to build in improvements to our processes and ways of working and to find better ways of identifying and supporting patients who have difficulty in accessing care in this way. We would like to maintain high quality, virtual outpatient appointments for a significant proportion of our patients.

We are working to return to at least 80 per cent of our pre-pandemic activity by June 2021 – and to continue increasing our capacity from there - which means we will be able to safely treat all urgent patients and many with less urgent needs who have been waiting a long time. But, because we expect to see more people join the waiting list as we emerge from the second Covid-19 wave, we expect our long waits to continue to climb for a while. And we will continue to see growing health and care demand generally, as a factor of population changes and new diagnostics and treatments.

It's therefore really important that we also plan for longer-term, more strategic and sustainable improvements. We want to work with patients and wider stakeholders, drawing on evidenced best-practice and deeper collaboration, to build further on improvements to models of care and care pathways.

**If you have any queries about this Report or wish to inspect any of the Background Papers, please contact Report Author.**

**APPENDICES:**

For any supplementary documentation; especially from external stakeholders or documents which do not fit this template.

**BACKGROUND PAPERS**

This section is for any background papers used to formulate the report or referred to in the body of the report.

City of Westminster

**Adult Social Care and Public Health**

| | |
|---|---|
| **Title:** | Covid Impact |
| **Division:** | Adult Social Care and Public Health |
| **Briefing Date:** | April 2021 |
| **Purpose:** | Overview of the health impact of Covid-19 and recovery planning |
| **Approved By:** | Bernie Flaherty, Executive Director Adults and Health |
| **Author:** | Anna Raleigh, Director of Public Health |

**Covid-19 impacts and Recovery Planning**

1. The Covid-19 pandemic has changed all our lives, disproportionately impacted our communities, and in many cases worsened health inequalities between groups locally. The impact has been felt across the board. For example, children and young adults have been unable to go to school and socialise with their peers, those with relationship difficulties and unpaid carers have been unable to draw on their usual support outlets, and people with frontline occupations who cannot work from home have been at greater risk of exposure.

2. One of the most important things that the public health system can do is to highlight problems that affect the health of disadvantaged population groups, so that we collectively repurpose our efforts from treating ill health to dealing with the causes and collaborating on prevention and solutions to stop them arising in the first place. Professor Sir Michael Marmot articulated why it is so important for Public Health to focus our attention on reducing health inequalities when asking: 'What good does it do to treat people and send them back to the conditions that made them sick?'.

3. The Public Health department recently developed a Health Impact Assessment which provides a summary of the current evidence of the direct and indirect impacts of Covid-19 on the health and wellbeing of Westminster residents during the first wave of the pandemic. This l includes health disparities which existed before Covid-19. For example, the life expectancy of a baby boy born in Queen's Park is 78.2 years compared to 86.8 years for a baby boy born in Abbey Road.

4. The full report will be available online at jsna.info in May 2021, and key findings on impact and disparities include:

   - Locally, during the first wave, 60% of Covid-19 deaths were men despite an even split in gender for residents who tested positive. The majority of residents who sadly died were aged 65+.

   - During the first wave, national data indicated that people from Black ethnic groups were most likely to be diagnosed with COVID19 and people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity (*PHE, 2020*). Initial analysis of local registered deaths data between March and July 2020 reveals that there has been a higher rate of deaths among people from a BAME background (both Covid19 and non-Covid19) when compared to last year. Due to small numbers, the local conclusion should be treated with some caution due to the relatively small numbers of people who have sadly died. For this reason, it is also not possible to break this analysis

down further by ethnic group Further analysis of cause of death will be undertaken in 2021 to better understand any differences.

- Most residents who have died from Covid-19 have had an underlying health condition. 41% of the GP registered patients aged 16 and above in Westminster have at least one long-standing health condition in 2019. It is important to emphasise that social and economic disadvantage influences the distribution of these underlying conditions. For example, around 4% or patients registered with local GPs have diabetes, lower than the London (6.8%) and England (7.1%) average. However, there is variation across wards in the borough, for example diabetes prevalence is around 9% in Church Street. (*PHE Fingertips 2019/20; JSNA Ward Health Profiles 2019)*.
- The 2020 Westminster City Survey shows that Black African residents were more likely to be concerned about the impact of Covid-19 than other ethnic groups.
- Research focused on BAME communities in North Westminster, conducted by Support When It Matters (SWIM) Enterprise, identified that 62% were reluctant to vaccinate and only 44% would use Track and Trace. Only 38% of respondents stated that they would have a vaccination against Covid-19.
- The Westminster City Survey found that 46% of residents were concerned about their mental health and wellbeing. Women and older residents were more likely to be concerned, as were those who were unemployed. Residents from mixed ethnic minority groups were more likely to be concerned about their mental health and wellbeing.
- In Westminster the prevalence of depression, diabetes, hypertension, obesity and Severe Mental Illness (SMI) in the GP registered population is, overall, higher amongst BAME groups compared to residents of white ethnic background. Asian and Asian British residents are shown to have similar rates of SMI as residents of white ethnic background.
- ONS research found that nationally, disabled adults were more likely (45%) to report being very worried about the effects of COVID19 than non-disabled adults (30%) in the early part of lockdown. They were also more likely to report spending too much time alone (*ONS, 2020*)
- Local community intelligence has highlighted concerns around the negative impact on mental health and wellbeing, including isolation and loneliness, anxiety and stress, fear and stigma, suicide and bereavement. National research tells us it is likely that certain groups of people will be particularly affected e.g. young adults, women, people with lower educational attainment or income, people living alone, and adults with long term conditions or disabilities.
- The number of people claiming out-of-work benefits from January to August 2020 more than doubled in Westminster.
- Locally, people reported not going out at all and not letting children out, with physical activity dropping completely for many residents.
- Between July and September 2020 there was an increase in referrals to local domestic violence services, to the highest levels in five years.
- National research indicates drinking habits changing in the first lockdown, with 1 in 5 people drinking more alcohol. However, there some local evidence that a number of service users have taken the opportunity to reduce alcohol or drug use with the pandemic interrupting habituated patterns of behaviour and social networks.

5. Covid-19 is exposing and exacerbating health inequalities that already existed in Westminster. The challenges we have faced with the uptake of the Covid vaccine are the same we face each winter with the flu vaccine and other preventative services.

6. The pandemic is far from over and the public health department continue to monitor population health with a greater focus than ever before of working with residents to improve our understanding of their needs, barrier and experiences. This is key to preventing ill health and responsive action to identified health disparities and emerging trends.

7. The findings of the Health Impact Assessments will be taken forward in the commitments made in the 2021 Director of Public Health's Annual report focused on the impact of Covid-19 and through our City for All programme. Westminster is committed to focussing on groups with the greatest needs, continuing to consult residents on their health and wellbeing to direct our effort, and innovating by codesigning campaigns and actions to bring us closer to the communities we serve.

8. Obesity is an increasingly worrying Public Health issue. The pandemic, and the societal changes associated with it, have increased sedentary behaviours and reduced the access to weight management services, physical activity and fresh, healthy food. In recognition of this additional challenge, Westminster has received an additional £88K from PHE to support adult healthy weight initiatives in 2021/22.

9. By focussing and committing to long term change, we can begin the journey of making significant in-roads to address the levels of inequality that are damaging the health and wellbeing in many of our most disadvantaged communities.

10. There is an urgent need to scale up prevention activity and address health inequalities – the levers for which lie predominantly outside health services. The conditions in which we live and work and the connections we have define how well and how long we live. A system-wide approach to recovery needs to be adopted which focuses much more attention on the communities with the greatest needs. It is recommended that all aspects of Council work are reviewed to consider their contribution to address health and social inequality (the driver of Covid-19 and other disease impact) and a robust approach is developed to measure collective impact in areas of deprivation.

11. Health service action is needed to reduce the risk of Covid-19 (action to identify and treat cardiovascular risk factors), and to rapidly respond to health needs unmet or exacerbated during lockdown e.g. missed screening and immunisations appointments (NHSE responsibility), increases in anxiety and depression, cancelled operations and routine appointments.

12. Through the Change and Innovation Board, we will work collectively to build back Fairer through:

- Focused attention on areas and communities with the greatest needs.

  We will focus on improving the health and wellbeing in areas and communities with the greatest need, including Black, Asian and minority ethnic communities. We have already started making changes to ensure there is equality of access and service experience. We have begun making calls to residents who haven't had a health check to ensure health conditions are picked up early and we tackle the most preventable deaths. We also want to expand the capacity of local BAME-led organisations offering much needed services to our communities. We have also engaged extensively with local voluntary and faith organisations supporting communities where there has been evidence of low vaccine uptake and the inequality in vaccine uptake between ethnic groups is narrowing.

- Ensuring that we systematically ask residents about their health and wellbeing and codesigning campaigns and actions to ensure that we better serve their needs.

  We will be consistent in asking residents about their health and wellbeing to better understand needs, barriers and experiences. We will also continue to advocate for ethnicity data collection to be mandatory across all our systems. We will also advocate for this data to be broken down beyond 'BAME', making sure our responses do not treat non-white communities as one homogenous group.

- Innovate by codesigning campaigns and actions to bring us closer to the communities we serve.

  Working with grass roots organisations, local communities and community leaders we will innovate to ensure that residents are actively involved in the development and delivery of public health services, campaigns, and disease prevention programmes. By doing so, we aim to achieve a proportionately equal uptake of flu and Covid-19 vaccines across all ethnic groups. We are proud of the work already being done to engage with our communities. We have translated materials into Arabic, Bengali (Sylheti), Somali, Farsi, Kurdish, Tigrinya and Portuguese to promote testing and the Covid-19 vaccine. In addition to recruiting 138 Covid-19 health champions to promote Covid messaging widely in the communities, we have provided accurate and up-to-date messaging to 90 community champions to support 1:1 information giving and signposting in project neighbourhoods of Church Street, Harrow Road, Mozart, Westbourne Park and Churchills Gardens/ Tachbrook, engaging with a range of Bangladeshi, Somali, Black African-Caribbean, Arabic speaking and mixed communities.

- Investing £3m of our Public Health grant into local Covid-19 Recovery programmes

  We will invest in the COVID19 recovery programmes to address health inequality and improve residents' chances of living a healthy and happy life. We will measure our success every year in how far we see a narrowing gap in the existing health inequalities.

City of Westminster

# Adult Social Care and Public Health Policy & Scrutiny Committee

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| **Date:** | 28 April 2021 |
| **Classification:** | General Release |
| **Title:** | **2020/21 Work Programme** |
| **Report of:** | Lucy Glover, Acting Head of Governance and Councillor Liaison |
| **Cabinet Member Portfolio:** | Cabinet Member for Adult Social Care and Public Health |
| **Wards Involved:** | All |
| **Policy Context:** | All |
| **Report Author and Contact Details:** | **Artemis Kassi** akassi@westminster.gov.uk |

## 1. Executive Summary

1. This report asks the committee members to consider unallocated items from the committee's 2020/2021 work programme. The Committee is also asked to consider the work programme for 2021/2022 and to ask the Cabinet Member and officers present at the meeting for suggested topics for the next municipal year's work programme.

## 2. Meeting dates for the 2021/2022 year

2.1 The Committee is advised that the scheduled meeting dates for the 2021/2022 year are:

- 14 June 2021
- 27 September 2021
- 8 November 2021
- 24 January 2022
- 21 March 2022

## 3. Suggested topics

3.1 The Committee is asked to discuss potential topics for the next municipal year's work programme. Some suggested topics are:

- Social isolation and loneliness
- Adult mental health and emotional wellbeing, including how services have adapted during the pandemic
- BAME inequalities and COVID, including vaccine uptake in BAME communities.
- Obesity and metabolic disease in adults
- Tooth decay and oral health in adults

**If you have any queries about this report or wish to inspect any of the background papers, please contact Artemis Kassi.**

**akassi@westminster.gov.uk**

## ADULTS AND PUBLIC HEALTH POLICY AND SCRUTINY COMMITTEE

COMPOSITION

Eight (8) Members of the Council (five Majority Party Members and three Minority Party Members), but shall not include a Member of the Cabinet.

TERMS OF REFERENCE

(a) To carry out the Policy and Scrutiny functions, as set out in Article 6 of the Constitution in respect of matters relating to all those duties within the terms of reference of the Cabinet Member for Adult Social Care and Public Health.

(b) To carry out the Policy and Scrutiny function in respect of matters within the remit of the Council's non-executive Committees and Sub-Committees, which are within the broad remit of the Committee, in accordance with paragraph 13 (a) of the Policy and Scrutiny procedure rules.

(c) Matters within the broad remit of the Cabinet Members referred to in (a) above which are the responsibility of external agencies.

(d) Any other matter allocated by the Westminster Scrutiny Commission.

(e) To have the power to establish ad hoc or Standing Sub-Committees as Task Groups to carry out the scrutiny of functions within these terms of reference.

(f) To scrutinise the duties of the Lead Members which fall within the remit of the Committee or as otherwise allocated by the Westminster Scrutiny Commission.

(g) To scrutinise any Bi-borough proposals which impact on service areas that fall within the Committee's terms of reference.

(h) To oversee any issues relating to Performance within the Committee's terms of reference.

(i) To have the power to scrutinise those partner organisations under a duty to that are relevant to the remit of the Committee.

(j) To consider any Councillor Calls for Action referred by a Ward Member to the Committee.

(k) To discharge the Council's statutory responsibilities under Section 7 and 11 of the Health and Social Care Act 2001 with regard to any planned substantial developments and variations to NHS services.

(l) To oversee strategic and accountability issues within local health commissioners and providers.

February 2021

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