Minutes

HEALTH AND SOCIAL CARE SELECT COMMITTEE

22 July 2025

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Nick Denys (Chair), Reeta Chamdal (Vice-Chair), Tony Burles, Becky Haggar, Kelly Martin, June Nelson and Barry Nelson-West (In place of Sital Punja) **Also Present**: Sean Bidewell, Assistant Director – Integration & Delivery / Acting Joint Borough Director, North West London Integrated Care Board (NWL ICB) Carleen Duffy, Your Voice in Health and Social Care (Healthwatch) Edmund Jahn, Chief Executive Officer, GP Confederation Lisa Taylor, Managing Director, Healthwatch Hillingdon **LBH Officers Present**: Nikki O'Halloran (Democratic, Civic and Ceremonial Manager)
12.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillor Sital Punja (Councillor Barry Nelson-West was present as her substitute).
13.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
14.	**MINUTES OF THE MEETING HELD ON 19 JUNE 2025** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 19 June 2025 be agreed as a correct record.**
15.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**
16.	**SINGLE MEETING REVIEW: GP COVERAGE IN HILLINGDON** *(Agenda Item 5)* The Chair welcomed those present to the meeting. Witnesses had provided a response to many of the key lines of enquiry highlighted in the scoping report in advance of this single meeting review – this information had been circulated to Members of the Committee on 15 July 2025. Mr Edmund Jahn, Chief Executive Officer at The Confederation Hillingdon CIC, advised that the Confederation represented 42 of the 44 GP practices in Hillingdon.

These practices were grouped into six Primary Care Networks (PCNs) which each had Clinical Directors who sat on the Confederation Board. The two practices that had not joined the PCNs were owned by the same person and the central primary care team worked closely with them to plug any gaps.

Members queried the value in being part of the PCN and why two would have opted out. Officers advised that they did not know why they had opted out but that, whilst the practices would provide appointments, the PCN offered additional support and signed up to single offer additional contracts. Mr Jahn advised that all PCNs employed pharmacists in practice teams which most independent GPs were unable to do. They also provided GPs with access to social prescribers and other specialist services such as physiotherapists, podiatrists and dieticians to help their patients. Ms Lisa Taylor, Managing Director at Healthwatch Hillingdon (HH), advised that Healthwatch Hillingdon had the ability to rank GPs based on patient satisfaction, and that they had made a recommendation in their recent report to review the utilisation of enhanced services to identify any inconsistencies. GPs could be ranked based on patient satisfaction and how well GPs were accessing enhanced services but this was inconsistent.

Action was being taken to try to introduce more personalised care for patients with complex needs as well as dealing with same day access for other patients. Pharmacy First consultation service enabled patients to be referred into community pharmacy for a minor illness or an urgent repeat medicine supply. It enabled community pharmacies to complete episodes of care for seven common conditions following defined clinical pathways: infected insect bites, impetigo, shingles, sinusitis, sore throat, urinary tract infections and ear infection.

Ms Taylor had undertaken a review of Pharmacy First and was currently writing up the findings and recommendations of the review. This would be shared with the Committee in due course.

Mr Sean Bidewell, Integration and Delivery at NWL ICB, advised that pharmacies had been alleviating pressure on GPs. Since May 2025, 58 of the 59 pharmacies in Hillingdon had been delivering support for some of the seven common conditions. 56 of the pharmacies also offered a hypertension case finding service and 53 provided a contraception service. Other services such as flu and covid vaccinations and smoking cessation support were also provided by some pharmacies. Between January and May 2025, there had been around 4k individuals with common conditions seen by pharmacies in Hillingdon and about 5½k patients seen in relation to their medicine supplies. Around 12k people had had their blood pressure monitored at a Hillingdon pharmacy during this same period.

Mr Jahn noted that the scoping document for this single meeting review had picked up on several themes regarding GP coverage in Hillingdon. GPs were nationally contracted with GP Directed Enhanced Service (DES), General Medical Services (GMS) or Alternative Provider Medical Services (APMS) contracts. GPs were also contracted by North West London Integrated Care Board (NWL ICB) for some services. Whilst the services provided could be commissioned, each practice was independent and would be able to deliver those services in their own way.

In Hillingdon, although practices could cover the majority of services required, they were able to pull together as PCNs to run clinics for things like diabetes. In addition, the Confederation provided services that were not provided by the practices or the PCNs. This tended to be at scale, for example, the integration of the care home

service in partnership with Central and North West London NHS Foundation Trust (CNWL). Specialist services such as women's clinics and warfarin monitoring were also undertaken by the Confederation and top up work was available if practice capacity dipped (GPs were able to refer patients to Confederation clinics to ensure that they met 100% of patient requirements).

GPs used to get quite a lot of support from the NHS / CCG in relation to issues such as workforce / training, technical / digital and estates but, over the last 3-4 years, this had moved to the ICB and diminished, with responsibility shifting to the providers themselves. Increasingly, collaboration was becoming the norm to maximise the services available to patients. Whilst GPs would have a Practice Manager, they would not have an HR Manager, Digital Manager, etc. However, they were able to receive this support from the Confederation.

Mr Jahn advised that the NWL ICB was a strategic commissioner which measured GPs against targets based on local contracting agreements. The PCNs organised who did what amongst the practices and a lot of contracting was undertaken locally by the Confederation to fulfil PCN decisions and meet strategic contracts and objectives.

It was noted that a major engagement exercise had been undertaken with regard to access plans with 5% of the Hillingdon population participating. Six access plans had been produced for the coming year which set out changes in delivery. The NWL ICB had identified what access improvements it would like to see which included a requirement for practices to answer 90% of calls within ten minutes.

Mr Jahn noted that there had been an increase in the overall number of GP appointments available but feedback on the patient experience was still not where the Confederation would like it to be. In terms of improving this, a lot of effort was being made, but more listening was needed across all practices. Members queried whether this increase in appointments was solely for GP appointments or whether it included appointments for things like nurse practitioners. Mr Bidewell advised that there had been an increase in activity but that he was not sure about the proportions (the national GP data set on activity could be broken down by face-to-face, telephone, etc). In 2022/23, there had been 1.7 million appointments with a 6% increase in 2023/24 and a 9% increase in 2024/25 (68% of these had been face-to-face which was an increase on the previous year). There had been an increase in the number of patients wanting a same day appointment (up from about 3k to 3½k).

Mr Bidewell advised that he was part of the Borough team based in the Civic Centre and worked with Hillingdon Health and Care Partners. The ICB had a strategic commissioning role and linked with partners for monitoring and managing. Locally, the team worked with partners to look at the local delivery of the strategic commissioning priorities. Although the ICB would continue at a NWL level centrally in some form, it was unclear what the changes being made to the organisational structure would mean for the Borough team.

The Integrated Neighbourhood Teams were working to bring care closer to patients including the PCNs and core services such as community nursing, musculoskeletal (MSK), adult social care, third sector and acute services. The Paediatric Clinics were a good example of this closer working in the community which saw teams from different organisations working together to improve patient experience and increase the number of patients seen. These clinics were being run from the Integrated Neighbourhood Hub. Practices were able to book appointments at the Hub through patient contact with

GPs. In future, neighbourhood working meant that patients should be able to be booked in to see the community nurse and the community nurse should be able to book the patient in to see their GP.

Ms Taylor advised that HH had recently published its report on GP access. The most common cause for residents to contact HH was in relation to getting a GP appointment – patient satisfaction had not improved even though there had been an increase in the total number of appointments available.

HH's research for the GP access report had started in 2024 but, as the survey had been put on hold whilst NWL ICB looked at same day access issues, discussions had been undertaken with groups such as carers, travellers and asylum seekers. Although 62% had been satisfied with GP contact there were concerns about issues such as booking appointments, telephone systems and continuity of care (these concerns were largely from people of working age).

The PATCHS system had been introduced to try to reduce phone waiting times by enabling patients to make an appointment request online. However, access times were limited and there had been some technical issues which meant that practice staff were having to call patients back. Furthermore, issues had been identified with regard to the telephone call back system which was not currently working properly and the use of multiple platforms for various elements of the NHS had been causing confusion for some patients (this was not helpful to those members of the public who were not technologically confident or competent). Mr Jahn advised that it had been recognised that patients were not able to specify a convenient time for a call back so might be busy and unable to answer when the call came. There were four Digital Transformation Managers that had been looking at this type of issue to help simplify it from the patient perspective.

Other concerns raised by residents in Hillingdon included data security, continuity of care and inconsistent follow ups. The reliance of some practices on locums had impacted on patient confidence in their GP as there was a lack of familiarity with their health history and they were having to repeat their story multiple times. There had also been some language barriers where interpreters were not always provided and people with hearing impairments were not being supported through the telephone system (there could be a confidentiality issue if patients were reliant on a third party to interpret for them).

Ms Taylor advised that patients would often be unaware of the role of each individual in a practice and sometimes felt that they were not being seen by the most appropriate person. They were also not always happy about giving personal information to reception staff even though they needed this to be able to triage.

Mr Jahn advised that there had been an increase in the number of GPs in Hillingdon and proactive action had been taken to increase the number of training practices in the Borough. Once full trained, trainee GPs at these practices tended to get their first job once fully qualified within the area that they had trained which had had a positive impact on numbers. In addition, use had been made of fellowships and supporting them with mentorships.

There had been an expansion of general practice capacity through the Additional Roles Reimbursement Scheme (ARRS) which enabled PCNs to claim reimbursement for the salaries of certain roles within the multidisciplinary team, selected to meet the needs of

	the local population. This had resulted in two new GPs being recruit in the last year and 3-4 more GPs currently in the process of being recruited. However, Mr Jahn noted that around 25% of Hillingdon's GP were nearing or beyond retirement age (which was a high risk), with demand continuing to increase and many new GPs being portfolio based (working part time as a GP as a lifestyle choice or so that they could work somewhere else as well). Members queried what action was being taken to provide a GP services across all of the Heathrow Villages (particularly Harmondsworth, Sipson and Longford) and what progress had been made to secure a site for a general practice in the area. Mr Bidewell advised that he did not know about the plans to secure land for a GP practice in Heathrow Villages so would ask Mr Keith Spencer (Managing Director at Hillingdon Health and Care Partners) and Ms Sue Jeffers (Borough Director at NWL ICB) to provide Members with an update. He was, however, aware that a contract had been put in place for the HESA Centre in Hayes to take on some of the patients in the Heathrow Villages. Ms Jeffers had also been reaching out to pharmacies to see what support could be provided for residents in this area. There had been efforts to ensure that women were able to see a female GP (or other female professionals) if required. Members queried whether the same priority was given to men. Ms Taylor was unaware of any such requirement but suggested that the same focus ought to be given to men's health as women's as this appeared to be a gap in the system. Members queried how patients from different practices were able to access the same services (for example, dressings) and where they would be provided, particularly if they were unable to use / access IT. Mr Jahn advised that healthcare was complex and that staff often tried to deal with that complexity behind the scenes but that this didn't always work. There were at least five patient digital systems in use by General Practice in Hillingdon (possibly six) that patients needed to interact with for different things (this should probably be a maximum of two). The computer systems tended to be siloed and patient were often passed between them. The NHS should be able to work as a single team without the patient having to intervene but the data governance needed to be sorted out. Mr Bidewell advised that this challenge was bigger than NWL ICB but that, locally, work was being undertaken to enable systems to talk to each other through Whole Systems Integrated Care (WSIC) dashboards which provided a linked integrated summary of patient's health and social care. This information could be used to case find and case manage patients who required more targeted and proactive care. Members expressed concern that residents might get lost in the system between services and queried how GPs received communication about the actions taken by other clinicians. Mr Jahn advised that, in many ways, the last four years had seen better cooperation across practices and networks, and staff had been collaborating more than ever. First contact physiotherapists were employed in general practice with another tier in CNWL (MSK) and anther at the hospital. These siloes had still not be joined together and patients might be asked to complete similar forms for each of the services asking for very similar information. Ideally, as part of the 3-5 year plan being developed across and between local NHS providers (including GPs), there would be integrated physiotherapy teams collocated in each of the three Hubs. In Hillingdon, a partnership had been established between the GP Confederation, local hospital, CNWL and others. This had been a significant step and was quite advanced,

with officers pushing and championing the joined up way of working to ensure that Hillingdon was in the first wave in 2026 for the formal introduction of neighbourhood working.

It was queried how the NHS planned its future provision. For example, a new GP surgery had been planned for inclusion in the St Andrews Park development but this had not happened. As a result, a large number of patients had had to join the Uxbridge practice list, making it one of the largest practices and putting it under greater pressure. Mr Jahn advised that this type of question would usually need to be answered by the commissioners. The Confederation had worked closely with the Council, NWL ICB and providers to recently put an integrated estates strategy in place but, during his seven years as Chief Executive Officer, he noted that the development of general practice had not followed a plan very closely. He noted that there were some gaps where some GP practices catered for four times as many patients for the same size practice as others and it was hoped that the strategic plan would address these inconsistencies (for example, more GP capacity was needed in Yiewsley / West Drayton).

Members queried who proactively decided where and when additional GP capacity was needed and how this was done in practice. Mr Jahn advised that commissioning would be involved. When the last GP in a practice retired, would the practice close and the patient list need to be redistributed? If a practice was needed, it would be referenced on the basis of the strategic plan. Freeing up capital allocation would be a Government decision and, although commissioners had not had it in their gift over the last ten years, they now had a reference document / plan. Closer working relations had been developed with the Council so there was a possibility of sharing estate (and the local authority had fewer restrictions so provided better options).

In terms of monitoring the quality of, and complaints about, GP services, the CQC inspected practices and was able to issue improvement notices if standards were not being achieved (the CQC had been very active in Hillingdon). Data about GPs was very visible, for example, the qualities and outcomes framework, and there were 188 measures included in NWL ES GP contracts alone. GPs would deal with complaints and incidents through their own governance processes so work was needed on this as it was fairly self-contained.

Members queried what additional services were being explored to take the pressure off GPs. Ms Taylor advised that a Children and Young People's Champion role had been appointed in one of the PCNs as a one year pilot to alleviate the impact of mental health presentations on GPs and get young people and their families to the right support as quickly as possible (there was a need to reduce the reliance on CAMHS by diverting to other services that were available and more appropriate). There were also plans to introduce additional roles such as practice nurses in some PCNs. As the neighbourhood population needs were analysed, action would be needed to ensure that services were tailored to meet those needs. Members asked that the Children and Young People's Champion be invited to attend a future meeting of the Health and Social Care Select Committee in about six months.

Members were asked to forward any additional questions that they might have for those present (or for Ms Jeffers or Mr Spencer) or suggested recommendations to the Democratic, Civic and Ceremonial Manager by Friday 1 August 2025.

The Chair noted that this would be Ms Taylor's last attendance at the Committee's meetings. He thanked her for her insightful contributions over the years and wished

	her well. Ms Carleen Duffy would be taking the service forward from 1 August 2025. **RESOLVED: That:** **1. Mr Keith Spencer and Ms Sue Jeffers be asked to provide the Committee with a written update on progress with regard to securing land for a GP practice and providing pharmaceutical services in Heathrow Villages;** **2. the newly appointed Children and Young People's Champion be invited to attend a future meeting in about six months;** **3. Members forward any additional questions that they might have for those present (or for Ms Jeffers or Mr Spencer) or suggested recommendations to the Democratic, Civic and Ceremonial Manager by Friday 1 August 2025; and** **4. the discussion be noted.**
17.	**CABINET FORWARD PLAN MONTHLY MONITORING** *(Agenda Item 6)* Consideration was given to the Cabinet Forward Plan. **RESOLVED: That the Cabinet Forward Plan be noted.**
18.	**WORK PROGRAMME** *(Agenda Item 7)* Members agreed to cancel the meeting scheduled for 21 April 2026 and move the health updates item to the meeting on 26 March 2025. The new Children and Young People's Champion that had been appointed to one of the Primary Care Networks would be invited to attend the meeting on either 20 January 2026 or 17 February 2026. It was agreed that the update on the implementation of recommendations from the review of the CAMHS referral pathway be moved to coincide with this attendance. **RESOLVED: That the Work Programme, as amended, be agreed.**
	The meeting, which commenced at 6.30 pm, closed at 8.07 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on nohalloran@hillingdon.gov.uk. Circulation of these minutes is to Councillors, officers, the press and members of the public.