APPENDIX B

HILLINGDON
LONDON

External Services Select Committee Review Scoping Report 2018/19

GP Pressures

Aim and background to review

Introduction

A review into GP pressures was originally initiated in 2015/16. Given that this topic continues to be of considerable importance and relevance today, the Committee has agreed to resume the review at this juncture. The proposed new review by an External Services Select Panel aims to consider the work undertaken by the previous Working Group. It will also examine changes which have occurred more recently with a view to making recommendations to Cabinet.

The NHS

The NHS was launched in 1948. It was born out of a long-held ideal that good healthcare should be available to all, regardless of wealth – a principle that remains at its core. With the exception of some charges, such as prescriptions and optical and dental services, the NHS in England remains free at the point of use for anyone who is a UK resident.

There are currently more than 66.6 million people in the UK, nearly 54 million people in England alone. The NHS in England deals with over 1 million patients every 36 hours. It covers everything from antenatal screening and routine screenings such as the NHS Health Check and treatments for long-term conditions, to transplants, emergency treatment and end-of-life care.

The NHS employs more than 1.5 million people, putting it in the top eight of the world's largest workforces together with the US Department of Defence, McDonalds, Walmart and the Chinese People's Liberation Army amongst others. The NHS in England is the largest part of the system by far, employing approximately 1.2 million people. Of those, the clinically qualified staff include approximately 106,430 doctors; 285,893 nurses and health visitors; 21,597 midwives; 132,673 scientific, therapeutic and technical staff; 19,772

ambulance staff; 21,139 managers; and 9,974 senior managers[1]. Nationally, it is estimated that GPs undertake approximately 90% of NHS activity for 7.5% of the cost, seeing more than 320 million patients each year.

In September 2016, there were (full-time equivalent): 15,827 nurses in GP practices; 10,009 GP direct patient care staff; and 65,334 admin/non-clinical staff. While the number of nurses in GP practices had increased by 429 (2.79%) since September 2015, the number of practice nurses declined by 67 (0.57%) over the same period. In March 2017, there were 33,423 full-time equivalent GPs (excluding locums), which is a reduction of 890 (2.59%) on March 2016[1].

Funding for the NHS comes directly from taxation. Since the NHS transformation in 2013, the NHS payment system has become underpinned by legislation. The Health and Social Care Act 2012 moves responsibility for pricing from the Department of Health, to a shared responsibility for NHS England and Monitor. When the NHS was launched in 1948, it had a budget of £437 million (roughly £9 billion at today's value). In 2017/18, planned spending for the Department of Health in England was around £124.7 billion.

GP Networks

General practice in England is under significant strain. Many GPs and their teams are struggling to meet the increasing pressures of decreasing resource and an increased burden of patients with long term conditions. Fundamental changes in the way the NHS works (financial rules and the creation of a competitive market) encourage competition between companies to bid for areas of work in the NHS and there are already a wealth of independent sector organisations providing services to patients under NHS contract.

An increasing number of GP practices are considering entering into some kind of collaborative arrangement with other practices. GP networks go by many names: federations, networks, collaborations, joint ventures, alliances. These terms are often used interchangeably to describe multiple practices coming together for a common goal. Whether this is driven by the desire to share costs and resources (for instance, workforce or facilities) or as a vehicle to bid for enhanced services contracts, providing general practice at scale is increasingly being viewed as the future of general practice.

The Hillingdon Primary Care Confederation has been created and HCCG has put measures in place to strengthen the existing GP Network infrastructure to support it to become fully operational and a more active provider of enhanced health care services. It is anticipated that this will ensure the GP community has the best opportunity to deliver consistently high quality healthcare to its local population. In 2017/2018, there were 46 GP practices in Hillingdon, 44 of which were members of the Hillingdon Confederation.

Joint Commissioning

In April 2017, full delegation of primary care commissioning authority was transferred from NHS England (NHSE) to HCCG. There are a number of benefits in exercising full delegation such as:

- Local management of medical contracts enables the CCG to offer more responsive 'customer care' to contractors and patients, grounded in better understanding of local needs.

[1] NHS Confederation - http://www.nhsconfed.org/resources/key-statistics-on-the-nhs

- Opportunity to develop closer relationships with a wide range of local stakeholders including local GP practices.
- Clearer lines of responsibilities and decision-making.
- More integrated strategic management of primary care enables a more joined up vision for primary care, which is aligned with the CCG's overall strategic objectives.
- Ability to manage primary care budgets locally that includes control of the CCG allocations, surpluses and various funding streams under GP Forward view.
- More flexibility in the design and development of Local Incentive Schemes that may include the development of alternatives to national Directed Enhanced Service (DES) or Quality and Outcomes Framework (QoF) if locally agreed.
- Full delegation may also help the development of new models of care as contracting with GPs networks and federations for a defined population requires a joined up local commissioning model, where a single, outcome-based contract may be agreed.
- Delegated commissioning also offers CCGs further opportunities to improve out-of-hospital services for local people and to support a shift in investment from the acute to primary and community settings.

In April 2106, NHSE set out plans to enable CCGs to commission and fund additional capacity across England to ensure that, by 2020 everyone has improved access to GP services including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services. In February 2018, NHSE published guidance which required CCGs to provide extended access to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. This must include ensuring access is available during peak times of demand including bank holidays and across the Easter, Christmas and New Year periods.

As pharmacists are well placed and well qualified, some GP networks have been engaging pharmacies with a view to help deliver long term conditions care. It is hoped that initiatives like this will enable GPs to have more time to deal with long term conditions and therefore provide continuity to patients.

To address the increased demand for hospital services, The Hillingdon Hospitals NHS Foundation Trust (THH) has been working with HCCG. A number of successful small pilots have been undertaken to provide better access to GPs and consideration is being given to how this can be scaled up across the Borough.

Better Care Fund (BCF)

The Better Care Fund (BCF) is thought to be one of the most ambitious programmes across the NHS and local government to date. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems.

In Hillingdon, the NHS and Hillingdon Council are looking for ways to improve the way that they work together as, when things go wrong, people can get stuck in hospital or be admitted to expensive nursing care when they would rather manage at home. A good example of where health care and social care need to work together is around agreeing the care needed at home to allow an older person to leave hospital sooner after a fall.

Work in Hillingdon includes a number of schemes which concentrate on:

- better services in communities
    - to provide support to people at risk of falls, dementia and/or social isolation
    - to offer better services at home for people who are terminally ill
    - to ensure that community services and GP practices work together more closely
    - to support people providing unpaid care for relatives or friends
- helping to prevent admissions to hospital
    - by offering good alternatives to the A&E service
    - by offering good community services every day of the week
    - by making it easier for GPs to keep an eye on people with more complex health needs
- getting people home quicker when they've been in hospital
    - by working better with care homes and nursing homes
    - by joining up the services we offer at people's homes

Challenges

GPs are currently facing a number of challenges and it is likely that improvements to the healthcare pathways will raise additional issues. These challenges include:

- the shortage in the number of individuals training to become a GP;
- the increasing population;
- the increasing acuity and number of conditions experienced by patients;
- the positive move to improve the health and social care pathway which will result in more patients being monitored by GPs;
- the increasing trend to move the care of people with long term conditions out of a hospital setting and closer to home at the GP surgery;
- the number of GPs that could retire in the next 5 years or move abroad; and
- Government proposals to ensure that everyone in England has access to GP services seven days a week.

Whilst the Council has limited direct responsibility in this area, the issues can still be reviewed locally with a view to making recommendations on behalf of the Council and residents.

Terms of Reference

The following Terms of Reference are proposed:

1. To review the evidence gathered by the GP Pressures Working Group in 2015/2016;
2. To understand the key / central current pressures that are faced by GPs;
3. To explore the possible implications for residents of expected changes to services provided by GPs;
4. To identify what support is currently in place for GPs and whether this level of support will be sufficient in the future;
5. To examine best practice elsewhere through case studies, policy ideas and witness sessions;
6. To explore ways in which services can improve and work more collaboratively to alleviate the pressures faced by GPs in the Borough, and recommend these to the appropriate body; and

7. After due consideration of the above, to bring forward recommendations to the Cabinet and, if required, the Health and Wellbeing Board, in relation to the review.

INFORMATION & ANALYSIS

Methodology

It is proposed that a Working Group be set up to examine background documents and receive evidence at its public and private meetings from officers and external witnesses. Research into relevant documents and websites would also be undertaken to provide background information for Members.

Witnesses

Possible witnesses include:

1. Local Medical Committee
2. GPs
3. Hillingdon Clinical Commissioning Group
4. The Hillingdon Hospitals NHS Foundation Trust
5. Public Health
6. Central and North West London NHS Foundation Trust
7. Healthwatch Hillingdon
8. GP Confederation
9. Local Pharmaceutical Committee

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WITNESS, EVIDENCE & ASSESSMENT

The table below sets out the possible witnesses that could be invited to present evidence to the Committee. It is proposed that witnesses are invited to attend themed sessions to ensure that issues arising are dealt with comprehensively and strategically. Members are reminded that this is not an exhaustive list and that additional witnesses can be requested at any point throughout this review.

Meeting	Action	Purpose / Outcome
ESSC: 10 October 2018	The scoping report will be presented to the Committee. Members will have the opportunity to agree/amend the terms of reference and/or propose alternative/additional witnesses.	Information and analysis
Working Group: 1st Meeting - TBC	Introductory Report / Witness Session 1 To gain evidence from the GPs to establish the pressures that they are facing	Evidence and enquiry
Working Group: 2nd Meeting - TBC	Witness Session 2	Evidence and enquiry
Working Group: 3rd Meeting - TBC	Draft Final Report	Proposals – agree recommendations and final draft report
ESSC: TBC	The draft final report will be presented to the Committee by Chairman of the Working Group.	Consider Draft Final Report
Cabinet*:* TBC	The draft final report will be presented to Cabinet by the Chairman of the Committee.	Cabinet may approve, amend or reject as many of the report's recommendations as it wishes.

Members may also wish to consider whether appropriate site visits should be undertaken on areas in which they require further information.

Assessment

As is standard practice for a Policy Overview and Select Committee review, once a report's recommendations have been agreed by the Cabinet, officers will be asked to begin delivering the necessary changes. The monitoring of officers' work is a fundamentally important aspect of the Committee's work and, as such, regular reports on progress can be requested by Members and a full update report will be added to the future work programme of the Committee.

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Resource requirements

This review will be undertaken within current resources. The plan set out above will be co-ordinated and delivered by Democratic Services. The additional resource of staff time required to present, collect and format evidence for witness sessions will also need to be considered.