Item 9 Appendix A

GP SERVICES
TASK AND FINISH GROUP
FINAL REPORT

March 2018

Working for Warwickshire

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1.0 Introduction

1.1 Executive Summary

Through this comprehensive review process, members have considered substantial written information and held four evidence gathering sessions, with representatives from a wide range of organisations. This resultant report proposed a number of recommendations which were approved by the Adult Social Care and Health Scrutiny Committee. It will be submitted to Cabinet, the Warwickshire Health and Wellbeing Board and partner organisations to consider. The recommendations can be seen at Section 2 (Page 6 onwards) and are grouped under the headings of:

National Issues - The evidence consistently showed a range of issues that will require national support and direction.

Issues for the Coventry and Warwickshire 'System' - As system leaders, the Coventry and Warwickshire Health and Wellbeing Boards are able to coordinate service delivery within the component organisations.

Areas within the control of an individual agency - The TFG makes recommendations for changes by the agency responsible for that service.

1.2 Appointment

The Adult Social Care and Health Overview and Scrutiny Committee (OSC) appointed a member task and finish group (TFG) to conduct a review of GP Services. It was agreed to co-opt representatives of district and borough councils to ensure the five areas of the County were represented. Through a scoping exercise, the TFG agreed to focus on the following areas:

- Primary Care profile in Warwickshire to include resources, demand, outcomes, quality.
- Primary Care Estate.
- Response to population changes and local plans.
- Community Resilience and Social Prescribing (subsequently, this aspect was withdrawn; another task and finish review is focussing on community capacity).

It was explicitly agreed that the review would not include patient experience, screening services, health checks and self-harm.

1.3 Members and Contributors

The eight members appointed to the Task and Finish Group were Councillors Margaret Bell (Chair, also representing North Warwickshire Borough Council), Keith Kondakor, Penny O'Donnell (Stratford District Council), Anne Parry, Dave Parsons, Pam Redford (Warwick District Council), Jerry Roodhouse and Jill Simpson-Vince.

The Task and Finish Group was supported throughout the review by The Director of Public Health, two of his staff and the Democratic Services Team. External support was provided by Clinical Commissioning Groups (CCGs) both through Chairs and executive officers, Healthwatch Warwickshire, with contributions from the local pharmaceutical and medical committees, planning officers from district and borough councils and the County Council's Infrastructure Development Manager.

1.4 Evidence

In order to achieve an understanding of the review topic, the Task and Finish Group considered both primary and secondary evidence from a range of sources. This included context from Dr John Linnane, Director of Public Health, a presentation from the Public Health Department which signposted to a variety of secondary information sources and a presentation from CCGs. In Section 3 of this report you will find the detailed reports on the evidence heard and key findings.

1.5 Dates and Timescales

Stage 1: A meeting to provide context and agree the scoping document for this task and finish review (See Appendix A) – October 2017.

Stage 2: Consideration of primary evidence, through presentations, questioning and more general discussion over four meetings – November and December 2017, January and February 2018.

Stage 3: The consideration of conclusions and recommendations from this Task and Finish Group (TFG) – March 2018

Stage 4: Approval of the final TFG report by the Adult Social Care and Health Overview and Scrutiny Committee – May 2018

Stage 5: Presentation of the TFG report to Cabinet and the Warwickshire Health and Wellbeing Board Executive – June and September 2018

2.0 Recommendations

The TFG and Adult Social Care and Health OSC make a series of recommendations grouped under the headings of 'National Issues', 'Issues for the Coventry and Warwickshire System' and 'Areas within the remit of individual agencies'. The rationale for each of the recommendations is summarised below. Subsequent sections of the report and appendices provide the detail which supports these recommendations.

1. **National Issues** - The evidence consistently showed a range of issues that will require national support and direction.

Recommendation 1.1 – Lobbying of National Government and Others

(i) That the Adult Social Care and Health OSC and Warwickshire Health and Wellbeing Board be recommended to lobby national government and planning authorities about the definition of infrastructure, the need for both capital and revenue funding streams and the need to recognise workforce within this context.

Rationale – Lobbying of Central Government by these bodies is recommended on the issues identified in the conclusions. There needs to be national recognition that it is not always the physical infrastructure which has limits on capacity. New housing developments should factor in the impact on workforce infrastructure and where necessary support this through developer contributions. The rules on infrastructure contributions from development, the current pooling limitations related to smaller developments and the different funding constraints on health and local authorities should all be reviewed, given the aims to integrate services.

(ii) That the Department of Health be lobbied to strengthen communications around appropriate NHS service use.

Rationale – There needs to be a national drive to raise awareness / educate people on the appropriate use of NHS services in order to alleviate pressures on general practice and enable GPs to focus on patients with the most complex needs. This should clearly set out the full range of self help, online and face to face services available to patients and the public, such as NHS 111 and local pharmacies.

2. **Issues for the Coventry and Warwickshire 'System'** - As system leaders, the Coventry and Warwickshire Health and Wellbeing Boards are able to coordinate service delivery within the component organisations.

Recommendation 2.1 – GP Capacity and Service Developments

That the Health and Wellbeing Board and Adult Social Care and Health OSC receive periodic updates on GP capacity and the locally derived solutions to meet the demands of population growth, which may include alternative provider medical services and funding for new services.

Rationale – Many of the conclusions reached in relation to the national issues are recognised by health commissioners and providers. Different solutions are put in place to respond to these issues appropriate to the locality. Sharing best practice on innovative solutions and where necessary lobbying at the national level are recommended.

Recommendation 2.2 – A Unified Response to Development Proposals

That the Health and Wellbeing Board seeks assurances across the Coventry and Warwickshire health economy that a unified and coordinated approach is taken to responding to housing growth and District and Borough local plans.

Rationale – NHS organisations are responding individually to planning applications. This may have an impact on where contributions are distributed. A more unified approach should ensure contributions are given to the services with the greatest capacity needs in relation to a particular area.

Recommendation 2.3 – 'Your Health is Your Responsibility'.

That the Health and Wellbeing Board, through its constituent partners publicises initiatives under the banner of 'your health is your responsibility'.

Rationale – This links to the lobbying of the Department of Health above. National coverage about the links between lifestyle choices and health impacts. There is a role for the Health and Wellbeing Boards as system leaders to champion this message as part of the proactive and preventative work stream of Better Health, Better Care, Better Value and the 'Year of Wellbeing'.

3. **Areas within the remit of individual agencies** - The TFG and OSC make recommendations for changes by the agency responsible for that service or where other agencies can assist.

Recommendation 3.1 – Assisting with Communication

That Warwickshire County Council and the five district and borough councils provide support to CCGs with awareness raising and publicity. Areas where we can assist are:

- ***Raise awareness / educate on appropriate use of GP services through joint communication with CCGs.***
- ***Strengthen the social prescribing / care navigation offer to ensure that patients are accessing the right services at the right times.***

Recommendation 3.2 – Suggested areas for further research

That CCGs give further consideration to the following areas identified through this review process:

- ***Appropriate use of pharmacies to provide additional capacity to GPs.***
- ***Research how the time required for clinical correspondence between acute service providers and GPs can be streamlined to increase capacity for GPs***
- ***Areas of good practice identified from reviews of GP surgeries by the Care Quality Commission and Healthwatch being shared by commissioners with all GP surgeries.***

Rationale – It is acknowledged that CCGs have plans in place and are undertaking extensive work, but they could articulate them better to local authorities and the wider population. Local authorities can assist with this communication role.

Warwickshire County Council and the district and borough councils are large employers. There are well established communication channels in each authority to publicise initiatives. Through Council departments and elected members, local authorities can assist with awareness raising of initiatives of commissioners and providers of services.

Part of the pressure on GPs is due to the inappropriate use of appointments so ensuring that referrals are made to other health and wellbeing services when necessary may help alleviate pressure. System capacity is also affected by people missing appointments. Many surgeries use text message reminders, which could be advocated to all GP surgeries as an area of best practice. There was evidence of the significant time required for clinical correspondence. Streamlining this will provide additional capacity for GPs.

Collaborative working between GPs and Pharmacists was an area discussed at some length. A recommendation could be formulated to the Health and Wellbeing Board (HWBB) to encourage the local medical and pharmaceutical committees (LMC and LPC) to work collectively on this. There were some concerns from a commissioning perspective. Ultimately this is a matter for CCGs and it will be impacted by the overall financial envelope available.

Recommendation 3.3 – Improve Communication of Service Developments.

That clinical commissioning groups (CCGs) work with district and borough councils to provide periodic briefings to the Adult Social Care and Health OSC and other Warwickshire local authorities to keep them informed of known substantial residential developments, the additional service requirements and how the CCG will respond.

Rationale - There is evidence of established communication channels and good working arrangements between the CCGs, district and borough councils and the County Council. This recommendation will ensure that the dialogue extends to elected representatives to assist with wider communication of the plans to improve health services and facilities. It could form part of an annual report on commissioning intentions.

Recommendation 3.4 – Future Review Area – Securing New / Improved facilities

That the Adult Social Care and Health OSC reviews the processes required to secure new and extended medical services. This should include potential barriers/blockages and how they can be resolved more efficiently. It is recommended that this includes consideration of pilot projects using GP clusters of flexible working arrangements to enable people to access GP services in different ways.

Rationale - Evidence gathered through this review shows the potential for delays at several stages in providing new GP practices and other services. The replacement GP practice at Brownsover in Rugby Borough demonstrates this particularly. An area for further review is how to streamline the processes associated with Section 106 contributions, the viability arguments against developer contributions, achievement of ‘triggers’ for funding release at the earliest possible date and then understanding how agencies can work together more efficiently to utilise the funding to deliver new services in a timely manner to meet service demand.

Warwick and Stratford District Councils secure some infrastructure contributions through the Community Infrastructure Levy. The remaining districts and boroughs use the Section 106 provisions. This is a matter for each local authority, but there may be a useful dialogue between them to secure the maximum (and consistent) contributions across the County.

Data shows that younger patients generally favour modernised flexible ways to access GP services more than some older patients. The complexity of the patient's condition also influences whether they wish to visit the same GP throughout their treatment. People with chronic, long-term conditions generally prefer to see the same doctor.

Recommendation 3.5 – Review of Contracts

That Strategic Commissioning revisits its contracts with residential care homes to explore opportunities to seek incorporation of primary care service provision into developments and that the relevant CCG is involved in these discussions. It is recommended that the Adult Social Care and Health OSC add this as an area to its future work programme.

Rationale - An area for further consideration is the care sector and the impact for GPs when called to residential or nursing homes. The elderly patient cohort has the most complex healthcare needs and places the greatest level of demand on GP time and capacity. Some of the functions that GPs are now called for could be delivered in other ways. This requires a system approach to reduce calls for GP service when they could see more patients during the same time in surgery.

3.0 Overview

3.1 Background

At its meeting on 13 September 2017, the Adult Social Care and Health OSC commissioned this task and finish review of GP Services. The drivers for a review at this time were the GP Five Year Forward View and to understand the impact of projected residential development throughout the County. The areas of focus suggested were the need for extra GP surgeries, the location of additional surgeries, issues for rural areas and workforce aspects.

3.2 Objectives

The objectives of this review were:

- To gain an understanding of service demand and levels of pressure on GPs.
- Identify the potential to reduce these pressures and particularly areas where the County Council has an influence, including through the Health and Wellbeing Strategy and CCG strategies.
- An education role to reduce unnecessary GP appointments
- Directing people to the appropriate health services including pharmacies or NHS helplines.

A copy of the full scope for the review is attached at Appendix A.

4.0 Detailed Findings

4.1 Secondary Evidence

An initial presentation was provided by the Public Health department, which signposted members of the TFG to a range of information sources. Each document was considered by the Group.

4.2 Primary Evidence

The TFG invited contributions through a number of evidence gathering sessions. The detailed report of each session are provided at Appendix B (from page 21):

24 October	Context from the Director of Public Health
20 November	Presentations and evidence from Public Health and CCGs
5 December	Presentations and evidence from the Warwickshire Local Pharmaceutical Committee and Healthwatch Warwickshire
17 January	Evidence from the Warwickshire Local Medical Committee
19 February	Evidence from Infrastructure Delivery Manager and district and borough council planning officers

5.0 Conclusions and Recommendations

5.1 Findings

The Task and Finish Group noted a number of recurring themes from the different evidence sources. The conclusions and from these the recommendations fall under categories of:

- ✓ National issues – these cannot be resolved for Warwickshire in isolation and require recommendations for national assistance.
- ✓ Those which require a Coventry and Warwickshire 'system approach'. These are areas to be considered by the Health and Wellbeing Boards for Coventry and Warwickshire.
- ✓ Those which can be progressed by the County Council and other individual agencies, through recommendations to commissioners or providers of services.

5.2 National Issues

The evidence consistently showed a range of issues that will require national support and direction. It is concluded that the key aspects are:

- The traditional GP partnership model is unlikely to be sustainable.

- There are GP staffing shortages, exacerbated as 600 GP training places are not filled each year. Once trained, only two thirds of GPs are planning to work in the NHS, with many younger GPs preferring to be salaried, to work as locums, privately or going abroad. GP's are retiring early, due to a number of drivers and 40% of GPs are over 50 years of age. Part time working is a further issue.
- Service redesign needs to provide the best working model for the patient. It is important to recognise that different models will be needed for different locations, but it is equally important not to create dual systems, which will complicate working arrangements with other parts of the health system. Some patients (and GPs) are resistant to change. Data shows that younger patients generally favour modernised flexible ways to access GP services more than older patients.
- Assistance with meeting increasing service needs. There are different funding systems and constraints for CCGs and local authorities. The key funding sources arising from development are the Community Infrastructure Levy (CIL) and Section 106 agreements. Timing for the release of this funding doesn't easily fit with the increased service need arising from population growth.
- Innovative solutions are needed, including shared use of premises and co-located services to deliver a health and wellbeing approach. In rural areas there aren't the economies of scale to have co-located services.
- Each GP is a private business. It has a 'red line' boundary beyond which it is not obliged to offer services. Furthermore a practice could 'close the list' and not be required to take on additional patients within its boundary.
- There are a range of issues associated with population increases from additional housing development. Provision of capital funding (for example for a new building) is not always the solution; contributions to meet the longer term revenue costs are also needed. This is not feasible through Section 106 funding. There are limits on aggregating contributions from smaller developments as only five developments can be 'pooled' for this purpose. Lobbying to remove these national pooling restrictions could be helpful.

5.3 Issues for the Coventry and Warwickshire 'System'

As system leaders, the Coventry and Warwickshire Health and Wellbeing Boards are able to coordinate service delivery within the component organisations. The conclusions directed to these bodies comprise:

- The TFG acknowledges it is the role of CCGs to look at major site developments (and the cumulative impact of smaller developments), the existing GP surgeries covering the area and the options available to meet future population need.
- Review the timeline and the processes required for provision of a new or expanded GP practice, with agencies working cohesively to understand and remove causes for delay.

- Areas of good practice from reviews of GP surgeries by the Care Quality Commission (CQC) and Healthwatch should be shared by commissioners with all GP surgeries. It is recognised that each GP is a private business, so these can only be recommendations and not mandatory. Each practice will have differing circumstances and some recommendations won't suit all practices.
- Patient migration has been referenced. GP shortages in some locations may mean patients don't move GP when they relocate, for example from Coventry to Warwickshire. Cleansing of GP patient records is advocated There are two issues, first people who have moved within UK but not moved their registration. The second are people who came to the UK to work or study and have since left the UK. These are the ones that are called ghost patients.
- There is potential to develop the current work on care navigation. The TFG heard evidence from the Local Pharmaceutical Committee (LPC), about changes to the Herefordshire system to provide pharmacy support to alleviate some of the current pressures on GPs. This could help for example with assessment of minor ailments, medication reviews and increasing the dosage of medications authorised in advance by GPs.
- It is recognised that there is a range of complexities including an additional training need for GP receptionists to provide this 'care navigation' advice, to build relationships between the GP and pharmacists, with the benefits of co-located pharmacies being referenced. Warwickshire CCGs are training some receptionists and working with CAVA on signposting / care navigation. There was some scepticism amongst GPs and particularly the Local Medical Committee (LMC) on the capacity of pharmacy to take on further roles.
- Issues around patients not taking their prescribed medication and/or repeat prescriptions being automated where the patient doesn't continue to need some of those medicines. This is an unnecessary cost to the health system.
- For smaller/rural GP surgeries, the option of a co-located pharmacy may not be feasible. A suggestion to provide these services on rotation, or to establish rural dispensing practices, with a pharmacist as part of the team.
- Locating staff in nursing and residential care homes, to provide an initial filter, reducing avoidable GP appointments. Lost time and reduced appointment availability when the GP visits patients in the care home.
- Recognition that pharmacists, like GPs are private businesses. There are areas where pharmacy could reduce GP workloads and the Health and Wellbeing Board could consider this from a system-wide approach. There is an opportunity when commissioning new or additional services.
- Clinical correspondence and the optimisation of medical reviews are potential areas for review to enable GPs to focus more on patients.

Reducing the administrative workloads generated between acute trusts and GPs would be helpful.
If some, but not all GPs adopt the recommendations this would result in a dual system of service provision which would be less efficient than the current arrangements. A round table discussion involving GPs, commissioners and pharmacy is suggested to discuss how this approach could work in practice. A key role for the County Council to educate communities, through its elected members as community leaders and the council's staff.

- Undertaking pilot schemes where patients with minor ailments are signposted to pharmacists. A need to identify willing partners to participate in trials. The revised commissioning requirements to meet substantial housing growth in Rugby, was suggested as an area where this could be trialled.
- Commissioning of services delivered at care and nursing homes. Workforce issues associated with Brexit are significant, both for medical staff and care workers. A solution could be to train staff locally, but there is no career progression currently from care to nursing. Making care work and nursing more attractive is an area of needed change.
- Agreeing protocols with care homes to reduce unnecessary reliance on GPs and other parts of the NHS. Some care homes have policies which didn't align with NHS or national guidelines, an example being the 'no lifting' policy after a resident has a fall. A proactive approach is needed to manage demanding cases in the community and to change the culture of reliance on GPs.
- The Local Medical Committee (LMC) perceived a lack of consultation on some service development issues, despite there being a formal requirement to do so. Its representatives were concerned about the increasing demands associated with care home developments where patients had to be visited, rather than them attending the practice. In Rugby area there was a current shortage of GPs and significant development plans. Care homes now accepted people who previously would have resided in a nursing home. Those residents had more medical needs and there were increasing numbers of dementia cases. Nursing homes no longer provided the services they used to, with GPs now attending for such things as providing vaccinations or to confirm the death of a resident.
- Ensuring care homes remained sustainable and financially viable was a challenge and taking a system approach was advocated. For example, investment in nursing staff in care homes would reduce demands on GPs, but the cost to social care would rise and consideration would be needed of how to fund this as a system.
- WCC was working with Coventry University to explore the viability of a course which spanned both social care and health.
- On GP service delivery, the LMC was asked how best practice could be shared with and adopted by other GPs. The LMC was concerned at the ability to adopt such an approach without reducing the number of

patients they were able to see. The focus should be to meet patient 'needs' not 'wants'. Many GPs went 'over and above' core requirements.

- There are a range of issues associated with population increases from additional housing development. There can be substantial delays between commencement of development and the additional monies being received. This creates a timing challenge to assess when new services will be needed and impacts on existing services in the interim. Cross border developments also have to be taken into consideration. There are different issues for more rural communities. The CCGs have plans to expand and/or provide additional GP surgeries, having undertaken options appraisals for some areas already.
- Agencies have to balance contributions against the developers' viability argument and in some cases agencies don't claim all entitled contributions.
- An area for further consideration is borrowing against known future S106 funding contributions, to deliver new premises in a more timely and cost efficient way. Building costs for new facilities will increase. At paragraph 6.1, Finance colleagues have provided additional context that will need to be weighed. This is not a cost neutral option. The costs of servicing the resulting debt would need to be funded from the relevant organisation's revenue resource. This is not a cost free option. There is however the option for organisations to provide forward funding for infrastructure developments.
- Similarly, the time from planning consent to construction often meant an increase in the value of each house. This should be considered when developers used the viability argument to reduce infrastructure contributions. Officers do revisit contributions where they can.
- Some developers pay their S106 contributions at an early stage, which presents a different challenge, in that spending of the monies has to be achieved by a deadline, or there is the potential for 'clawback' of the monies.
- From the discussion with planning officers, the value of regular discussion between the various agencies in planning for large developments was stated. Avoiding the potential for individual challenges or an aggressive approach to securing funding and the need to evidence spending of infrastructure contributions, to avoid potential 'clawback' of unspent monies was noted.
- There are established forums for liaison between the agencies and a regular dialogue between officers on planning and the potential for infrastructure contributions. It is evident that those in the south of the County are better established and can be developed for the north of Warwickshire. A need to ensure that Coventry is involved also.
- For future planning applications, adopting a site specific approach is suggested to bring together the relevant agencies for that area.

5.4 Areas for individual agencies including the County Council

There are several aspects where the County Council can assist directly as a large employer and through its elected members as community leaders. Similarly there will be other areas where individual agencies can do likewise.

- Assist with communication strategies to reduce the numbers of cancelled and unnecessary GP appointments. Publicise internally to WCC staff and elected members and externally in communities, through parish councils, patient forums and partner organisations. This consultation role could extend to the points about care navigation.
- Make patients more aware of their responsibility for their own health and to manage their conditions.
- Through publicity and engagement, work with CCGs to inform the public about new models of delivery for primary care.
- From the oral evidence session with the LMC, an area where local councils could do more was engagement on planning matters.
- It would be useful to investigate how the County Council, GPs and care homes could agree a way forward on the filtering the calls made to GPs where other parts of the system could respond.

6.0 Financial and Legal Implications

The views of relevant Directors/ Heads of Service, Finance, Legal and Equalities and Diversity have been sought on this report, prior to its submission to the Adult Social Care and Health Overview and Scrutiny Committee. Their feedback is set out below.

6.1 Finance

There are no direct and immediate financial implications arising from the recommendations of the Task and finish review of GP Services for the County Council. However, several of the recommendations, depending on how they are taken forward, may have financial implications in the future. These include:

- A recognition of the increased need for funding for enhancing GP capacity and alternative provider medical services when prioritising the infrastructure needs, arising from new housing developments.
- The review of Strategic Commissioning contracts with residential care homes to seek incorporation of primary care service provision into developments.

Any financial implications or priorities for investment identified, be brought forward for consideration through the process for agreeing the One Organisational Plan and the associated medium term financial planning and

annual budget refresh. In this way the issues can be considered alongside other priorities for the use of the Council's scarce resources.

There are references in the report for the timing of receiving developer funding and when the need for infrastructure on the back of housing developments arises. The advance funding for infrastructure will always be a cost, whether incurred by the developer or forward funded by the relevant public body. The option for any public section organisation, (including the County Council), to borrow against known future S106 funding contributions is not cost neutral. The costs of servicing the resulting debt would need to be funded from the relevant organisations revenue resource until such time as the S106 funding is received.

Appendix A
Scoping Document

Review Topic (Name of review)	GP Services Task and Finish Group
TFG Committee Members	Councillors Margaret Bell, Keith Kondakor, Penny-Anne O'Donnell (SDC), Anne Parry, Dave Parsons, Pam Redford (WDC), Jerry Roodhouse and Jill Simpson-Vince.
Co-option of District and Borough members (where relevant)	District and borough council representation has been sought to ensure local input from each of the five areas of Warwickshire. Councillors Penny O'Donnell (SDC) and Pam Redford (WDC) appointed. Councillor Margaret Bell represents both WCC and NWBC.
Key Officers / Departments	John Linnane (Director of Public Health), Emily Fernandez and Gemma McKinnon (Public Health)
Lead Democratic Services Officer	Paul Spencer
Relevant Portfolio Holder(s)	Councillor Les Caborn, Portfolio Holder for Adult Social Care and Health
Relevant Corporate Ambitions	The Health and Wellbeing of all in Warwickshire is protected
Type of Review	Task and Finish Group (TFG)
Timescales	Complete review and report to the March 2018 Adult Social Care and Health Overview and Scrutiny Committee
Rationale (Key issues and/or reason for doing the review)	Identifying the problems that exist now and those anticipated in the future, including the aging population, increasing demands on health services, at the same time as decreasing GP numbers.
Objectives of Review (Specify exactly what the review should achieve)	To gain an understanding of service demand and levels of pressure on GPs. Identifying the potential areas to reduce these pressures and particularly areas where the County Council has an influence, including the Health and Wellbeing Strategy and CCG strategies. An education role to reduce wasted/unnecessary GP appointments and directing people other services including pharmacies or NHS helplines, where these are appropriate.

Scope of the Topic (What is specifically to be included/excluded)	<u>Include - There are four main themes</u> 1. Primary Care profile in Warwickshire to include resources, demand, outcomes, quality: • Consideration of the GP Five Year Forward View: https://www.england.nhs.uk/gp/gpfv/ • Mapping of services. Examine current GP service capacity and future capacity based on predicted population growth. Use waiting times for non-urgent appointments and the availability of emergency appointments as indicators. • Establishing a baseline of what constitutes 'good practice', which could include co-located services, alternative models of service delivery, out of hospital commissioning and from this learning, to share the good practice with others. • Qualitative research on comparative demands for health services. • Review recent CQC and Healthwatch data for Warwickshire GP practices. 2. Primary Care Estate • Seek information on the CCG 'estates', their adequacy for the next 10 years and additional planned provision of medical centres and GP practices, being mindful of the 'other work being undertaken' section below. • Travel distance to the GP and the proportion of patients who aren't registered with a GP. 3. Response to population changes and local plans • Patient migration. This will include the implications of older people housing developments and the costs of providing medical services for those with complex/greater medical needs**.** • Explore with CCGs how they interact with the planning process to secure financial contributions for health services from new developments and the 'triggers' for release of funds. 4. Community Resilience and Social Prescribing • Examine how the One Organisational Plan contributes to social prescribing, the sustainability of the voluntary sector and the increasing reliance on this sector. It is important to focus on the areas where the County Council has most influence, also avoiding duplication of work as there is a planned review of community resilience due to be scoped shortly. <u>Does not include</u> • Patient experience, screening services, health checks and self-harm are outside the review's scope.

How will the public be involved? (See Public Engagement Toolkit / Flowchart)	• Ask Healthwatch Warwickshire to contribute as the patient voice and given the extensive work on GP 'enter and view' visits. • Invite representatives of the Patient Participation Group Chairs' forum. • Review CQC patient surveys.
What site visits will be undertaken?	• No site visits are planned.
How will our partners be involved? (consultation with relevant stakeholders, District / Borough reps)	• Involvement of the three clinical commissioning groups, Healthwatch Warwickshire and the Patient Participation Group Chairs. Also, meet with the local medical committee (GP representatives) and the local pharmaceutical committee
How will the scrutiny achieve value for money for the Council / Council Tax payers?	• Provide evidence, conclusions and recommendations for consideration and implementation both within the County Council and by its partners. • Explore the synergies that can be achieved from partnership working.
What primary / new evidence is needed for the scrutiny? (What information needs to be identified / is not already available?)	The following people be invited to contribute: • The three clinical commissioning groups, Healthwatch Warwickshire and the Patient Participation Group Chairs. • Kushal Birla - the County Council's lead officer on social prescribing. • Paul Tolley, CAVA - the voluntary sector perspective on social prescribing • The local medical committee (GP representatives) and the local pharmaceutical committee • Mark Ryder, Chair of the County Infrastructure Group
What secondary / existing information will be needed? (i.e. risk register, background information, performance indicators, complaints, existing reports, legislation, central government information and reports)	• General Practice Five Year Forward View Document. • CCG briefing and overview of the key work programmes • Director of Public Health to pull together a GP data pack of key information, with patient numbers per GP and patient profiles, working with the Observatory and others, the data pack to be disaggregated for each district/borough area, **if possible** • Links to web sources including the CQC inspection reports and Healthwatch 'enter and view' visits to GP surgeries. • Data on CCG estates and an infrastructure spreadsheet.

Indicators of Success – (What factors would tell you what a good review should look like? What are the potential outcomes of the review e.g. service improvements, policy change, etc?)	• The review should conclude with a report containing a series of recommendations to the Overview and Scrutiny Committee, Cabinet and partners outside the County Council. This may identify further areas for consideration as subsequent reviews.
Other Work Being Undertaken (What other work is currently being undertaken in relation to this topic, and any appropriate timescales and deadlines for that work)	There is a range of work being undertaken around GP service planning: • All three CCGs as commissioners of primary care have undertaken an utilisation exercise to understand the capacity within the current estate. This also factors in planned housing growth to highlight how existing estate would manage growth. • From these plans the CCGs produced strategic estates plans which identify any potentially estate opportunities and constraints across the locality. These also factored in the emerging STP work and GPFV • Alongside these strategic plans the CCGs host regular Local Estates Forums (LEF) with a range of health and local authority partners to discuss health infrastructure on a locality by locality. It is here that discussions around S106 requests, responses to planning applications and general estate updates are given. • These groups feed into the wider STP Estates Strategy Group which is where discussions aligning to any estate plans are held and where governance dictates that any new plans and/or disposals have to go through the group to be approved. • For SWCCG the GP practices attend on a rotating basis, dependant on the locality focus and this is where main engagement takes places and opportunities for CCG, providers and GPs to have an open discussion • For WNCCG each project has a smaller team and within the engagement with GPs takes place.

Appendix B
Primary Evidence Detail

1.1 Context – 24 October

As part of the scoping of the review, Dr John Linnane, Director of Public Health summarised the national issues faced by General Practice (GP) doctors:

- A national shortage of GPs, but the position in Warwickshire was not as bad as some locations.
- Only 76 practices across a large rural county (approximately the same number of GP practices serve the city of Coventry).
- A recent GP practice closure and other planned mergers / closures being considered in both Warwick and the north of the County.
- GPs taking early retirement in their fifties and a proportion of GPs who work on a part time basis.
- A shortage of practice nurses.
- National and local drivers for change - GP Five Year Forward View and the Out of Hospital Programme.
- Changes to the way public bodies deliver community services, working with the voluntary and community sector through a 'hub' approach.
- Social prescribing - there are many differing unconnected models of delivery. A conversation is needed to share good practice.

1.2 Evidence Session – 20 November

1.2.1 Public Health Presentation

To provide a baseline and background a presentation with high level data was provided which included links to further reading and information sources. The presentation included:

- GP practices in Warwickshire
- Population profiles and growth
- Care Quality Commission (CQC) reports
- Further data available at GP level
- GP workforce, practice size and GP to patient ratios
- Local plans on demand
- SHAPE tool (information mapping for each practice)
- Joint Strategic Needs Assessment place based profiler tool

1.2.2 CCG Contribution

Throughout the evidence gathering stage of the review, support was provided by the Chairs and executive officers of the three Coventry and Warwickshire

CCGs. The CCGs commission services for their respective area, including GP Services. The CCG Chairs are current or retired GPs, also serving on the Warwickshire Health and Wellbeing Board, making them a valuable contributor to the work of this group.

1.2.3 The CCGs made a combined presentation, giving background, current national drivers and local issues. This included:

- Data on patient population, the number of practices, the move to delegated commissioning, practice changes and CQC inspections.
- GP patient surveys, showing overall patient experience, access and confidence in GPs and nurses.
- General Practice Forward View (GPFV), the five pillars on which it is built – Investment, Workforce, Workload, Practice Infrastructure and Care Redesign and how the CCGs are responding.

1.2.4 Learning points from this evidence:

- There are current GP staffing shortages. Contributing factors are early retirements and part time working. There are extra costs for the practice where several people are employed as one full time equivalent.
- Population age is directly linked to levels of service need. This is notable for the Coventry and Rugby areas (covered by the same CCG). In Coventry, there is a high number of students, unlike Rugby and the rest of Warwickshire, which have an older population.
- The traditional GP partnership model is unlikely to be sustainable. Many younger GPs are salaried or choose to be locums. A shortage of new GPs and many are not choosing to work in the NHS.
- Service redesign needs to provide the best working model for the patient. Some patients (and GPs) are resistant to change. Data shows that younger patients favour modernised flexible ways to access GP services more than older patients.
- Planning for predicted growth. Related to this are migration of population, the link between economic and population growth and government direction on increasing affordable housing development.
- Understanding GP capacity both now and in the future as a result of housing growth. A finding that additional GPs will not provide the whole solution. GP services are only part of primary care services.
- Complexities around funding for development of additional and expanded GP Services. CCGs cannot own assets but do contribute towards additional / expanded premises. For leased premises, a disparity between the assessed and commercial rent levels. Variance across the County and between town centre and edge of town /out of town locations.
- Innovative solutions include shared use of premises, with co-located services to deliver a health and wellbeing approach. This may include third sector, charity groups, faith groups and local authority services.

This will recycle the funding contributions from development back into the public sector.

- In rural areas there aren't economies of scale to have co-located services. Different solutions will be needed for smaller communities. There are differing issues across the County. In some areas it is more difficult to attract GPs, whilst in others there are additional service demands due to a higher number of care homes. It takes much longer for home visits, reducing the number of patients seen in surgery.
- Delays in providing new services. The example quoted was for the replacement Brownsover GP surgery.
- Comparing the location of current GP surgeries and the areas they serve with known development requiring additional services. In Rugby, for the mast site development there are presently just two GP practices within the area affected. Each practice has a 'red line' boundary beyond which it is not obliged to offer services. Furthermore a practice could 'close the list' and not be required to take on additional patients within its boundary. GP practices are private businesses.
- There are different funding systems and constraints for CCGs and local authorities. The key funding sources arising from development are the Community Infrastructure Levy (CIL) and Section 106 agreements. Timing for the release of this funding doesn't easily fit with the increased service need arising from population growth.

1.2.5 Areas identified for further discussion:

- Overlaying the 'red line' boundaries of current GP practices with development plan sites to see if some are outside the boundaries of current GP practices.
- A timeline and the process required for provision of a new GP practice. Understanding and removing causes for delay.
- There is a known shortage of GPs and practice nurses nationally. It would be useful to consider how services could be delivered differently, with more involvement from the third sector and use of social prescribing. Diverting demand away from primary care is a key strand of the Out of Hospital work currently underway.
- The use of Section 106 and CIL monies. Advice to be sought from WCC officers about how to 'pump prime' developments / services. Another way might be the contribution of land in exchange for development to secure services.
- The TFG should review areas deemed as good practice and share its findings with other GP surgeries.

1.2.6 Potential Action Areas:

- Assist with communication strategies to reduce the numbers of cancelled and unnecessary GP appointments. Publicise internally to

WCC staff and elected members and externally in communities, through parish councils, patient forums and partner organisations.
- Make patients more aware of their responsibility for their own health.
- Through publicity and engagement, work with CCGs to inform the public about new models of delivery for primary care.

1.3 Evidence Session – 5 December

1.3.1 Contribution from Warwickshire Local Pharmaceutical Committee (LPC).

Fiona Lowe and Theresa Fryer of the Coventry and Warwickshire LPCs provided evidence to the TFG. Fiona is Chief Officer of the Coventry, Warwickshire, Hereford and Worcestershire LPCs.

1.3.2 The areas discussed and key findings were:

- There are 113 community pharmacies across Warwickshire, of which 80 are healthy living pharmacies.
- Service reviews in Herefordshire to ‘signpost’ some patients away from the GP to other service providers. Additional training is required for GP receptionists to provide this ‘care navigation’ advice.
- Consideration of potential Warwickshire services which could be directed to pharmacy including some minor ailments.
- A range of complexities and potential barriers to success
    - some services are not available to all age ranges
    - a financial argument for patients entitled to a free prescription
    - some medicines can’t be supplied without a prescription.
- The work in Herefordshire started in November; the initial feedback was positive, but a longer timeframe would give more meaningful data.
- The need to build relationships between the GP and pharmacists. This is easier where a pharmacy is co-located in the GP practice. Potential barriers are frequent staffing changes in larger pharmacies and use of online prescription services.
- Care navigation. Warwickshire CCGs are training some receptionists and working with CAVA on signposting / care navigation. Differing views amongst GPs about care navigation and it isn’t suitable for all patients.
- Pharmacists cannot prescribe medication. Aside from the potential conflict of interest, GPs have the diagnosis responsibility, before a pharmacist could fulfil the prescription.
- There are monies from Public Health Warwickshire, to ‘pump prime’ healthy living pharmacies and initiatives around prevention, wellbeing and to assist with chronic illnesses.
- Issues around patients not taking their prescribed medication and/or repeat prescriptions being automated where the patient doesn’t

continue to need some of those medicines. This is an unnecessary cost to the health system.

- Electronic prescriptions for some lifetime conditions are helpful.
- Some patients (and GPs) are resistant to change. A considered communication plan would be needed. This is an area where local councils and MPs could assist, rather than lobbying against service changes.
- Rotating pharmacy services around smaller GP surgeries, where they can't be collocated on a permanent basis. Another option is to have a rural dispensing practice, with a pharmacist as part of the team.
- Limitations on influence. Pharmacists and GPs are private businesses. Whilst there are areas where pharmacy could reduce GP workloads, it was a case of recommendation and suggestion rather than instruction on proposals for improvements for patients.
- GP services are not sustainable in their present form. There is a growth in demand from an ageing population, long term illnesses and increasing numbers of frail elderly people. There needs to be a common sense and system-wide approach rather than silo working.
- A good role for this group and the County Council is to recommend changes to contribute to that system wide approach including to the Health and wellbeing Board.
- Clinical correspondence has been recognised as a key area of GP workload that could be directed elsewhere.

1.3.3 CCG Commentary on Pharmacy Contribution

The attendance of CCG officers and GPs at this session was helpful. They were able to explain the initiatives already being implemented:

- Workforce models are being reviewed.
- There is a shortage in the numbers of people receiving training and once trained many move on to more senior roles.
- Increasing demand for support in care homes. GPs, pharmacists and others could be collocated at the home, but the residents have choice of which GP they registered with.
- The optimisation of medical reviews was seen as an area for review.
- CCGs are already working on many of the areas referenced, but perhaps could articulate this better.
- The potential for recommendations from the TFG to be adopted by some, but not all GPs. This could result in a dual system of service provision within an area which would be less efficient than the current arrangements.
- An opportunity when new services were commissioned and through that processes could be redesigned.

1.3.4 Summary of key learning on areas where pharmacy and others could assist GPs, together with the measures required to facilitate this:

- Assistance by pharmacy with medical reviews and treatment of minor ailments.
- Increasing the dosage of medications authorised in advance by GPs (often repeat appointments for a GP where a gradual increase could be authorised in advance, in conjunction with the pharmacist).
- Support in nursing and residential care homes, to provide an initial filter, reducing avoidable appointments.
- More medical reviews could be undertaken by practice nurses. They could act as a filter, only raising issues of significance with the GP.
- Good communication and a formal two-way referral system between the GP and pharmacist are essential.
- Reducing the waste of resources for unneeded repeat prescriptions.
- A public education role that the County Council would assist with.
- A round table discussion involving GPs, commissioners and pharmacy to discuss how this approach could work in practice.
- Recognising the training need for medical receptionists and allocating sufficient resources to give capacity for care navigation. However, this shouldn't provide a barrier to a person seeing their GP.
- Sharing the learning from this review to educate residents, through elected members as community leaders and the council's staff.
- Undertaking pilot schemes where patients with minor ailments are signposted to pharmacists. A need to identify willing partners to participate in trials. The revised commissioning requirements to meet substantial housing growth in Rugby, was suggested as an area where this could be trialled.

1.3.5 Healthwatch Warwickshire (HWW)

Chris Bain, Chief Executive of HWW gave an overview of the work completed over a two-year period to assess every GP surgery in Warwickshire through 'Enter and View' visits. A copy of the report is available via this link: (http://www.healthwatchwarwickshire.co.uk/our-reports/gp-practices/).

Key findings from the HWW work were:

- The demographics of Warwickshire - a growing and aging population, some people have complex conditions.
- The Secretary of State for Health had stated the need for an extra 5000 GPs nationally by 2020, which was not achievable with the training lead time required.
- An increase in GPs working on a part time basis.
- GPs not wanting to be a practice partner.
- 600 GP training places are not filled each year.

- Once trained, only two thirds of GPs plan to work in the NHS, with many working as locums, privately or going abroad.
- GP's retiring early; 40% of GPs are over 50 years of age.
- The implications of Brexit – there had been a significant reduction in the number of overseas GPs coming to the UK.
- There is a shortage of practice nurses too.

From its findings, Healthwatch had suggested potential solutions:

- Don't address primary care in isolation – a system wide approach is needed.
- The need for the public to take more responsibility for their own care and manage their conditions. This was a potential communication aspect for the County Council and others.
- An enhanced role for community nurses in care homes.
- Making the health and care professions more attractive; there is a lot of training needed and to retain these people after their training.

The key learning from this session was:

- On staffing levels, long term vacancies for GPs and workforce issues associated with Brexit are significant concerns. The same concerns are pertinent for the County Council and for the care sector. A solution could be to train staff locally, but there is no career progression currently from care into nursing. Making care work and nursing more attractive is an area of needed change.
- Reducing the administrative workloads generated between acute trusts and GPs would be helpful.

1.4 Evidence Session – 17 January

1.4.1 The Local Medical Committee (LMC) gave oral evidence at this session, being represented by Drs Bill Fitchford, Lesli Davies and David Weston. The LMC's perspective was sought on current issues for GPs and areas where the County Council may be able to assist.

1.4.2 There seemed a lack of consultation with the LMC on some issues where it should be involved, to give the view of local doctors. An area where local councils could do more was engagement with the LMC on planning matters. The staffing issues for both GPs and practice nurses raised at previous TFG meetings were reiterated. Many staff are leaving the service and recruitment of replacements is a challenge. In the Rugby area there is a shortage of GPs and significant development plans (the mast site). Additionally there has been a practice closure and considerable delays in providing its replacement. On GP service delivery, system capacity is an issue and the focus should be to meet patient 'needs' not 'wants'.

1.4.3 There has been an increase in the number of care homes in the south of the County. New care homes import people with higher dependencies who have to be visited, rather than them attending the practice. This takes much more of the GPs time. Hospital discharge processes and the provision of adequate care packages were raised. If these were not in place or were inadequate, GPs were involved and the patient could be readmitted to hospital.

1.4.4 Questioning and discussion took place on the following areas:

- How the LMC and CCGs work together. There is a frequent dialogue, but a view that CCGs were not representative of all GPs.
- Consultation on major planning developments included CCGs, but not the LMC. The CCGs hold bimonthly estate forums to which local GPs are invited. The meetings could include discussion of any major development proposals. It was noted there was a statutory requirement for CCGs to consult the LMC on new practice developments.
- A perceived system disconnect between different parts of the NHS and the care sector. Care homes should be viewed as a part of primary care. A need for a proactive approach to manage demanding cases in the community and to change the culture of reliance on GPs. This could be raised through the HWBB to seek a system wide approach.
- Views were sought about how pressure on GPs could be reduced by redirecting some patients to other parts of the system. Could minor ailments be referred to a pharmacist? The LMC representatives' view was there were already many demands on pharmacists. The key factor was the variable levels of training. The co-location of a pharmacist was considered beneficial. From a financial perspective, if the co-located pharmacy was making a loss, then after three years the GP surgery had to support it financially.
- The perceived differences between the north and south of Warwickshire in terms of GP numbers and being 'under doctored'.
- It was questioned how best practice identified in GP surgeries could be shared with and adopted by other GPs. An aspiration of a 'gold standard' couldn't be afforded. Many GPs had areas of interest, which meant they provided additional services or support for those areas, even though the practice received no additional funding for it. If a gold standard approach was implemented, the time with each patient would increase and less patients would have access to their GP. Alternatively, if GPs only delivered contracted services, the level of service would be less than currently provided.
- Data showed a reduction in the number of care home beds across the county. In the south, there were several new developments, because of the profit they generated. In the north of Warwickshire five GP practices had closed their patient lists as they were at capacity, due to the service demands from care home residents.
- It was questioned how to alleviate the service demands created by care homes. Each care home visit to a patient in rural areas like Rugby took

a long time which could be used to see several patients in the surgery. A key area was training for care home staff to avoid the need for a GP visit unless it was necessary. Some care homes had policies which didn't align with NHS or national guidelines, an example being the 'no lifting' policy after a resident fell. Capturing data on those care homes that repeatedly used GP services unnecessarily would be useful. A possible area for the County Council to initiate was how WCC, GPs and care homes could agree a way forward on this issue.

- Care homes now accepted people who previously would have resided in a nursing home. Those residents had more medical needs and there were increasing numbers of dementia cases. Nursing homes no longer provided the services they used to, with GPs now attending for such things as providing vaccinations or to confirm the death of a resident.
- There was an increasing need for care home places given Warwickshire's aging population. Ensuring care homes remained sustainable and financially viable was a challenge and taking a system approach was advocated. For example, investment in nursing staff in care homes would reduce demands on GPs, but the cost to social care would rise and consideration would be needed of how to fund this as a system.
- Points were made about the low salaries of care home workers and their inability to progress into other areas. WCC was working with Coventry University to explore the viability of a course which spanned both social care and health.
- Approximately 70% of the people in Warwickshire care homes self-funded their care (less in the north of the county). It was noted that the rate the Council paid for its placements was below the market rate.
- Paying a higher fee for a care home place didn't necessarily mean a better quality of care. Training and retention of good staff were more important. The age profile of care home staff, the proportion from EU countries and potential implications of Brexit were also referenced.
- Securing financial contributions through the planning process. Section 106 provides capital funding for new premises, but continued revenue funding is also needed for the staff to occupy them. When a new practice is approved, the lengthy time taken for its completion is a frustration.
- Questions to the LMC about how WCC could assist as the provider of social care to both adults and children. In response a view that the current system wasn't working. Better dialogue was sought.
- Other areas discussed were loneliness and the care navigator system, social prescribing and how to address the current shortfall in GPs. It was confirmed that more GPs were needed, but training course places were not fully occupied. The attractiveness of general practice had reduced.

1.4.5 The Chair provided a summation of the key learning points from this evidence session:

- It was difficult to look at GP services in isolation, without regard for the other primary care services and care homes.
- One of the recommendations from the review could be other areas for research by scrutiny or the Health and Wellbeing Board.
- Confirmation of the staffing issues affecting GPs, practice nurses and the social care sector.
- How to better engage the LMC in the planning process for development of new surgeries and to assess the impact of care home developments.
- How the LMC could be represented on or interact with the Health and Wellbeing Board.
- How to work collectively to address the risk averse approach of some care homes, to reduce demand on GP services.

1.4.6 **Contribution from NHS England (NHSE)**

Salma Ali, Programme Director of NHSE West Midlands had agreed to a telephone conference to provide the perspective of NHSE. It was noted that most of the commissioning decisions were now taken locally by CCGs and was agreed to receive evidence from NHSE through written questions.

1.5 Evidence Session – 19 February 2018

1.5.1 Planning and Infrastructure.
The purpose of this session was to understand how local authorities through the planning process, secure financial contributions from developers to meet the costs of infrastructure and additional services associated with population growth.

1.5.2 Janet Neale, the County Council's Infrastructure Development Manager gave an outline of the Infrastructure Development Team's work with district and borough councils and with health services. The Infrastructure team had been formed three years ago to provide a single voice to developers working with local authorities and the health sector, with the aim of building relationships and coordinating activity. Through work with CCGs and hospital trusts on a number of large planning applications, an understanding had been gained of what could and couldn't be achieved. Some cases had been tested on appeal and provided a good evidence base for future applications. These had secured capital funding and in the case of South Warwickshire Foundation Trust a financial contribution equivalent to a year's running costs. A proactive approach was taken and there were benefits of early dialogue between the agencies and developers. There was a good track record of success on cases and as a result of this developers now were less likely to challenge the contributions requested. This robust

approach needed to be replicated across the County as there were known significant developments planned for both Rugby and the north of Warwickshire.

1.5.3 The key learning from this evidence session were:

- There was a lengthy delay between commencement of development and the Section 106 financial 'triggers' being reached, when monies were actually received. In the interim, existing services had to absorb the additional service demands. In some cases, developers would slow down or cease development of a site when nearing such triggers.
- Agencies had to balance securing contributions against the developers' arguments of viability. In some cases the County Council had not claimed all the contributions it could have because of the viability argument. In other cases developers sought to reduce for example the affordable housing element.
- Provision of capital funding (for example for a new building) was not always the solution; contributions to meet the longer term revenue costs were also needed.
- Aggregating contributions from a number of smaller developments to provide a contribution to new facilities. Only five developments could be 'pooled' for this purpose. Removal of these national pooling restrictions would be helpful.
- what constituted a large development, with figures of 100-300 units being quoted.
- Cross border developments impacted on health services and infrastructure more generally.
- CIL was explained in more detail. The local planning authority held the CIL monies and different agencies submitted bids for individual schemes from the fund for example for highways, health or education schemes. Some large scale developments did not provide any contribution from the Community Infrastructure Levy (CIL), due to other known infrastructure costs to improve the road network. The costs of addressing land contamination could also be used as a means of avoiding or reducing CIL.
- CCGs had timing challenges to assess when new services would be needed. They had to balance when funding from development would be received against the amount of development that had taken place and the service demands it created. An area of discussion around whether monies could be provided to agencies to hold in advance. This would enable them to prioritise service delivery, but there are a number of constraints on the release and use of such monies. Costly legal variation orders would be needed to achieve this.
- People in rural areas have to travel to access a GP. Questions about capacity in the system. The CCGs have plans to expand and/or provide additional GP surgeries, having undertaken options appraisals for some areas already. Funding for new developments and the implications of the HS2 rail development were also raised.

- Questioned if borrowing could take place against known future S106 funding contributions, to deliver new premises at an earlier date. The delay from agreeing the S106 to receipt of funds meant an increase in building costs. This would be an issue for those receiving the S106 contributions to assess, in terms of risk.
- Similarly, the time from planning consent to construction often meant an increase in the value of each house. This should be considered when developers used the viability argument to reduce infrastructure contributions. Officers did revisit contributions where they could.
- The County Council was trying to establish a fund for delivery of infrastructure improvements at an early stage, with the fund being replenished when the S106 funds were received. Something similar could be sought for health contributions, but this would need discussion of which organisation held the funds.
- Some developers paid their S106 contributions up front or at an early stage. This presented a different challenge, in that spending of the monies had to be achieved by a deadline, or there was the potential for 'clawback' of the monies.
- It was evident that well established communication channels had been developed in the south of Warwickshire between the CCG and the district councils.

1.5.4 Contribution from District and Borough Planning Officers

All district and borough councils had been invited to submit written evidence and to attend this meeting. A pack of written evidence was circulated and verbal evidence was taken from planning officers of Warwick District (WDC) and North Warwickshire Borough Councils (NWBC).

There were complex financial rules around local authority and health service use of development contributions. The early involvement of agencies was advocated. They should be engaged at the strategic stages of the local plan and infrastructure planning. There was an opportunity to engage at the pre-application discussion stage for major applications and at various stages of the formal process. Planning authorities viewed infrastructure as a key priority, to ensure that transport, health and education needs were met.

WDC had started to use CIL, a fixed tariff based on the floor area of each development, in December 2017 and this offered some additional flexibility. CIL worked by having a list of known projects. Contributions from smaller developments could be included in the CIL fund. The planning authority determined which projects would be progressed, in liaison with the other agencies. It was noted that if a project was listed for CIL, it could not attract S106 monies as well.

Jeff Brown of NWBC explained the difficulties of delivering infrastructure through the planning function. The local plan was the core document in identifying the numbers of new houses and infrastructure required. For NWBC, there were cross border issues with developments in Staffordshire and it was important to have a coordinated evidence base to show the requirements for developer contributions.

An area where learning from the south of Warwickshire could be adopted county-wide was coordination of agencies to secure financial contributions arising from development. An example was quoted where George Eliot Hospital had demanded contributions from developments, threatening the Judicial Review (JR) of planning applications. It wasn't helpful when agencies needed to work together to secure the infrastructure needed for the area. A collaborative response was normally provided to planning applications on behalf of the various agencies, but in these cases, GEH had responded directly and through a legal route.

Through discussion, the key learning from this session was:

- The benefits of early discussions between the various agencies in planning for large developments.
- The need to improve dialogue and joint working to remove the potential for individual challenges or an aggressive approach to securing funding.
- The need to evidence spending of infrastructure contributions. There is the potential for developers to 'clawback' unspent monies.
- The HWBB has a role as system leaders, to lever accountability out of the partners.
- Acute service providers are not statutory consultees for planning applications. However, WCC circulates planning applications which could potentially secure an infrastructure contribution to them.
- Whilst a complex area, it is worth revisiting the 'viability' argument to explore the potential for contributions from developers.
- There are established forums for liaison between the agencies and a regular dialogue between officers on planning and the potential for infrastructure contributions. It is evident that those in the south of the County are better established and can be developed for the north of Warwickshire. A need to ensure that Coventry is involved.
- For future planning applications, adopting a site specific approach is suggested to bring together the relevant agencies for that area.
- The national agencies (NHS England, NHS Improvement and the Care Quality Commission) needed to give space to let the local dialogue happen.

Appendix C - Glossary

Term	Definition
Care Navigation	A referral system to ensure patients are seen by or referred to the appropriate primary care service
Warwickshire Community and Voluntary Action (CAVA)	The countywide infrastructure organisation for Warwickshire providing vital support to the volunteers, groups, organisations, enterprises and charities
Care Quality Commission (CQC)	The independent regulator of all health and social care services in England. The Care Quality Commission monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services
Community Infrastructure Levy (CIL)	A funding mechanism to provide infrastructure linked to planning applications through a fixed tariff based on the floor area of each development by having a list of known projects the CIL is used for
Clinical Commissioning Group (CCG)	An NHS body that funds delivery of services in its locality
DPH	Director of Public Health
GEH	George Eliot Hospital
GP	General Practice Doctor
HWBB	Health and Wellbeing Board – a body comprising key partners from across the health, third sector and local authorities
HWW	Healthwatch Warwickshire
LMC	The Local Medical Committee is a representative body comprised of General Practice doctors.
LPC	The Local Pharmaceutical Committee is a representative body comprised of pharmacists
NWBC	North Warwickshire Borough Council - district and borough council representation was sought for this review to give a local perspective
OSC	Overview and Scrutiny Committee. That relevant to this review is Adult Social Care and Health OSC
SDC	Stratford District Council - district and borough council representation was sought for this review to give a local perspective
Section 106 contributions	A funding mechanism under planning legislation to provide infrastructure linked to new development. Sometimes abbreviated to S106
Triggers	The point at which infrastructure contributions are due to be provided by the developer
TFG	Task and Finish Group
WCC	Warwickshire County Council
WDC	Warwick District Council - district and borough council representation was sought for this review to give a local perspective

Appendix C
Scrutiny Action Plan

Recommendation National Issues		PfH Comments	Cabinet Comments	Target Date for Action	Lead Officer	OSC Update	Progress Notes
1.1	That the Adult Social Care and Health OSC and Warwickshire Health and Wellbeing Board be recommended to lobby national government and planning authorities about the definition of infrastructure, the need for both capital and revenue funding streams and the need to recognise workforce within this context.						
1.2	That the Department of Health be lobbied to strengthen communications around appropriate NHS service use.						
Recommendations Issues for the Coventry and Warwickshire System		**PfH Comments**	**Cabinet Comments**	**Target Date for Action**	**Lead Officer**	**OSC Update**	**Progress Notes**
2.1	That the Health and Wellbeing Board and Adult Social Care and Health OSC						

	receive periodic updates on GP capacity and the locally derived solutions to meet the demands of population growth, which may include alternative provider medical services and funding for new services.						
2.2	That the Health and Wellbeing Board seeks assurances across the Coventry and Warwickshire health economy that a unified and coordinated approach is taken to responding to housing growth and District and Borough local plans.						
2.3	That the Health and Wellbeing Board, through its constituent partners publicises initiatives under the banner of 'your health is your responsibility'.						
Recommendation Areas within the remit of individual agencies		**PfH Comments**	**Cabinet Comments**	**Target Date for Action**	**Lead Officer**	**OSC Update**	**Progress Notes**
3.1	That Warwickshire County Council and the five district and borough councils provide support to CCGs with						

	awareness raising and publicity. Areas where we can assist are: • Raise awareness / educate on appropriate use of GP services throughout joint communication with CCGs. • Strengthen the social prescribing / care navigation offer to ensure that patients are accessing the right services at the right times.						
3.2	That CCGs give further consideration to the following areas identified through this review process: • Appropriate use of pharmacies to provide additional capacity to GPs. • Research how the time required for clinical correspondence between acute service providers and GPs can be streamlined to increase capacity for GPs • Areas of good practice identified from reviews of						

	GP surgeries by the Care Quality Commission and Healthwatch being shared by commissioners with all GP surgeries.						
3.3	That clinical commissioning groups (CCGs) work with district and borough councils to provide periodic briefings to the Adult Social Care and Health OSC and other Warwickshire local authorities to keep them informed of known substantial residential developments, the additional service requirements and how the CCG will respond.						
3.4	That the Adult Social Care and Health OSC reviews the processes required to secure new and extended medical services. This should include potential barriers/blockages and how they can be resolved more efficiently. It is recommended that this includes consideration of pilot projects using GP clusters of flexible working arrangements to enable people to access GP services in different ways.						

3.5	That Strategic Commissioning revisits its contracts with residential care homes to explore opportunities to seek incorporation of primary care service provision into developments and that the relevant CCG is involved in these discussions. It is recommended that the Adult Social Care and Health OSC add this as an area to its future work programme.						