GP SERVICES
TASK AND FINISH GROUP
DRAFT REPORT

December 2022

Working for Warwickshire

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Appendices

1.0 Introduction

1.1 Executive Summary

Through this review process, members have considered written information, presentations and held three evidence gathering sessions, with representatives from a wide range of organisations. This resultant report proposes a number of recommendations which will be submitted to the Adult Social Care and Health Overview and Scrutiny Committee, to Cabinet, the Warwickshire Health and Wellbeing Board and to partner organisations for them to consider. The recommendations can be seen at Section 2 (Page 6 onwards).

1.2 Appointment

The County Council approved a motion that the Adult Social Care and Health Overview and Scrutiny Committee (ASC&H OSC) review and make recommendations about the provision of health centres within Warwickshire. The Clinical Commissioning Group (CCG) was asked as part of the motion to share with the Council its work on the provision of health facilities across the County. It should be noted that national changes were implemented during the period of this review, which replaced Clinical Commissioning Groups with Integrated Care Systems. For references to the CCG within this report, the responsible body is now the Integrated Care Board (ICB).

To undertake this, the OSC appointed a member task and finish group (TFG). The membership of the group included a co-optee of a district/ borough council from Warwick District Council (WDC). Participation in the group's discussions included representatives of the Coventry and Warwickshire Clinical Commissioning Group (C&WCG), Healthwatch Warwickshire (HWW) and representatives of the Local Medical Committee (LMC).

A scoping exercise was undertaken resulting in the scoping document attached at Appendix A to this report.

1.3 Members and Contributors

The members appointed to the Task and Finish Group were Councillors Richard Baxter-Payne, Judy Falp, John Holland, John Horner, Marian Humphreys, Jerry Roodhouse and Mandy Tromans. Councillor Pam Redford (WDC) was co-opted onto this review.

The Task and Finish Group was supported by the Strategic Director of the People Directorate, two officers from Public Health (PH) and Democratic Services. External support was provided by the C&WCCG, HWW and the LMC.

1.4 Evidence

In order to achieve an understanding of the review topic, the TFG considered both primary and secondary evidence from a range of sources. This included circulation of the previous review report from 2018. One of the evidence sessions included a comprehensive presentation, delivered jointly by the CCG and LMC. In Section 3 of this report (from page 8) more details are provided of the evidence heard.

1.5 Dates and Timescales

Stage 1: A meeting to consider the review's scope (See Appendix A) – November 2021.

Stage 2: Consideration of primary evidence, through presentations, questioning and more general discussion over two meetings held in February and May 2022. Additionally, information was circulated on the NHS primary care estates linked to new residential developments.

Stage 3: The consideration of conclusions and recommendations from this Task and Finish Group (TFG) – 7 December 2022

Stage 4: Approval of the final TFG report by the Adult Social Care and Health Overview and Scrutiny Committee – Consideration by Committee 15th February 2023.

Stage 5: Presentation of the TFG report to Cabinet and the Warwickshire Health and Wellbeing Board – 18 April and 3 May 2023 respectively.

2.0 Recommendations

The TFG make a series of recommendations for the Coventry and Warwickshire Integrated Care System (ICS) and those 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.

Recommendation 1 - Communications Activity

1. That coordinated communications activity continues to be undertaken to explain to the public the revised primary care service delivery rationale. This is an area where partners in the local Integrated Care System, including councillors as community leaders and the Health and Wellbeing Board members can assist, but should rest primarily with the Integrated Care Board.

Rationale – There has been misunderstanding at both the national and local level about access to primary care services and especially general practice (GP). The evidence found that communications activity is already planned by the former CCG. The move to an ICS provides the opportunity for further promoting a consistent message across all partners. Such communications activity should address concerns and misconceptions, explaining the revised service delivery approaches required.

Recommendation 2 – Involvement of Primary Care and Public Health in the ICS

2. That the ICS includes involvement at all levels of both primary care and Public Health, especially as the new arrangements embed. There is a periodic monitoring role for the commissioning Adult Social Care and Health OSC post-implementation to ensure adequacy of representation.

Rationale – Evidence from this review showed the value of broad input from Primary Care and Public Health at all levels. The ICS is a complex structure with many tiers and organisations involved. There is a close interrelationship between primary and secondary healthcare services, especially when patients are discharged from an acute hospital to community settings. Public Health has broad experience and can contribute to discussions at all levels. There is value in ensuring that these bodies are represented at all levels of the ICS and this can be monitored periodically by elected scrutiny members.

Recommendation 3 – Monitoring Patient Involvement in Decision Making

3. That the Adult Social Care and Health OSC undertakes periodic monitoring around patient/resident involvement in the new ICS. There were perceived concerns that decision making may be moving away from the patient, which is not the intention.

Rationale – During the evidence gathering this was identified as an area for future monitoring, to ensure that the many tiers and complex structures involved in the ICS do not reduce patient involvement in decision making. There is a periodic monitoring role for the elected scrutiny members and Healthwatch Warwickshire. There is a role for the ICS to consider wider people engagement. The patient engagement function is important from a primary care perspective and there needs to be a mechanism for this to report into the ICS.

Recommendation 4 – Monitoring of Future Estates Provision

4. That periodic engagement is undertaken with the Integrated Care Board (as the body responsible for commissioning of general practice services and, associated with this, general practice estate planning and infrastructure delivery) to understand the delivery progress of its general practice estate programme.

Rationale – The key strand of this review is to ensure adequate provision of health centres to meet the needs of a growing and aging Warwickshire population. The estates data supplied by the ICB showed the GP practices within each Primary Care Network (PCN), the known housing developments, completed infrastructure development projects (a mixture of new build and extension projects) and proposals to provide additional capacity. It did show for the majority of PCN areas that the PCN total clinical rooms is currently less than the estimated future (2031) requirement and therefore there is planning and infrastructure delivery work underway to address the shortfall. The ICB provided extensive evidence regarding the systematic approach that it takes in relation to estate planning. However, the mechanisms for the release of funding linked to development for provision of new and extended health facilities are complex. There are two processes known as Section 106 agreements and the Community Infrastructure Levy. This is an area where councillors can bring influence through the planning process. There is a finite resource available from developer contributions for health and other services. This may cause competition between different health services, upstream preventative measures and other infrastructure sought from developer contributions. A coordinated and prioritised approach to the use of such funding would be helpful. Periodic monitoring of capacity by the scrutiny committee is also advocated, seeking updates from the ICB.

3.0 Overview

3.1 Background

At its meeting in March 2021, the County Council approved a motion that the ASC&H OSC review and make recommendations about the provision of health centres within Warwickshire. The CCG was asked as part of the motion to share with the Council its work on the provision of health facilities across the County.

The ASC&H OSC commissioned this task and finish group (TFG) to undertake the requested review and to make recommendations about the provision of Health Centres within Warwickshire.

3.2 Objectives

The objectives of this review were to establish a clear picture of current provision of primary care to enable needs and evidence-based planning for the health centres across Warwickshire including proposals for addressing any access issues. A copy of the full scope for the review is attached at Appendix A.

3.3 Context

Significant national changes coincided with the period of this review, not least the move to an Integrated Care System (ICS) and ongoing discussions as these arrangements embed. Additionally, there are the NHS Long Term Plan and the recently published Dr Claire Fuller review, commissioned by NHS England to assess how newly formed ICSs and primary care can work together to improve care for patients.

3.4 Acknowledgements

The TFG value the significant input to this review from Officers of the C&WCCG, GP representatives of the LMC and Healthwatch. Members also wish to place on record their thanks for the WCC Officer support.

4.0 Detailed Findings

4.1 Secondary Evidence

A copy of the review report from the 2018 TFG was provided as background at the commencement of the review. A joint presentation was provided by the C&WCCG and LMC. This was subsequently updated to include more information on estates capacity linked to known population growth through additional residential development.

4.2 Primary Evidence

The TFG invited contributions through evidence gathering sessions. The detailed report of each session is provided at Appendix B (from page 16):

29 November — The focus for the first meeting was scoping of the review. The outcomes were to finalise the scope at the subsequent meeting, also for Public Health and CCG Officers to compile a range of information for consideration at that meeting.

28 February — Further discussion of the review's scope with context from a GP perspective provided by the LMC. An outcome of minor changes to the review's final scope. It was agreed to provide a data session including demographics, population data, capacity and GP numbers. It was planned to visit a health centre in Wellesbourne. Finding a mutually convenient date for said visit proved problematic.

25 May — A comprehensive presentation delivered jointly by the CCG and LMC to provide evidence and respond to member questioning. An outcome from this session was the need for more estates data around capacity.

5.0 Findings and Conclusions

5.1 Overview

The key finding from this work is a much deeper understanding of the way that GP services are commissioned and configured. GP Services are private businesses and provide services in accordance with the framework of NHS requirements. The detail of the research is shown in Appendix B (from Page 16). These conclusions and the recommendations at Section 2 suggest providing support, influence and future monitoring of health centre provision as the new integrated care arrangements embed.

During the scoping of this review, it became evident that there are many interrelated service areas and it is challenging to focus on parts of the health system in isolation.

5.2 Findings from Evidence Sessions

5.2.1 The key evidence session took the form of a joint presentation from the C&WCCG officers and GP doctors from the LMC which included:

- Overview of general practice landscape in Coventry and Warwickshire
- Overview of national policy impacting general practice

- Impact of Covid-19 pandemic on general practice
- Improving timely access to general practice as a national and local priority
- Workforce
- General Practice Estate Planning and Infrastructure Delivery

5.2.2 The learning points from this evidence:

- The remit was a focus on the provision of health centres within Warwickshire. It is the people and services which are provided from these centres that are key.
- There is a need to manage increasing demand, with reducing resources, through working at scale. The public 'ask' of a patient centred approach and continuity of care by the same GP does not fit with the capacity challenges. There is a need for triage to other clinicians and for different methods of delivery than just 'face to face' appointments.
- Tensions are created between commissioners and patient expectation, due to the move to working at scale, as well as political and media messaging, not least the campaign to drive face to face access, which conflicts with the national guidance to increase digital access.
- There are several tiers and many bodies involved in the commissioning and delivery of health services. It is a complex structure, with significant new arrangements from the move to an ICS. In Warwickshire there are three Warwickshire 'Places' (North, Rugby and South) and more locally Primary Care Networks (PCNs), which are groups of GP practices. Additionally, there are a number of other bodies which coordinate and oversee the local health and care system.
- Linked to the capacity challenges is a communication piece to inform the public of the reasons why they may be referred to another clinician. There will be new ways of working, an example being group consultations rather than seeing people on an individual basis. This may not suit all patients.
- Many facets of a GP's role are unseen by the media and patients. This was demonstrated by an account from the LMC of a GP's typical day and an iceberg graphic showing the many roles that went unseen.
- Disparaging comments from the media and public due to a lack of understanding is not helpful. Accounts were provided of the impact, which included clinicians leaving general practice and a proportion (30%) of local, newly qualified doctors having no intention of becoming a GP.
- There are systemic issues which impact on GP services, an example being discharge from an acute hospital setting inappropriately, requiring complex aftercare by GPs for vulnerable people at home.
- Delivery of the services patients needed, rather than those they wanted. This would be assisted by more time efficient appointments by telephone or through using video technology. A need to address the

misperceptions created by negative media coverage regarding use of such technology.

- It is evident patients have different views about their treatment. For some, access to any GP is sufficient. Some do not like telephone consultations. For others with longer-term conditions, continuity of care is more important with a preference for face-to-face appointments. There is an incremental reduction in face-to-face appointments and personal contact with the GP.
- The PCN approach has a number of benefits from working collaboratively, providing resilience and additional services.
- Infrastructure is being developed or has been put in place to support general practice to work more efficiently. An example is the 'hub' to route telephone enquiries for non-urgent matters. A single patient portal is proposed enabling patients to manage their own health enquiries, for general practice, community services or in an acute setting. The exchange of data and information will allow all parts of the health system to collaborate and coordinate services.
- A national shortage of 7,300 GPs. There are aims for recruitment and to provide 50 million additional GP appointments, but currently there is no national workforce plan to achieve this. Locally the aim is to recruit another 556 full-time equivalent roles to join the general practice workforce by March 2024. Additional roles are being recruited to as part of the PCN approach.
- The data on estate planning and capacity shows the majority of PCN areas are 'at risk' in terms of GP capacity by 2031, due to the known additional residential developments in their respective areas. This is an area for further research and monitoring. Whilst there are well-established working arrangements between the NHS and planning authorities, this is an area where councillors can bring influence to enhance the existing arrangements.

5.3 Conclusions

5.3.1 An identified need for coordinated communications activity to explain to the public the service delivery rationale. This is an area where partners in the local health and care system, including councillors as community leaders and the Health and Wellbeing Board members can assist.

5.3.2 The impact of the transition to the new ICS. A need for primary care and Public Health to be involved at all levels of the system. This could be an area for monitoring post-implementation to ensure adequacy of representation.

5.3.3 Some concerns were raised that decision making may be moving away from the patient, which is not the intention. A future action to check where decision making takes place and how patients/residents are kept involved.

5.3.4 The need for periodic engagement with the Integrated Care Board (as the body responsible for commissioning of general practice services and, associated with this, general practice estate planning and infrastructure delivery) to understand the delivery progress of its general practice estate programme, details of which were shared with the Task and Finish Group as part of the review.

6.0 Financial and Legal Implications

The views of relevant Directors/ Assistant Directors, 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 financial implications for Warwickshire County Council as a result of this review.

6.2 Legal:
There are no legal implications for Warwickshire County Council as a result of this review.

Appendix A
Scoping Document

Review Topic (Name of review)	Provision of Health Centres within Warwickshire / GP Services
TFG Committee Members	Councillors Richard Baxter-Payne, Judy Falp, John Holland, John Horner, Marian Humphreys, Jerry Roodhouse and Mandy Tromans.
Co-option of District and Borough members (where relevant)	Councillor Pam Redford (Warwick District Council)
Key Officers / Departments	Nigel Minns, Strategic Director, People Directorate Gordan Djuric and Gemma McKinnon, Public Health
Lead Democratic Services Officer	Paul Spencer
Relevant Portfolio Holder(s)	Councillor Margaret Bell, Portfolio Holder for Adult Social Care and Health
Relevant Corporate Ambitions	Warwickshire's communities and individuals are supported to be safe, healthy and independent. Support Warwickshire residents to take responsibility for their own health and wellbeing and reduce the need for hospital or long-term health care.
Type of Review	Task and Finish Review
Timescales	To be determined.
Rationale (Key issues and/or reason for doing the review)	The County Council approved a motion that the overview and scrutiny committee review and make recommendations about the provision of health centres within Warwickshire. The Clinical Commissioning Group was asked as part of the motion to share with the Council its work on the provision of health facilities across the County.
Objectives of Review (Specify exactly what the review should achieve)	To establish a clear picture of current provision of primary care to enable needs and evidence-based planning for the health centres across Warwickshire including proposals for addressing any access issues.

Scope of the Topic (What is specifically to be included/excluded)	Include • Audit progress from the earlier review (inc. uptake on recommendations) • Take stock of current primary care provision – details of locations/number of GPs currently in all the Primary Care Networks (PCNs), estimates of the number of additional GPs needed and other workforce shortages. Consider actual demands from both a business and medical perspective, and whether there was a greater medical need for GPs. • Equity in access to services – physical access, face to face appointments, booking arrangements and addressing inequalities in the service provision • Primary care (health centres) estate and workforce planning including modelling for population growth • CCG colleagues, including Local Medical Committee members, to provide an outline of the process followed for development of new facilities and improvements to existing premises, the increasing partnership work on estate planning. Provide information on digital services, more flexible spaces, co-location and joining up of services. This could include pharmacy and social prescribing. • Modelling for population growth – share existing information and methodology used. This will include demographic changes and the aging population • What does a modern health centre look like and how does it integrate to other services such as community pharmacy? Does not include The scope needs to be tight and not lead to a wider review.
How will the public be involved? (See Public Engagement Toolkit / Flowchart)	The involvement of Healthwatch Warwickshire will ensure the patient and public voice is captured.
What site visits will be undertaken?	Planned to visit a Health Centre in Wellesbourne
How will our partners be involved? (consultation with relevant stakeholders, District / Borough reps)	This review includes participation from the Coventry and Warwickshire Clinical Commissioning Group (CCG). Seek lived experience and patient voice input from Healthwatch Warwickshire. The involvement of doctors from the Local Medical Committee. There is a co-opted representative from Warwick District Council.

How will the scrutiny achieve value for money for the Council / Council Tax payers?	There will be no additional costs incurred from undertaking this review.
What primary / new evidence is needed for the scrutiny? (What information needs to be identified / is not already available?)	Primary evidence to be sought from the Coventry and Warwickshire Clinical Commissioning Group (CCG). The involvement of doctors from the Local Medical Committee will capture a range of practical considerations. Input from Chris Bain, Chief Executive of Healthwatch Warwickshire will assist the review including feedback HWW receives and the lived experiences of patients.
What secondary / existing information will be needed? (i.e. risk register, background information, performance indicators, complaints, existing reports, legislation, central government information and reports)	Secondary evidence is available from the previous task and finish group completed in 2018. This will provide both background and a baseline for comparison. The Clinical Commissioning Group and WCC Officers to provide a pack of information for consideration by members of the group to provide additional background. This should identify gaps in information for further oral / written contributions.
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 TFG formulates a detailed report with the outcomes from its research. Recommendations are made to the CCG and others from the findings to assist with future health centre provision and addressing identified need for services and improved access issues.
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 and estates planning, led by the Clinical Commissioning Group.

Appendix B
Primary Evidence Detail

1.1 Context and Scoping – 29 November 2021

1.1.1 As part of the scoping of the review, Nigel Minns Strategic Director for the People Directorate reminded of the motion approved at Council in March 2021 with the following resolutions:

That the Council

1. Will seek with partners to shape future requirements for Health Facilities across the County and work with providers to deliver the same.

2. Requests the Adult Social Care and Health Overview and Scrutiny Committee to review and make recommendations about the provision of Health Centres within Warwickshire.

3. Asks the Clinical Commissioning Group to share with the Council its work on the provision of health facilities across the County.

1.1.2 Key areas raised on the scope of the review:

- The TFG's purpose was looking at health centre provision, working with partners, particularly the CCG to shape future health centre provision. This should provide a valuable long-term benefit influencing and shaping that provision. The TFG may be less suited to a wider review, for example looking at some of the current issues.
- The Chair of the commissioning scrutiny committee requested involvement of the LMC.
- The work of the CCG on estates planning and the significant progress made, which could be brought to the TFG. The CCG did work closely with planning authorities and the County Council using a methodology to assess population growth and to ensure infrastructure provision.
- Staffing challenges were discussed. A need for a baseline of existing services, the current number of GPs and the number of additional GPs required. Linked to this were variance in services across the county and factoring in the impact of a growing and aging population with more complex health needs. The impact on services from significant housing development in Warwickshire was referenced.
- It was hard to separate GP services from other parts of the health service. Examples raised were community pharmacy, ambulance and A&E services. Some services were used inappropriately, in part because of challenges around primary care access.
- How new health centres would be designed and utilised with a range of co-located services. Points about digital services, more flexible spaces,

pharmacy, social prescribing and in one case co-location with a Citizen's Advice Bureau.
- The differing challenges for urban and rural areas.
- The need for good communication and proper engagement with people about future service provision.

1.1.3 The outcomes from this session were:

- The feedback would be used to update the scoping document.
- WCC Officers and CCG colleagues to compile the background information requested.

1.2 Evidence Session – 28 February 2022

1.2.1 Scoping Document

Discussion of the TFG's scope, with input from Dr Tim Preece, a GP doctor and representative of the LMC. This provided further context and direct evidence of the perspective of a GP.

1.2.2 Key areas raised:

- Access issues and capacity challenges. There were many contributing factors from other parts of the NHS, a quoted example was the backlog of hospital waiting times.
- Demand had more than doubled over the previous 10-20 years. Additional work areas such as vaccinations, Public Health campaigns, hospital requirements, pressures from social services and 'tick box' exercises. It was suggested that the demand and capacity aspects should be strengthened in the scope.
- The GP workforce was reducing in real terms, when compared to population growth. This caused longer working hours, with some senior GPs leaving the service due to burnout. There was not workforce capacity to meet the health demands, let alone the additional services imposed. An example used was authorisation of a bus pass on medical grounds. There was evidence of a shortage of GP appointments equating to 17.5 full time equivalent GPs in Warwickshire. Significant financial investment was required to cover this current shortfall.
- Funding aspects, specifically the proportion of patient contacts versus share of NHS funding.

The TFG members and Officers responded to the points raised, many of which were included within the scope. It was agreed to expand the population growth aspect, to include demographic changes and the aging population. The other aspect concerned actual demands from both a business and medical perspective, and whether there was a greater medical need for GPs.

1.2.3 General discussion

Councillors contributed on the following areas:

- The differing approaches of GP practices, an example being the availability of face-to-face appointments during the pandemic.
- There were capacity challenges within Public Health, but data could be collated from other sources to inform the review. There was an in-house business intelligence service; information could be collated from communities, from district and borough councils and examples of best practice in GP surgeries sought.
- Points about public misconception of the need to see a GP, as there were other trained professionals in primary care who could assist them just as effectively. This showed a need for communication and education of the public.
- Recognition that GP practices were private businesses; each determined its own operating model.
- Significant housing development was increasing the population of Warwickshire, the associated demand for primary care services and impacting on capacity.
- Discussion about the ratio of GPs to patients, looking at the registered patient numbers at each practice and primary care services available from that practice. Further points about modelling demand and greater patient expectations. GPs were now dealing with more complex issues, as patients spent less time in an acute hospital setting, were discharged and then cared for in community settings by GPs.

CCG Officers referred to the wider reviews taking place including the move to an ICS, the general practice review and the launch of a local campaign promoting all the new roles in general practice. An outline was provided on CCG estates development work. This included new and expanded GP practices, responding to demand from new housebuilding. Warwickshire like most of the country was responding to large population growth. New facilities had been provided within the three Warwickshire 'Places'.

Healthwatch offered a patient perspective. Access to GPs was the point raised most often. It was difficult to look at GP services in isolation and there was a need to look across the ICS as the local system. There were linked aspects including NHS111, mental health services, the Integrated Care Board, care collaboratives, the place executives and place partnerships.

1.2.4 Outcomes

Minor updates were agreed to the draft scope to include demographic changes and demand issues. Further information would be provided to the next meeting on demographics and capacity, numbers of GPs and the respective populations in each area of the County. The CCG was asked to include information on workforce plans to address the current shortfalls,

including the new roles proposed. It was suggested that a visit to a new health centre take place with that at Wellesbourne suggested. Despite numerous efforts, a mutually convenient date and time could not be found for the visit. A further aspect to brief the TFG on was the clear and coherent process for provision of new facilities linked to housing development.

1.3 Evidence Session – 25 May 2022

1.3.1 CCG and LMC Presentation

This provided a comprehensive overview of general practice and the challenges it faces. The presentation included:

- Overview of general practice landscape in Coventry and Warwickshire
- Overview of national policy impacting general practice
- Impact of Covid-19 pandemic on general practice
- Improving timely access to general practice as a national and local priority
- Workforce
- General Practice Estate Planning and Infrastructure Delivery

1.3.2 Learning points from this evidence:

- The presentation gave an understanding of how the services operated, how general practices were funded, workforce models, primary care networks and the additional roles undertaken in general practice. Finally, details were provided of the local communication campaign that was taking place.
- Evidence was provided on the need to manage increasing demand, with reducing resources, through working at scale. The public 'ask' of a patient centred approach and continuity of care by the same GP did not fit with the capacity challenges. There is a need for triage to other clinicians and for different methods of delivery than just 'face to face' appointments. Tensions are created between commissioners and those related to patient expectation, due to the move to working at scale, as well as political and media messaging. There had been a media campaign to drive face to face access, which conflicted with the national guidance to increase digital access. It was expected that there would be a new approach following the review and stocktake by NHS England, led by Dr Claire Fuller. A full and detailed report was awaited on the priorities for general practice.
- There are many different tiers and bodies involved in the commissioning and delivery of health services. At the national level, from 1st July 2022, a move to ICSs, IC Boards and IC Partnerships. Within the local Coventry and Warwickshire IC System there are four 'Places'. There are Place Partnership Boards, and a Primary Care Collaborative. More local still are Primary Care Networks (PCNs), which are groups of GP practices. It is a complex system. Reassurance

was provided that the intention was not to move decision making away from the patient.

- A key challenge around stretched resources, both GPs and other clinicians. The focus was on access to services not continuity of which clinician provided that service.
- A recognition that there had been many reorganisations over the years. It was expected that such changes would not only continue but become more frequent.
- Linked to the capacity challenges was a communication piece to inform the public of the reasons why they may be referred to another clinician. There would be new ways of working, an example being group consultations rather than seeing people on an individual basis. This may not suit all patients.
- The impact of the transition to the new ICS. A need for primary care and Public Health to be involved at all levels of the system. This could be an area for monitoring post-implementation to ensure adequacy of representation.
- Similarly, a future action to check where decision making was taking place and how patients were kept involved.
- The Covid-19 pandemic had seen an acceleration of initiatives to address service demands, especially new ways of working through technology.
- Demand for services was continuing to grow, demonstrated by the 515,000 GP appointments in March 2022 across Coventry and Warwickshire, being one in every two residents.
- Many facets of a GP's role were unseen by the media and patients. This was demonstrated by an account from the LMC of a GP's typical day and an iceberg graphic showing the many roles that went unseen. Disparaging comments from the public due to this lack of understanding were hurtful and many GPs were looking to move to other clinical roles. Local evidence showed that 30% of newly qualified doctors had no intention of becoming a GP.
- Data on the funding provided to GP practices, based on a formula, which was around 7% of the total NHS budget.
- The systemic issues impacting on GP services such as patients discharged inappropriately from hospitals and the resultant challenges for GPs in providing care for vulnerable people at home.
- Councillors were asked to use their influence with decision makers.
- A need for a united narrative that primary care delivers the best possible services with the resources currently available.
- A need to think about the workforce and for everyone to take responsibility, including patients.
- Delivery of the services patients needed rather than those they wanted, given the capacity challenges. This could be assisted by more time efficient appointments by telephone or using video technology. There is a need to address the misperceptions created by negative media coverage regarding use of such technology.

- From feedback, it was evident that patients had different views about accessing services. For some access to any GP was sufficient. Some did not like telephone consultations. For others with longer-term conditions, continuity of care was more important with a preference for face-to-face appointments. There was an incremental reduction in face-to-face appointments and personal contact with the GP.
- The PCN approach had a number of benefits from working collaboratively, providing resilience and additional services.
- Infrastructure was being developed or had been put in place to support general practice to work more efficiently. Examples were networks to support the PCN model, and a hub approach to route telephone enquiries for non-urgent matters. A single patient portal was proposed. Patients would be better able to manage their own health enquiries, for general practice, community services or in an acute setting. The exchange of data and information would allow all parts of the health system to see it and provide patients with better care coordination.
- Data on workforce and the current shortage of 7,300 GPs nationally. Aspirations for recruitment and 50 million additional GP appointments. However, there was no national workforce plan to achieve this. Locally the aim was to recruit another 556 full-time equivalent roles to join the general practice workforce by March 2024. Additional roles were being recruited to as part of the PCN approach.
- Detail was provided on general practice estate planning and infrastructure delivery, there being established arrangements between the ICB and planning authorities in relation to securing developer contributions to support general practice infrastructure delivery via both Section 106 and Community Infrastructure Levy regimes. Various areas of challenge were highlighted: finite resources are available and may be called upon to support delivery of many different types of infrastructure; the timeliness of availability of Section 106 funding relating to larger strategic housing development sites which may involve multiple developers and be built out over many years, etc. This may be an area where councillors could bring influence to enhance the existing arrangements.

1.4 Circulation of Supplementary Written Information

1.4.1 Estates Information

Time constraints at the 25th May evidence session limited discussion of the estates aspects, a key part of this review's scope. Therefore, additional written information was requested from ICB colleagues which provided a position update on capacity at the Place and PCN level. For each of the three places of Warwickshire North, Rugby and South Warwickshire, this used a RAG (Red, Amber, Green) rating of capacity at 2021 and that projected for 2031. It showed the GP practices within each PCN, the known housing developments, completed infrastructure development projects (a mixture of new build and extension projects) and proposals to provide additional capacity. It did show

for the majority of PCN areas that the PCN total clinical rooms is currently less than the estimated future (2031) requirement and therefore there is planning and infrastructure delivery work underway to address the shortfall. The ICB provided extensive evidence regarding the systematic approach that it takes in relation to estate planning, which is subject to national legislation, policy and guidance. Progress updates are reported in public to the Commissioning, Planning and Population Health Committee of the ICB Board.

Appendix C - Glossary

Term	Definition
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
GP	General Practice Doctor
Health and Wellbeing Board (HWBB)	The Health and Wellbeing Board is a body comprising key partners from across the health, third sector and local authorities
Healthwatch Warwickshire (HWW)	Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.
Integrated Care Board (ICB)	In July 2022 a revised system was introduced. The ICB is the NHS commissioning organisation. For this review, it is the body responsible for commissioning of general practice services and, associated with this, general practice estate planning and infrastructure delivery.
Integrated Care System (ICS)	In July 2022 a revised system was introduced. ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services.
Local Medical Committee (LMC)	The Local Medical Committee is a representative body comprised of General Practice doctors.
OSC	Overview and Scrutiny Committee. That relevant to this review is Adult Social Care and Health OSC
Primary Care Network (PCN)	These are GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices.
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 D
Scrutiny Action Plan

Recommendation National Issues		PfH Comments	Cabinet Comments	Target Date for Action	Lead Officer	OSC Update	Progress Notes
1.	That coordinated communications activity is undertaken to explain to the public the revised primary care service delivery rationale. This is an area where partners in the local Integrated Care System, including councillors as community leaders and the Health and Wellbeing Board members can assist.						
2	That the ICS includes involvement at all levels of both primary care and Public Health, especially as the new arrangements embed. There is a periodic						

	monitoring role for the commissioning Adult Social Care and Health Overview and Scrutiny Committee (ASC&H OSC) post-implementation to ensure adequacy of representation.						
3	That the Adult Social Care and Health Overview and Scrutiny Committee undertakes periodic monitoring around patient involvement in the new ICS. There were perceived concerns that decision making may be moving away from the patient, which is not the intention.						
4	That periodic engagement is undertaken with the Integrated Care Board (as the body responsible						

	for commissioning of general practice services and, associated with this, general practice estate planning and infrastructure delivery) to understand the delivery progress of its general practice estate programme, details of which were shared with the Task and Finish Group as part of the review..						