Select Committee Review

Thursday 15 November 2018

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor Mrs Bowyer, Vice Chair.
Councillors Corvid, James, Laing, Dr Mahony and Parker-Delaz-Ajete.

Also in attendance: Tony Gravett (Healthwatch); Mark Procter (Joint Director of Primary Care, New Devon and South Devon and Torbay CCG), Laila Pennington (Head of Primary Care, NHS England); Dr Liz Thomas (Deputy Medical Director, NHS England); Amanda Ratsey (Head of Economy, Enterprise and Employment, Plymouth City Council); Sarah Lees (Public Health Consultant, Plymouth City Council); David Bearman (Chair of the Devon Local Pharmaceutical Committee); Dr Andrew Eynon-Lewis (Head of Primary and Community Care Education, Health Education, Southwest), Ross Jago (Lead Officer) and Amelia Boulter (Democratic Support Advisor).

The meeting started at 10.00 am and finished at 4.20 pm.

Note: At a future meeting, the Panel will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

1. **Declarations of Interest**

There were no declarations of interest made.

2. **Chair's Urgent Business**

There were no items of Chair's Urgent Business.

3. **Minutes**

The minutes of the meeting held on the 29 November 2017 were confirmed.

4. **Response to GP Select Committee Recommendations**

The Committee noted the response to the recommendations made at the 29 November 2018 meeting.

5. **Scoping Document**

The Chair highlighted to the Committee the scoping document which sets out what this meeting would cover.

6. **Healthwatch - User Experience**

Tony Gravett (Healthwatch) was present for meeting and it was highlighted that –

(a) they continued to engage with GP practices on accessibility and reported an improving picture, however, there was still room for improvement;

(b) there were continued frustrations around booking an appointment and appointment availability;

(c) two surveys to ascertain the public's understanding of the triage process and access to GP services. The survey's highlighted that if a patient required an urgent appointment then they would be seen within 48 hours, however, if a patient required a routine appointment or wished to see the same GP for continued treatment then the wait time for an appointment continued to be high;

(d) Healthwatch Plymouth were looking to undertake a piece of work on on-line services following similar work being undertaken at Healthwatch Torbay. The work would explore what was being offered within GP surgeries and how Patient Participation Groups (PPGS) could be utilised more effectively in the use of on-line services.

In response to questions raised, it was reported that -

(e) some practices were visited more than once to enable Healthwatch Plymouth to build a better patient picture around the accessing of GP services;

(f) continuity of care related to a patient accessing different services following a GP appointment and not necessarily around seeing the same GP. Concerns were raised by patients around delays in receiving an outpatient appointment following a GP appointment;

(g) they would like to receive more survey responses and to explore and encourage PPGs to undertake their own surveys and for Healthwatch Plymouth to feed into that process;

(h) access to vulnerable and hard to reach groups continued to be a challenge;

(i) the Healthwatch Plymouth website provides the option for people to select a preferred language making information accessible to all;

(j) they were currently working on children and young people's access to services and working with the hospital and Livewell SW on hospital discharge into a care home setting;

(k) patients can have a conversation with a GP without the need to visit the surgery, however, a significant amount of the population do not want to disclose their personal information to a health advisor, whereas others like that approach. The triage system stills needs time to embed and the GP community as a whole need a real solid discussion on how to best achieve this;

(l) would look to repeat this survey next year during the summer, we do undertake a review of the questions but will maintain consistency for trends, access to minority groups would be a priority within the next survey and how the survey would be delivered;

(m) capacity issues within the team hasn't allowed us to feedback to GP surgeries on results from the survey, this was something they were working on;

(n) a patient should be informed when making an appointment that they were seeing a nurse practitioner rather than a GP. Feedback from patients that had seen a nurse practitioner rather than an GP had been positive;

(o) quarterly visits to the Emergency Department (ED) were undertaken to ascertain why people had attended ED. The reasons given included; referred by NHS 111 or GP, self-referred with a small number unable to get an appointment with their GP;

(p) following a survey they pull together the information into a report to share back with surgeries. Surgeries receive individual feedback and an email sent to the Practice Manager with the opportunity to discuss further.

7. **Primary Care Programme Report**

Mark Procter (Joint Director of Primary Care, New Devon and South Devon and Torbay CCG), Laila Pennington (Head of Primary Care, NHS England) and Dr Liz Thomas (Deputy Medical Director, NHS England) were present for this item, it was highlighted that -

(a) it had been over a year since the last GP contract was handed back and they were now working more proactively with GP practices to address any issues;

(b) GP practices were starting to form alliances which were mutually beneficial, to share costs and to build resilience. There were now 22 alliances across the county;

(c) they applied to become part of a national pilot as a result of these alliances coming together and if successful the additional resources would be used to mature these alliances as well as supporting integrated care across the board;

(d) good progress had been made with Ocean Practice which had also merged with several other GP practices to form the Mayflower Group. They had yet to procure a permanent provider and were now pausing and reflecting to see what was required to make the offer more attractive;

(e) they were nationally required to improve access to GP services and had achieved the nationally required 30 minutes of extra appointment time with the introduction of 45 minute timeslots next year;

(f) they were looking at opportunities for patients to interact with their practice in a different ways by using systems such as E-consult and Patient On-line but this would be dependent on the systems in place within a practice;

(g) they were addressing the GP vacancies within Plymouth and with the support from Plymouth City Council launched the GP International Recruitment Scheme. The scheme has recently been extended to Australia and resulted in receiving 6 expressions of interest.

In response to questions raised, it was reported that -

(h) the retention of GPs was really important and they were therefore looking at different options such as flexible working, attractive retainer scheme for older Doctors, keeping in contact with Doctors that have left the service for a variety of reasons and making it easier for them to return to the service;

(i) clinical teams were dedicated and committed to caring for patients and in Plymouth every surgery has a CQC rating of good or outstanding. The GP Performance Advisory Group Committee addresses any efficiency in professional practice and it was reported that there was a low rate of GP suspensions and/or sanctions;

(j) they were working with partners such as the South West Ambulance Service Trust looking at portfolio careers into general practice which was key to the new model of general practice and how this could be undertaken without impacting on other services;

(k) there needs to be a single message to signpost people to the right services and to inform the population on when was the right time to visit the emergency department, minor injuries unit or Devon Doctors;

(l) they were reporting a more positive position than a year ago with exciting initiatives to take forward in the future but there was still more to do.

8. **Attracting GP's to Plymouth**

Amanda Ratsey (Head of Economy, Enterprise and Employment, Plymouth City Council) was present for this item and it was highlighted that -

(a) there were currently 23 vacancies across the city and Plymouth City Council have been working with the NHS for the last 12 months working on promotional material to attract GPs to the area;

(b) the lack of GPs within the city has had an effect on local businesses with employees finding it more difficult to get a Doctor's appointment. This has resulted in Citybus employing their own GP to help tackle staff sickness and wellbeing;

(c) the Living and Working in Plymouth leaflet can be tailored to suit different markets and has been adapted for the GP market;

(d) Plymouth has a good teaching hospital and therefore we need to explore how we retain students within the city.

In response to questions raised, it was reported that -

(e) it was important to target the right audiences and for GPS within the city to share their experiences and to promote Plymouth to GP trainees;

(f) equality and diversity was included within the talking heads material;

(g) the NHS employed a group of head hunters to target Europe and identified the Netherlands and Romania. They had a copy of the video and identified 12 people to come to the UK. A dinner was hosted in Plymouth and it was important to get the pitch right for the individual and their family. This was an expensive approach and unfortunately had no uptake from that round of recruitment.

9. **Living and Working in Plymouth (video clip)**

The Committee were shown the following video clip – https://www.plymouth.gov.uk/jobscareersandtraining/workingus/livingandworkingplymouth

10. **Health and Wellbeing Hubs**

Sarah Lees (Public Health Consultant, Plymouth City Council) was present for this item and highlighted that -

(a) the aim of the Health and Wellbeing Hubs is to align services so that they work better for local people for an easier and more coherent journey into services and to help people improve their own health and wellbeing;

(b) supporting a shift from GP services to wellbeing services and community support would start to release the pressure within the system;

(c) 20 percent of people that contact GP services were for a non-clinical reason such as social, economic, housing or because they were lonely. By signposting people to other services would enable them to look after their own heath better and therefore leading to the other issues they may have had being resolved;

(d) Third tier - universal hubs. The Central Library is the main hub and wellbeing champions trained to provide basic advice to sign post people to where they need to be. A network of universal hubs of libraries, pharmacies and children's centres directing people to a targeted hub for particular services bringing together commissioned services near to where people are and to complement the citywide offers;

(e) Second tier – targeted hubs. There are three targeted hub, Jan Cutting, Four Greens and Mannamead, these hubs bring together services that we have commissioned within the community to provide an improved offer;

(f) First tier - specialist hubs. These key existing health service providers add to the wellbeing offer to provide a holistic approach. The aim of the three tier of hubs is to take people out of statutory heath service where they may not need to be and to provide people with easier access to more offers in one place and to link into community groups with people with similar issues and needs;

(g) by having a whole system approach we should start to see the benefit of people getting the help they need with in the community and decreasing the need to access primary care.

In response to questions raised, it was reported that –

(h) the development of the Plymouth Online Directory (POD) would be useful tool to have in all the hubs. The wellbeing champions were trained to provide advice and signposting;

(i) some of the universal hubs were providing some intelligence around information that has been popular;

(j) information within the hubs was available in other languages, if not then they would use the NHS translation service to provide the information;

(k) they have commissioned a GP as part of the outreach service for homeless people and were developing plans to create a hub in the Stonehouse area;

(l) with the numbers of people that they were starting to see at Headspace they were exploring whether the system could fund additional sessions at that hub or additional sessions in different locations, this was being discussed. They were monitoring the flow of people and how they arrived at a crisis session and ensure that the emergency services were regularly updated.

11. **Pharmacy Developments - presentation**

David Bearman (Chair of the Devon Local Pharmaceutical Committee) was present for this item and provided a presentation to the Committee. It was highlighted that -

(a) nationally there was a drive to look at new ways of delivering healthcare across the population;

(b) the Community Pharmacy were starting to align itself within the system and looking at how they could operate in a more collaborative way at a neighbourhood level, however there were challenges around workforce, estates, contractual approaches and budget cuts which have impacted on the viability of some pharmacies;

(c) the aim was to make pharmacy a key contributor to the sustainability of primary care both through direct support in the practice and by the redesign of community pharmacy to be a key partner in community service provision to allow practices and community pharmacy to thrive in a new world.

In response to questions raised, it was reported that -

(d) discussions had taken place on how pharmacy could have a fundamental role within a health and wellbeing hub. Community Pharmacy has a role in self-care and public health and therefore there was a need to network into these hubs and this was on their agenda;

(e) consultation was still underway on NHS England's proposed prescribing restrictions for over the counter medicines. GPs would still be able to prescribe these but would be asked to limit the amount prescribed;

(f) they were looking to reduce the amount of faxes used within the pharmacy setting and hope to phase this out over time. They were now encouraging practices and out of hours services to use electronic prescriptions;

(g) there was a need to start changing the behaviours of the public to move towards the pharmacy which needs to be supported by effective marketing;

(h) it was important that training, safety protocols and integration with other clinicians to ensure that there were no risks to care quality and diagnosis.

12. **Peninsula School of Primary Care**

Dr Andrew Eynon-Lewis (Head of Primary and Community Care Education, Health Education, Southwest) was present for this item and highlighted that -

(a) the School of Primary Care has been ranked first by trainee Doctors because of the quality of the education provided and as a result we have excellent trainees within the south west;

(b) there was an annual intake of 105 trainees with around 90 completing the training. The GP training was the shortest programme of the all the specialities and currently have 78 GP trainees;

(c) in the next round of recruitment have secured incentive payments of £20,0000 for all 24 posts;

(d) they were working on the challenges faced within inner city practices and ensuring we promote the opportunities to attract people into the city.

In response to questions raised, it was reported that -

(e) the incentive payments were for Doctors in training and does not apply to students. The payments were part of the enhanced GP recruitment scheme and for the three year programme. If they resigned after a year they would have to pay a third back and there was no obligation to stay in the area;

(f) this year the medical school council had started a database to follow all students and track them once they leave, they would be assigned a GMC number and tracked throughout their career;

(g) we promote general practice to students with the support of role models looking at the recognition of the care within general practice, public health initiatives and broadening out the career options in those areas that overlap in general practice;

(h) the GP curriculum was being rewritten for August 2019 cohort and will address issues like mental health and it was important to get the balance between providing support to people and not over medicalising it.

13. **Recommendations**

The Committee received reports from a wide range of stakeholders and agreed –

1. That they were assured that the primary care system, in particular General Practice in Plymouth, had made substantial improvements since the last review.

2. That although system was fragile, significant work was underway to address recruitment issues.

3. To commend the work undertaken by NHS England in reference to recruitment but would recommend that additional resources are made available to extend this work, particularly across social media platforms nationally and internationally.

4. To review in 12 months the impact of the international recruitment campaigns.

5. That the availability of routine appointments continues to be an area of concern. The Committee will review this issue again in 12 months and also consider the impact of changes in community pharmacy and the impact of Health and Wellbeing Hubs.

6. That at a future meeting date, the committee would consider the performance, quality of information and outcomes of Health and Wellbeing Hubs.

7. To invite Healthwatch to present the survey in relation to GP practice in the New Year.

8. To support calls for Plymouth University to consider providing Undergraduate Pharmacy Study.

9. To commend the work being undertaken by the City Council with the NHS in highlighting Plymouth and the South West as attractive place to live and work.