OXFORDSHIRE COUNTY COUNCIL

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

General Practice Provision in Oxfordshire:

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

INTRODUCTION AND OVERVIEW

1. At its meeting on 18 April 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on the current state of General Practice (GP) provision in Oxfordshire.

2. The Committee felt it crucial to receive an update on the current state of GP services, particularly in light of the increased demand for such services throughout the County. The Committee also sought to assess the degree to which the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (ICB) was taking adequate steps to address the increases in demand for GP services.

3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes the nature of GP services, which are often the first point of contact for patients in the healthcare system. When commissioning this report on GP provision, some of the insights that the Committee sought to receive were as follows:

   - The levels of workforce within GP settings, and whether there is an adequacy of workforce.

   - Any measures that have been taken by the ICB to improve workforce recruitment and retention.

   - Whether any steps are being or will be taken to avert GPs from handing in their notice.

   - The steps being taken to improve capacity in Primary Care.

   - The capacity of existing Primary Care estates, and whether the ICB has specific plans to improve and increase Primary Care estates.

   - Whether there is an increased use of portacabins, and the feasibility and appropriateness around the use of these in specific contexts/surgeries.

   - As per the previous HOSC recommendation around access to Primary Care, whether any progress has occurred in regard to

working with the City/District Councils to coordinate the use of section 106 funds for primary care.

- The impact of increased housing developments on primary care and how the ICB is taking this into account.

- Details on any progress made toward expanding GP capacity in the Didcot area.

- The extent to which there is an increased use of physician associates, and if so, whether there is a standardised competencies assessment for such staff who are not trained doctors.

- The degree to which administrative/receptionist staff are sufficiently trained to facilitate not only their administrative work, but also their interaction with and support for patients.

SUMMARY

4. The Committee would like to express thanks to Julie Dandridge (Lead for Primary Care across Oxfordshire, BOB ICB) and Daniel Leveson (BOB ICB Place Director, Oxfordshire) for attending this meeting item on 18 April 2024 and for answering questions from the Committee.

5. The BOB ICB Lead for Primary Care across Oxfordshire introduced the report. The draft Primary Care Strategy had been co-produced with a number of stakeholders and the feedback was being collated into a final version, to be signed off by the ICB Board in May. There was a recognition of the increase in GP appointments, but also an acknowledgment that patients and the public were still having difficulty getting through to GPs by phone to get an appointment. There had been much progress in improving primary care estates. Some things were unfortunately beyond the control of the ICB, but work was continuing with GP leaders to try and improve access for patients.

6. The Committee asked in what respects had the National Recovery and Access to Primary Care Programme funded, influenced, and shaped the decisions and measures taken around GP provision in Oxfordshire. The BOB ICB Lead for Primary Care explained that the national primary care access and recovery had come with some funding to support it. This funding was partly for practices to have time to implement what they called modern general practice, which involved assessing how and by whom patients should be seen. All their practices had submitted plans on how they would do this at the primary care network level. There was also funding for IT, specifically to ensure that all their practices had functioning cloud-based telephony and to drive forward other innovations in IT.

7. The Committee queried the extent to which the development of the Primary Care Strategy involved adequate levels of public and stakeholder engagement. The BOB ICB Lead for Primary Care had stated that engaging everyone was challenging, and HealthWatch also stated that their involvement had been

rushed. They had co-produced the draft strategy with GP leaders and Primary Care Network clinical directors, and held webinars and sessions for the public and professional colleagues. A detailed public engagement report was available, and Healthwatch had been used to disseminate information and hold seminars. Feedback received from public engagement indicated a need for more co-production of communications. The Lead for Primary Care committed to find out from the ICB's communications team as to whether there was a reason for the rushed engagement.

8. The Committee asked for more information about the development of proactive and personalised care in the community setting for people with complex health needs. The BOB ICB Lead for Primary Care emphasised the importance of the development of care closer to home, with services being moved out of hospitals into the community for easier patient access. Integrated neighbourhood teams were brought together, uniting experts in care to move things forward in a unified direction. This was part of developing a patient-focused approach, which had been implemented in some cases, but not optimally across all areas. Resources included NHS staff in the community and staff in general practice. The goal was to join up and streamline processes, using the same records to release capacity for personalised care for those who needed it most.

9. The Committee enquired as to whether any extensive progress had been made for the ICB to work closely with District Councils to enhance GP access and services and deal with primary care estate issues. The BOB ICB Lead for Primary Care had explained that their town planner was actively participating in the District Councils' planning discussions, building relationships, and driving things forward in a more organised manner.

10. The Committee queried whether the Great Western Park project in Didcot was going according to plan. The BOB ICB Lead for Primary Care stated that they had made significant progress with the Great Western Park development. This progress was marked by the ICB's agreement and the extension of the Section 1 agreement that was already in place with the developer. The council was preparing to receive the land and the fund. Despite the complexity of the legal agreement involving three or four parties, they were on the right path and intended to maintain the momentum. The next steps, which included finalising the legal agreements and submitting a planning application, were clearly in sight.

11. The Committee enquired as to whether there was any record keeping of 'failed service requests', and whether this was followed up. The BOB ICB Lead for Primary Care had responded that, at that time, the only method of testing was through the GP patient survey. Nationally, from October, call data would be collected. They acknowledged the existence of a significant amount of unmet need and emphasised the importance of reaching those individuals who might be deterred from accessing their GP if they failed to get through.

12. The Committee asked whether the ICB monitored each practice against requests for online and urgent appointments being closed. The BOB ICB Lead for Primary Care explained that the Primary Care Strategy was initiated to

address the need for capacity in general practice. The ICB was aware and captured details about practices that struggled to remain open due to a lack of capacity and appointments. The default solution was to use the 111 service, which could perform early triage and determine the urgency of a patient's need to be seen, but efforts were being made to assist practices that regularly had to switch to the 111 service.

13. The Committee asked how the ICB was anticipating future housing developments and population increases. The BOB ICB Lead for Primary Care explained that their estates town planner played a crucial role. The planner was meeting with officers to review upcoming plans and submit requests for support for general practice primary care infrastructure. There were plans in place in some locations, for example they had strategies to increase provision across Bicester and Kidlington using developers' contributions. The planner was aiming to look ahead, to create long-term plans rather than reactive ones.

14. The Committee asked whether the ICB thought there was a need to explore more strategically the potential to partner with the local authorities in provision of new primary care premises. The BOB ICB Lead for Primary Care mentioned a Section 2 agreement for working in collaboration with local authorities and councils, which was a significant opportunity for general practice on the ground. They acknowledged that the ICB had no capital, and their only source of funding was through revenue. They saw potential opportunities in collaborating with local authorities and expressed a strong interest in exploring them.

15. The Committee asked why the initial focus was on prevention around cardiovascular disease. The BOB ICB Lead for Primary Care responded that they believed there was still significant room for improvement in cardiovascular disease. They acknowledged the substantial benefits this could have, not only for patients but also for the system and resources. They confirmed that cardiovascular prevention had been agreed upon as a BOB system priority. However, they had also received feedback suggesting that prevention should not be limited to just cardiovascular disease but should also encompass areas such as oral health and children’s preventative health.

16. The Committee enquired as to how the GP retainer scheme would help to enhance the retention of GPs. The BOB ICB Lead for Primary Care explained that there was a 'new to practice' GP fellowship that provided support to new GPs and the implementation and delivery of the Primary Care Strategy could attract new GPs. The introduction of innovative ways of working with patients was thought to help retain GPs and the developments to roles were found to be very rewarding for the staff.

17. The Committee asked whether administrative staff received appropriate training in being able to support clinicians and patients. The BOB ICB Lead for Primary Care responded that the receptionist had traditionally been the first point of contact for someone trying to access a GP appointment. They were upskilling those receptionists to become care navigators so that they could direct the right patients to the right place. The reception staff were trained to understand what the important questions were so that they could point patients to the right

clinician; whether that be a pharmacist, a physiotherapist, or the GP. There was a national training program for receptionist care navigators and most practices had their own training in place as well. All NHS staff, including administrative staff, were bound by confidentiality. The ICB was committed to work with the public to help shape what information they needed to participate and feel confident in the range of staff that were now working in general practice.

18. On the point relating to the increasing use of non-GP staff for the purposes of treating patients, the Committee queried and emphasised the use of any competency frameworks, in addition to the level of communication with the public, around the increasing use of such staff. It was highlighted by the Committee that there was public concern around the imperative for clear transparency for each alternative role. It was vital that there were clear impact and risk assessments, a clear competency framework, and a thorough communication plan with patients and the wider public.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

19. Overall, the Committee observes that there is a significant advancement around the serious issue of GP estates. The ICB's recruitment of a specific estates role is a positive development, and will enable serious and longstanding barriers on the spending of funding to be overcome. Given the urgent public need for funding to be spent and secured from developments, the Committee reiterates and urges that the estates' workforce are further increased in Oxfordshire to accelerate progress. The Committee observes that in light of the demands on primary care as well as workforce shortages, which are clearly also national issues, the Committee cannot give full assurance to the public about the state of primary care. Nevertheless, the Committee recognises the local work and makes the points of observation below as constructive points for local improvement.

20. Below are 6 key points of observation that the Committee has in relation to GP provision in Oxfordshire. These 6 key points of observation relate to some of the themes of discussion during the meeting on 18 April, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

Public Engagement and the Primary Care strategy: The Committee is supportive of the development of a primary care strategy by the ICB, and perceives the commitment to such a strategy as constituting a method through which to clarify the ICB's priorities around GP services. Nonetheless, the committee strongly feels that engagement with key stakeholders and the wider public should be at the heart of how the strategy is designed and delivered.

Therefore, that public engagement should be at the heart of the strategy is crucial for two reasons:

1. It can help to gather views and experiences from the public as to how they feel regarding the GP services they have been

receiving. This will prove valuable for how the strategy, as well as GP services more broadly, are designed in a manner that reflects public views and experiences.

2. The engagements with stakeholders and the public could help to inform the ICB as to which aspects of GP services are not functioning optimally, and could therefore help to further inform ways in which to improve frontline primary care.

Given the fact that the Primary Care strategy outlines the ICB's commitments to new and transformative methods for providing GP services, it is vital that the public and key stakeholders thoroughly understand the nature of such changes and how these will affect the ways in which residents could expect to receive GP services.

The Committee urges and recommends that in the spirit of transparency and effective public communication, that the ICB publishes the responses and/or provides evidence and sheds some light on some of the key feedback themes that were received from residents or stakeholder organisations from within Oxfordshire as to the strategy. The Committee also recommends that the ICB shares information regarding the engagement that has taken place in the context of the strategy's development, including which stakeholders had been identified and targeted as part of this. The committee recommends that any ICB considerations or responses to the key feedback themes are also made public.

Furthermore, the Committee feels strongly that the primary care strategy should also be accompanied by an explicit and elaborate delivery plan. This delivery plan should ideally outline the immediate, medium, and long-term priorities of the strategy (particularly in relation to GP provision given the increase in demand for this area). It is also crucial that clear and realistic timescales, as well as considerations around workforce and funding, should also be incorporated into such a delivery plan. This could help to set healthy targets for the ICB to work toward gradually implementing the strategy in a manner that produces tangible benefits for Oxfordshire's residents who strongly depend on GP services.

Additionally, the Committee also recognises that as with any strategy, there is a need for continuous stakeholder engagement, and that this should be well planned and should take on board the feedback from the public as well as the Oxfordshire and the BOB HOSCs.

Recommendation 1: *To ensure continuous stakeholder engagement around the Primary Care Strategy and its implementation; and for the ICB to provide evidence and clarity around any engagements adopted, to include evidence on key feedback themes and from which groups within Oxfordshire such themes were received from. It is also recommended that there is a clear implementation plan to be developed as part of the Primary Care Strategy, and for this to be shared with HOSC and key stakeholders.*

Importance and role of Prevention: The Committee understands that the ICB's initial focus on prevention would be around cardiovascular disease. The Committee acknowledges the substantial benefits this could have for the population, not only for patients but also for the system and resources. Nonetheless, it is vital that the ICB expands the focus of prevention to other areas as much as possible. Whilst it is understandable that the primary care strategy cannot feasibly encompass every aspect of health and prevention, there is also a point about tangible commitments that the NHS should ideally adopt around prevention of other long term medical conditions besides an exclusive focus on cardiovascular disease. The Committee is strongly supportive of the initiative to focus on prevention of cardiovascular disease, but urges and recommends that the focus of prevention is broadened to encompass other areas also.

The ICB could make use of some of the feedback heard as part of the public engagement around the development of the primary care strategy to understand how various other long-term conditions could be heavily impacting the lives of residents. This could help to inform and shape the ICB's commitments to other forms of prevention or to prevention for other long-term conditions. Additionally, the Committee encourages for there to be close coordination with local Primary Care Networks (PCNs), Healthwatch Oxfordshire, patient groups, as well as Oxfordshire County Council's Public Health team, to work toward a comprehensive prevention agenda.

Recommendation 2: *To continue to work on Prevention of medical and long-term conditions besides cardiovascular disease.*

Working with District/City Councils: The Committee is glad to see that the ICB has been working with District and City Councils for the purposes of improving primary care estates. The Committee would like to stress the importance of continued work with District Councils, and perceives the ICB's recruitment of a role for working with Districts as a positive step toward addressing some of the challenges around primary care capacity against the backdrop of the substantial increases in demand within Oxfordshire. It is vital that there is continued work for the purposes of coordinating the use of CIL funds held by the ICB and from executed Section 106 funds for Primary Care.

It is crucial that the ICB works to ensure that there is adequacy in capacity. This does not simply require close working with district authorities, but also that such work is coordinated in a timely manner so as to ensure demand is being met in a timely way which precludes undue risks to the health and wellbeing of residents, who are increasingly experiencing difficulties in accessing GP services. The Committee previously recommended role(s), and whilst one role is significant progress, it is urged that adequate capacity to enable the release of funding is made a priority.

Furthermore, another issue which highlights the importance of working with District Councils in a timely manner relates to how increases in housing developments in one part of the County could result in an increase in demand for GP services in a neighbouring authority (owing to the fact that the closest GP surgery for some may be across a district boundary). Hence, whilst general increases in housing developments create challenges around primary care capacity, the effects of increases in housing developments on primary care demand in neighbouring district boundaries is also an issue that the Committee urges the ICB to explore.

Recommendation 3: *To review ICB capacity with a view to increasing this to ensure adequacy, with a view that the ICB can work in a timely way with all District/City Councils across Oxfordshire on the securement and spending of health-infrastructure funding.*

Monitoring of practices closing e-connect & telephone requests: The Committee believes that econnect or telephone requests for urgent appointments are a crucial avenue through which patients can access GP services. For many patients, these are the two primary means through which to seek an appointment with their GP. Often, patients may be experiencing a health issue that they feel, or that may genuinely, requires urgent medical attention from a medical professional. Patients are often reluctant to contact 111 or to make a trip to emergency departments for two reasons:

1. They would fear the prolonged waiting times they would have to experience if they take these avenues.

2. They may not be sure as to whether their condition merits a trip to an emergency department, or whether it is an issue that could be resolved and treated by a GP.

The Committee understands that there have been reports of increasing difficulties experienced by patients in being able to access their GP. Patients may make telephone requests for an appointment, or often find that the practice they are registered with have closed e-connect and telephone requests for urgent appointments. This could, and indeed has, resulted in patients experiencing distress in not being able to simply access a GP when they need to, and in some cases patients have given up seeking help as their condition deteriorates.

The Committee recommends to the ICB that urgent action is taken to monitor which particular GP practices have been closing e-connect and telephone requests for urgent appointments, and for what reason this may be the case. It is also requested that HOSC are informed about these temporary closures. Such monitoring is important for two reasons. Firstly, it could help with the overall monitoring and performance management of individual GP practices. Secondly, it could act as a form of reassurance to patients and wider residents as to the steps the NHS

are taking to ensure that there is both transparency and accountability over such closures, as well as the commitments by the NHS to enhance access for patients to GP services. The Committee urges the ICB to support GP practices in communicating with their patients and the public as to the reasons they may no longer be taking requests for appointments and when such services are expected to be restored.

Furthermore, the Committee understands that some patients may even feel reluctant or put off from constantly seeking to navigate through the process of accessing a GP. This could also occur as a result of feeling powerless in being able to access a doctor to discuss any medical concerns they have. The risks with such scenarios are that such patients who feel this way could experience further decline in their physical or even their mental health as a result. Therefore, the Committee urges that the ICB effectively monitors patterns of closures for telephone requests and e-connect and identifies the reasons for this as well as where such closures are taking place.

The statistics on access suggest an improvement on last year, but if there are temporary closures the statistics may not be capturing people trying to access a service. We urge the ICB to consider the statistics on temporary closures and the likely numbers of people failing to make an appointment; and that the statistics on access are reviewed in the light of this with a view to further clarification on this matter.

Recommendation 4: *That the ICB checks which practices are closing e-connect and telephone requests for urgent appointments and for what reasons, and that it is also checked as to whether/how the public have been communicated with around such closures. It is recommended that there is improved clarity and communication about the statistics concerning access to appointments.*

Competency Frameworks: The Committee is aware of the NHS's plans to make increasing use of physician associates in the context of GP services, who are not qualified medical doctors, and is also aware of the development of alternative roles. The Committee has received concerns from the public, but does not perceive the development of alternative roles to be an entirely negative thing. Whilst this may constitute a means through which to manage the increases in demand for primary care, it could also potentially produce risks to patient safety if the necessary precautions and steps are not taken to effectively manage this.

The Committee is therefore recommending that there is clear transparency around any competency frameworks or risk assessments that staff who are not qualified as doctors, and who may be triaging or providing treatment to patients, are measured against. Such competency frameworks (which could include training as well as monitoring processes) and risk assessments would be crucial for two reasons.

1. This could help to maximise the safety of patients and minimise any risks involved with using staff who are not qualified doctors.

2. It can act as a form of reassurance to patients as well as the wider public as to what this means for the kind of GP services they will receive.

In addition, given that individuals who visit GP services may often be from vulnerable population groups, the Committee stresses the importance of ensuring that staff who treat such patients are as qualified or trained as possible so as to be able to draw the necessary conclusions from such patients' historical and medical records, and for them to be aware of and able to support or escalate their advocacy needs. This would help to inform the type of treatment they would provide to such patients.

Recommendation 5: *For there to be clarity and transparency around the use of any competency frameworks as well as impact and risk assessments around the role of non-GP qualified medical staff who are involved in triaging or providing medical treatment to patients. The Committee urges that the advocacy needs of patients are considered/provided for, and that patients are clearly informed about the role of the person who is treating them and the reasons as to why this is a good alternative to seeing their GP.*

Great Western Park development: The Committee is well aware of some of the key challenges around GP provision within the Didcot area. Didcot is an area that has witnessed increasing levels of demand for Primary Care services, including GP services. The increase in housing developments within the area is the primary reason for the increase in demand as new residents will need to access GP services. According to the Office of National Statistics mid-year population estimates, the population of Didcot increased from 24,373 in mid-2009 to 27,426 in mid-2019.

The Committee has been particularly concerned for some time that demand in Didcot is not being met, and has therefore strongly and consistently urged the ICB to take action to address this. The Committee is strongly supportive of, and is pleased to see, that the ICB has approved the business case for a new building and that it has agreed to provide funding in addition to the money from developer contributions. The Committee is also supportive of how Woodlands Medical Centre will manage the estate as a branch surgery. However, the Committee is recommending to the ICB that an expected date for the signing of the legal agreement on the Didcot Western Park site is provided to the JHOSC. This would help to reassure both the Committee as well as the wider public as to the likely timescale for the tendering process.

Recommendation 6: *That an expected date for the signing of the legal agreement on Didcot Western Park is provided to the JHOSC, so there can be reassurance about the likely timescale for the tendering process.*

Legal Implications

21. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 Power to scrutinise health bodies and authorities in the local area
 Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

22. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

23. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

Contact Officer: Dr Omid Nouri
Scrutiny Officer (Health)
omid.nouri@oxfordshire.gov.uk
Tel: 07729081160

May 2024