Rotherham Metropolitan Borough Council

Public Report
Health Select Commission

Committee Name and Date of Committee Meeting
Health Select Commission – 26 January 2023

Report Title
Scrutiny Review Recommendations – Access to Primary Care

Is this a Key Decision and has it been included on the Forward Plan?
No

Strategic Director Approving Submission of the Report
Jo Brown, Assistant Chief Executive

Report Author(s)
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Ward(s) Affected
Borough-Wide

Report Summary
This report summarises the findings and recommendations of the Health Select Commission spotlight review into access to primary care. The review was prompted by insight provided by Healthwatch Rotherham regarding continued inquiries from residents who were having difficulty accessing GP appointments.

Recommendations

1) That the report be noted.

2) That the findings and recommendations contained in the report by Healthwatch Rotherham into “Accessing GP Services in Rotherham” be noted.

3) That the following recommendations be submitted to Overview and Scrutiny Management Board for endorsement:

   a) That consideration be given to how to develop better understanding among patients of how to recognise symptoms as needing medical attention, where to seek help, and in what timeframe.

   b) That Rotherham Place, including NHS South Yorkshire and the Council, give due consideration to enhanced safety-netting to mitigate risks associated with an increasingly patient-led model of care initiation and follow up.

c) That Place partners, including the Primary Care Networks (PCNs), consider how to expand patients' understanding of the wider options when seeking medical advice, with a view to expediting consultation with the most appropriate professional or service to be able to address their need.

d) That consideration be given to how all Place Partners demonstrate shared responsibility to communicate honest wait times, where this information is available, for all services system-wide.

e) That NHS South Yorkshire consider how messaging and communications will figure in managing patient expectations around waits in the evolving model of care.

f) That consideration be given to how Councillors may play an expanded role in publicising available options and managing expectations among Rotherham residents as the sector works toward a new model of care responsive to the ongoing resource pressures on health services.

g) Whereas recruitment remains a limiting factor for expansion of social prescribing, that recruitment to social prescribing roles be prioritised, and consideration given to how to make participation in social prescribing in Rotherham more attractive to professionals.

List of Appendices Included
None

Background Papers
"General Practice Access." Presentation.

"Accessing GP services in Rotherham: A report into how Rotherham residents access GP services." Healthwatch Rotherham.

Consideration by any other Council Committee, Scrutiny or Advisory Panel
None

Council Approval Required
No

Exempt from the Press and Public
No

Scrutiny Review Recommendations – Access to Primary Care

1. Background

1.1 During the pandemic, Healthwatch Rotherham reported an increasing trend of inquiries from Rotherham residents who were having difficulty obtaining primary care appointments with their local General Practitioner (GP). Many residents had the ability to access appointments with their GP when they were sick or if they needed needed medical advice, but not all residents were able to do so. This signalled a health inequality that needed to be addressed.

1.2 The Council Plan includes the theme that people are safe, healthy, and live well. The ambition of this theme is to promote physical and mental wellbeing for all Rotherham residents, and to ensure that health inequalities are addressed. Councillors are aware that GP appointments play a key role in safeguarding and in helping people live independently for longer, because GPs often help signpost people to access other services that promote physical and mental wellbeing and safety.

1.3 For these reasons, Health Select Commission undertook a spotlight review of access to primary care in April 2022. Participating in the review were Cllrs Atkin, Cooksey, Elliott, Griffin, Havard, Hoddinott, Keenan, McNeely, Sansome, Thompson, Wooding, and Yasseen (Chair). The review consisted of a consultation with Rotherham Healthwatch to understand the trend in inquiries received as well sample feedback obtained from Rotherham residents around access to GP appointments. Then the Councillors met with the Head of Commissioning for Rotherham Place and the Chair of Rotherham Clinical Commissioning Group to discuss the current challenges facing GPs nationally and locally.

2. Key lines of inquiry

2.1 **Whose responsibility is access to GP appointments?**
Contracting with GP surgeries within the PCN was discussed. It was noted that each of the GP surgeries is an independent contractor within the PCN. The contract defines who should deliver services but does not define how the services are delivered. There are 28 practices within Rotherham and 3 different types of contract:

- GMS – Is the national standard contract with no end date – a GP has to be signature to the contract
- PMS - is another form of core contract but unlike the GMS contract, is negotiated and agreed locally by CCGs - the majority of Rotherham practices are on this contract with no end dates – again a GP has to be signature to the contract
- APMS – is a more flexible contract and has an end date, normally at 5 years and enables non GP led organisations e.g. third sector and private companies to undertake primary care – we only have

2.2 Parity between practices was discussed. The National GP contract provides for all practices to receive the same global sum amount, there are no variations to this for Rotherham. The Place has discretion for investment in local incentive schemes in Rotherham such as the Quality contract and

Innovation Fund. The same element of multi-disciplinary team (MDT) resource is allocated to every practice. It is up to the individual practice how they use the resource. There is variation in uptake, but opportunity for access is the same across all practices.

2.3 General practice functions as part of the wider community with services, for example, urgent mental health care, maternity care, and diabetes support. All of these services can be provided from within practices based on the strong relationships across health and social care. General practice has evolved to be a prevention led service e.g. screening, immunisation, case finding, chronic disease monitoring. The Rotherham GP ratio is 0.46 per 1000 patients compared to the national ratio of 0.45.

2.4 **What is considered a reasonable waiting time for an appointment?**
The Quality contract includes requirements for urgent appointments within 24 hours and routine appointments within five days.

2.5 **How is access being optimised and effectiveness monitored?**
The importance of effectiveness was discussed, including the need for patients to have confidence that they will receive the right diagnosis and treatment from a single appointment, rather than attending a series of appointments each with time lapse whilst seeking a solution. A GP is a generalist, rather than a specialist. It is therefore appropriate for a GP to care navigate patients to appropriate expertise both within and outside the practice.

2.6 Before the pandemic, six Primary Care Networks were put in place, each PCN was a grouping of practices to deliver services sustainably, share good practice, and share the workforce for additional roles. Extended access was also put in place, with weekday and weekend services in place 365 days a year. Tele-dermatology was introduced, which enabled an image to be sent to a consultant dermatologist enabling quicker diagnosis and treatment. The Rotherham Health App was implemented providing an alternative form of contact with practices and access to medical information.

2.7 During the pandemic, general practice had to adapt quickly to the country locking down. All practices transitioned from minimal telephone/video consultation to wider facility with these modes of consultation. The national mandate was to cease all routine work. Practices set up a ‘hot’ site and ‘hot’ visiting to ensure practices were not continually having to close down rooms because of infection control. Extended access continued, but also moved to support, predominantly by telephone, 365 days a year. General practice in Rotherham also led the vaccination programme.

2.8 General access capacity was examined, showing that Rotherham’s recovery of appointments compared to pre-pandemic levels was the best in South Yorkshire. Rotherham primary care has, since June 2021, met or exceeded pre-pandemic levels of appointments with a focus on recovery, Further focuses were sharing good practice, moving from a reactive to proactive model as the pandemic waned, and encouraging the use of the Deep Vein Thrombosis Local Enhanced Service.

2.9 A breakdown of Wider Access Fund and Extended Access appointments and PCN access appointments was discussed showing that 52% of appointments were same day for the period between April 2019 and February 2022. In the early phase of the pandemic, telephone consultations made up 43% of appointments, with 54% face to face. By early 2022, roughly two-thirds of all appointments were being conducted face to face.

2.10 All practices except one were on hosted telephony systems to improve call waiting times and extra resources had been identified to sustain increased capacity for call answering throughout 2022, including support for demand over the winter period. Over 20,000 patients were registered for the Rotherham Health App, utilising this for booking appointments, ordering repeat prescriptions, and checking symptoms. The Primary Care Networks were well-established with many coming together to deliver areas of work, for example, vaccination arrangements, same day appointments and minor surgery. Non-clinical vaccinators were trained to support the vaccine programme enabling practices to undertake business as usual.

2.11 **How are options being communicated to patients?**
There was a desire within the health and care sector to see many more clinicians enter the workforce to alleviate pressures, but this was not a realistic projection for the future of the health care sector. It was felt that people want to understand the waits, but public messaging around access needed to do a better job of highlighting the conditions and symptoms when patients need to be persistent to be seen without delay, such as when they are experiencing chest pains.

2.12 The Place needed to inform patients that there was a much wider workforce with much more expertise than within a GP, reminding the public that the GP is a generalist. For example, physios have far more knowledge of musculoskeletal conditions. Pharmacists are much more knowledgeable to undertake medication reviews. Social prescribers have more knowledge of all the available services in place to support patients with a variety of needs, including debt, loneliness, housing, etc. Over 89 whole time equivalent roles in addition to GPs support community care.

2.13 **How are practices taking on board feedback from patients around access?**
Modes of delivery were discussed, including appointments by telephone which were found to work well for some patients but not all. Some patients were better served having traditional 10-minute appointments, face to face. Practices had responded positively to the request to provide a variety of appointment delivery modes. Tele-dermatology in particular was felt to have been an effective digital access format.

2.14 **What are the local and national pressures?**
As noted, the PCNs are currently composed of 28 practices, following mergers. Each clinician sees 40 to 50 patients a day. It was noted that new recruits usually want to work 3.5 days per week, which means it takes two recruits to replace a full-time GP who retires. The recent closing of one local surgery due to quality issues was an example of how small, single-handed

practices can suffer if something happens to the GP. Single points of failure can make a practice difficult to run well.

2.15 Workforce challenges were discussed including, morale, vacancy, retention, and turnover within the workforce that provides primary care. Staff pressures in the UECC were noted, resulting in people going to their own GP rather than the walk-in centre. The Additional Roles (ARRS) supported general practices, for example, paramedics who supported home visiting, trainee nurse associates, health and wellbeing workers, physios, pharmacists, and social prescribers. The available resource had to be used effectively, as demand continues to rise year on year.

2.16 PCNs also had funding for additional roles, including physios, mental health professionals, and clinical pharmacy professionals. There was a general practice training scheme which had no vacancies. The challenge was to retain trainee doctors by making Rotherham an attractive place to work. Many trainees make the decision to leave Rotherham based on belief that there may be better working conditions elsewhere, but the shortages and pressures experienced by Rotherham are experienced everywhere else also.

2.17 **How are local providers responding to national changes, including those ushered in by the Health and Care Act 2022?**
Recognising the complication of long COVID and chronic fatigue, a service had been developed to respond. Outcomes from this service were shared with Health Select Commission members.

2.18 The effects of deconditioning and maturing chronic disease were discussed. Many patients received less attention and routine follow-up during the pandemic. Meanwhile, people did not have a good lifestyle, resulting in deconditioning. This applies to children as well as adults. Services would be responding to this in the coming years.

2.19 Potential impacts on the PCNs associated with the formation of the ICS were discussed. It was felt by GPs that the formation of the ICS could bring additional advantages, or could be on par with previous system. There was a need to make the most of the existing national funding during the window when it is available, acknowledging that, if the Secretary of State gives access to national moneys, these will require working within new parameters of success. Some prevention work, such as social prescribing, could later fall out of favour, requiring the Place to seek out other ways of funding. For this reason, efforts to maximise funding were ongoing.

2.20 As regards funding for specific prevention work, Rotherham were among the national leaders on social prescribing. Social prescribing takes routine nonclinical work away from doctors and empowers people to manage conditions using various services. However, investing in community-based services was required for success of social prescribing. Recruitment had become a limiting factor where there were good ideas but no available staff.

2.21 **What further steps are being taken to improve access?**
Education of patients becomes more important as pressures on the current model of care make evolution necessary. As part of the digitisation objectives of the strategy, the future of the Rotherham Health app involves transitioning into the South Yorkshire App. This app must be responsive to the needs of the patients, promoting equity of care for families. The app is designed to prevent the GP from becoming a bottleneck to accessing care. Further steps being taken were development of a communication strategy that involves digitisation, implementation of patient-initiated follow-up, and a Joint Place Communications Lead between the Council and ICB.

2.22 Care navigation was in place, which enables patients to self-refer into a number of services, either through the Rotherham Health App or, if not conversant with technology, via the practice receptionist. This approach helped residents to have good information around whom to speak to about their situation. Sometimes, this may be a pharmacist or other professional other than a GP, nurse, or AHP (Allied Health Professional). Many people who are experiencing loneliness, for example, end up requesting a GP appointment. The app can help join up efforts across many available services to meet people’s needs, alleviate pressures, and release needed capacity. There is then a knock-on effect releasing capacity at hospitals.

2.23 **Conclusion**
There was a need to manage expectations, to be honest about how long waits are, and options that are available to patients. Councillors can assist in helping keep people informed as providers work toward a new model of care that responds to the pressures that are being experienced within all areas of the health sector, locally and nationally. This model of care will build on learning from digitisation during the pandemic and linked up community-based care, in which social prescribing plays a significant role in prevention. It was felt that people have a desire to understand the reality of waits, and to be empowered to make decisions about the best place to go for advice or care. Public messaging around access needed to highlight when patients should be more persistent in certain cases where a patient needs to be seen in person, without delay, such as when there are chest pains. To accomplish this will require a shift in culture in which residents share more of the decision-making responsibility about their own care. This introduces risks, that can be mitigated by excellent partnership working and excellent access to good information. This evolution is necessary to ensure a resilient model of health care delivery continues to provide the right care for all to access at the point of need.

3. Options considered and recommended proposal

3.1 Members are recommended to approve the recommendations.

4. Consultation on proposal

4.1 Councillors were cognisant of the findings and recommendations contained in the recent Healthwatch report “Accessing GP services in Rotherham: A report into how Rotherham residents access GP services.”

Recommendations issued by Healthwatch Rotherham in respect of Access to GP services address the need for greater flexibility and choice as well as accessibility for residents.

4.2 Therefore, this spotlight review by Health Select Commission builds on without duplicating the findings and recommendations of Healthwatch. It is important to credit Healthwatch Rotherham for producing this key background document which gave insight into the experiences of Rotherham residents.

4.3 By reporting on the continued inquiries from members of the public relating to difficulty accessing GP services, Healthwatch Rotherham was instrumental in bringing to the attention of Health Select Commission members the need for this spotlight review. This is exemplary of strong partnership working which makes effective scrutiny possible.

5. Timetable and Accountability for Implementing this Decision

5.1 Implementation of any recommendation made to a partner organisation is at the discretion of the relevant partner organisation. Timescales associated with response to recommendations by partner organisations will be determined in liaison with the relevant commissioning partners, with any updates reported to members of Health Select Commission.

5.2 Implementation of recommendations addressed to a directorate of the Council is a matter reserved to the relevant directorate. Timescales for Council directorates responding to scrutiny recommendations are outlined in the Overview and Scrutiny Procedure Rules contained in the Constitution of the Council.

6. Financial and Procurement Advice and Implications

6.1 There are no financial or procurement implications directly arising from this report.

7. Legal Advice and Implications

7.1 There are no legal implications directly arising from this report.

8. Human Resources Advice and Implications

8.1 There are no HR implications directly arising from this report.

9. Implications for Children and Young People and Vulnerable Adults

9.1 There are no implications for children and young people and vulnerable adults directly arising from this report.

10. Equalities and Human Rights Advice and Implications

10.1 Members of Health Select Commission have due regard to equalities and human rights in developing recommendations. The aim of this review is to support achievement of the Council Plan objective to address health inequalities.

11. Implications for CO_2 Emissions and Climate Change

11.1 There are no implications for CO_2 emissions and climate change directly arising from this report.

12. Implications for Partners

12.1 The implications for NHS partners, including Primary Care Networks, are described in the main sections of the report. Members have regard for the logistical implications associated with making recommendations to outside bodies, as this review does to Rotherham's Primary Care Networks and Hospital Trusts. Implementation of any recommendation is at the discretion of the relevant partner organisation. The recommendations contained in this report are offered respectfully, acknowledging the contributions that have been made by GPs and all health professionals, especially throughout the pandemic.

13. Risks and Mitigation

13.1 There are no risks directly arising from this report.

Accountable Officer(s)
Emma Hill, Head of Democratic Services and Statutory Scrutiny Officer
Katherine Harclerode, Governance Advisor

Approvals obtained on behalf of:

	Name	Date
Chief Executive		Click here to enter a date.
Strategic Director of Finance & Customer Services (S.151 Officer)	Named officer	Click here to enter a date.
Assistant Director of Legal Services (Monitoring Officer)	Named officer	Click here to enter a date.
Assistant Director of Human Resources (if appropriate)		Click here to enter a date.
Head of Human Resources (if appropriate)		Click here to enter a date.
The Strategic Director with responsibility for this report	Please select the relevant Strategic Director	Click here to enter a date.
Consultation undertaken with the relevant Cabinet Member	Please select the relevant Cabinet Member	Click here to enter a date.

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