HASC GP Services Inquiry – 12 month progress on Recommendations

Select Committee Inquiry Report Completion Date: 25th November 2014
Date of this update: 24th November 2015
Lead Officer responsible for this response: Debra Elliot (NHS England for Recs 1,3,4,7), Richard Corbett (Healthwatch Bucks for Recs 5), Annet Gamell & Lou Patten (Aylesbury Vale & Chiltern CCGs for Rec 2 & 6

Accepted Recommendations	Original Response and Actions	Progress Update	Committee Assessment of Progress (RAG status)
1: NHS England should publish a national benchmark indicator of general practice funding per capita, facilitating comparisons with the funding received in different CCG areas. This benchmark should then be published as a routine at least annually in future.	I think we go some way to meeting this request for action though our publishing NHS payments to general practice 2013-14 through the Health and Social Care Information Centre. This was published just last week. This is a list of investment into each and every general practice, broken down to reflect payments from NHS England against a range of national enhanced services as well as core. This does not correlate directly with GP take home pay, - because for GP partners this is obviously dependant on the net profits arising from these payments having taken away running costs. The majority of these in primary care (as in NHS generally) being staffing costs. Whilst it is common to look towards some sort of benchmark, - it proves very difficult to be able to rank payments to practices in any logical form. – As you know, core funding to general practice is based on a weighted formula, - Currently, - practices do not receive equal levels of pay based on their weighted list size. – It is to address this inequality that the DH imposed a contractual change to withdraw MPIG over 7 years. Likewise, we have decided that PMS practices should be funded at the same level for the same work as GMS practices, and have agreed a transition of between 4-7 years to be determined locally. One could argue that the pace of change is too slow, however, we are aware that for a significant minority of practices this change in funding can be significant, alongside this, the Carr-Hill formulae is being revised, therefore we	N/A	

	cannot make assumptions about the eventual distance from target until the new weighting formulae which reflects better patient need, is agreed with the profession. Our position therefore is that whilst we are committed to more open and transparent information being available to the public in terms of investment into primary care, we need to be cautious about turning this into a benchmarking exercise as this fails to recognise the complexities in primary care funding and the inability to compare like with like.'		
2. A GP Demand Management Action Plan should be agreed by the CCGs and NHS England Area Team as part of the Primary Care Strategy to facilitate a coordinated and shared approach to reducing avoidable appointments and demands on GP services, as well as promoting greater self-care. This should be delivered either by the local CCGs or as an early co-commissioning project undertaken with the NHS England Area Team.	In order for the CCG's to deliver their vision for primary care as outlined in our strategy (currently in draft) a number of goals have been identified. Although a 'GP Demand Management Action Plan' is not referred to specifically, two of these goals will deliver what they believe the HASC require from this recommendation, which is to systematically reduce demand on primary care through actions such as increasing self-care or alternative signposting for patients. The goals from our draft strategy that this particularly relates to are: 1) Enable people to take personal responsibility for their own health and wellbeing, and for those that they care for, with access to validated, localised and readily available educational resources 2) Improved and appropriate access for all to high quality, responsive primary care that makes out-of-hospital care the default As a 5 year strategy, the document does not include details of how they will achieve this but in the next steps section the CCG commits to specific deliverables in year one. Of relevance are • to have a whole system programme to increase self-management • Implementation of a system-wide care planning approach Should they feel that this work will benefit from collective effort with NHS England this would be an opportunity to take forward through co-commissioning to maximise impact. (Louise Patten, AV CCG). We accept in full this recommendation, but can only accept responsibility for those parts that are within CCG control in terms of demand management (Louise Patten AV CCG).		 Implementation date April 2016

	From March 2015 -(Debra Elliot, NHS England Area Team). 'As you acknowledge, within General Practice the issues of demand management, "appropriate utilisation", signposting to other primary, community and social care services is very complex. The Primary Care strategies led by the CCGs, in conjunction with NHS England, are currently in production. Your suggestion to expand the range of 'other demands' is helpful. The CCGs will be able to indicate how they might be incorporated, where practical, into the strategies. However we wish to sound a 'word of caution'. The development of the strategies is critical work and we would not support any actions that might lead to delays. The CCG may be able to advise if further detail on this recommendation can be provided without leading to delay.'		
3. The NHS England Area Team, in liaison with local CCGs and the Local Medical Committee, should clarify roles, responsibilities and contacts for NHS engagement on land use planning matters, and how information will be shared between themselves and with local practices. The Area Team should review whether they have the processes and data in place to secure developer contributions for general practice investment	'We agree that our response was not completely comprehensive on the complex issues of health requirements in relation to spatial planning. The lack of detail is perhaps indicative of the complexity of planning across a range of Health & Social Care commissioners whilst encouraging innovative solutions from the market. Currently there is no single guidance document for this area. Co-commissioning should certainly assist in the joining together of NHS commissioners. Joint commissioning committees between CCGs and NHS England will require robust health & social care strategies looking to the 5 year forward view. In conjunction with the CCGs we are looking to strengthen and regularise our working arrangements with the Planning Authorities. The use of the Community Infrastructure Levy (CIL) is indeed an important mechanism in areas of change and growth. The NHS would want to utilise this where ever possible.'		 Implementation date April 2016
4. Following the publication of the Primary Care Strategy, the NHS England Area Team should agree with the local CCGs a plan for how the necessary investment in primary care premises will be encouraged, supported and delivered over the next five years.	NHS England funding will deliver on the promise of a new deal for primary care, as highlighted in the NHS Five Year Forward View. It is the first tranche of the recently announced £1billion investment to improve premises, help practices to harness technology and give practices the space to offer more appointments and improved care for the frail elderly – essential in supporting the reduction of hospital admissions. GPs across the country are being invited to submit bids to improve their premises, either through making improvements		 Implementation date April 2016

	to existing buildings or the creation of new ones. In the first year it is anticipated that the money will predominantly accelerate schemes which are in the pipeline, bringing benefits to patients more quickly. GPs are being invited to bid for the investment funding. They will need to set out how practices will give them the capacity to do more; provide value for money; improvements in access and services for the frail and elderly. This new funding, alongside our incremental premises programme, will accelerate investment in increasing infrastructure, accelerate better use of technology and in the short term, will be used to address immediate capacity and access issues, as well as lay the foundations for more integrated care to be delivered in community settings.		
5. Healthwatch Bucks in liaison with the CCGs should lead on the identification of less developed PPGs and the formulation of a support package for them which should be publicised on the Healthwatch Bucks website		Healthwatch Bucks has undertaken two projects looking at Patient Participation Groups as a result of the HASC recommendation. The first project benchmarked the number and size of PPGs across the County. The second project asked Practice Managers about their views of PPGs and how useful they were proving to be for the practice. Both projects showed that there is a very mixed picture across the County. From very effective large patient groups to a number of practices that have nothing. There was also a mixed view of how useful they were to the practices, while acknowledgement was made of how useful they could be. We have now started a project in the Chiltern PPG area to support the development of PPG groups. This will involve setting up three groups and providing a variety of support to 14 other practices. We will also provide generic support to all practices in the area and look to	

		share this support and learning to practices in the Aylesbury Vale area. This project started in October 2015 and will run for the next two years.	
6. The Primary Care Strategy should outline what the future of GP service delivery in Buckinghamshire should look like in five years' time, and how individual GP practices will be supported to deliver this	The Buckinghamshire wide primary care strategy is currently in draft form. Before it is finalised at the end of March there will be further consultation and feedback from stakeholders which will be completed through the Let's Talk Health website and with all those that fed into the original consultation. The strategy will include our vision for primary care, one of the goals of which is to support providers of primary care. In your letter a lead contact was requested for each recommendation.	Primary Care Strategy submitted to 24th HASC for comment and published by CCG's April 2015.	
7.NHS England acknowledge our concerns over the imbalance in local GP service capacity and demands, and commit to additional funding for CCGs undertaking co-commissioning of GP services with the Area Teams so this additional CCG activity is adequately resourced	I think we can highlight here the statement in the 5 year forward view that challenges the next government to recognise the significant investment required in the NHS if we are to continue to meet the growing demand from patients. The view however is that this is not just pressure in primary care, it is pressure across the system. The 5 YFV describes a need to move away from seeing primary and secondary care as separate entities, - undoubtedly, more investment is needed in both areas. But to invest across the system so that we could continue to meet the growing needs of the patient within the current model of health care is not possible within the current and likely future economic climate. – we cannot seek to grow the secondary care and specialist services bed base and primary care and community infrastructure, - to meet the needs of the aging population. Instead, we need to move towards new integrated models of care, - and these are being tested out through plans to launch 'vanguard sites' – local communities where investment is being focused to challenge and old ways of working and redesign care. It would be worth going back to the local counsellors to highlight that whilst the intention is to test out • Multi-professional community providers • Primary and acute care systems • New models pf care around community hospitals		

	• New care pathways for patients in nursing / residential homes The NHS cannot do this alone, - with increasing numbers of patients needing to be cared for with their LTCs, - not cured by the NHS, - local authorities need to recognise the integral part hey need to play in providing support and care for patients in the community NHS England is working with CCGs to develop opportunities for them to take the lead locally as NHS commissioners, - co-commissioning will unlock many of the barriers to commissioning integrated care and CCGs can invest from secondary to primary care. To do this though, CCGs need to be confident that GPs and the wider primary care teams, can develop the capacity to care for more patients with complex needs in the community. – and to do this, - we are going to need to work with local authorities to support this shift in care.'		

RAG Status Guidance

	*Recommendation implemented to the satisfaction of the committee.*		*Committee have concerns the recommendation may not be fully delivered to its satisfaction*
	*Recommendation on track to be completed to the satisfaction of the committee.*		*Committee consider the recommendation to have not been delivered/implemented*