Contact Officer: Nicola Sylvester

KIRKLEES COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

Wednesday 1st October 2025

Present:	Councillor Jo Lawson (Chair) Councillor Bill Armer Councillor Eric Firth Councillor Alison Munro Councillor Habiban Zaman
Co-optees	Helen Clay
In attendance:	Michelle Cross, Executive Director, Adults & Health Councillor Nosheen Dad, Portfolio Holder Catherine Wormstone, Director of Primary Care, Integrated Care Board Gemma Brady, Kirklees Health and Care Partnership Dr Khalid Naeem, Kirklees Health and Care Partnership Lindsay Greenhalgh, Kirklees Health and Care Partnership Vicky Duthchburn, Accountable Person, Integrated Care Board (Virtually)
Apologies:	Councillor Darren O'Donovan Kim Taylor (Co-Optee)

11 Membership of the Panel

Apologies were received on behalf of Councillor Darren O'Donovan and Kim Taylor (Co-optee).

12 Minutes of previous meeting

RESOLVED: That the minutes of the meeting dated 6th August 2025 be approved as a correct record.

13 Declaration of Interests

No interests were declared.

14 Admission of the public

All items were considered in public.

15 Deputations/Petitions

No deputations or petitions were received.

16 Public Question Time

No public questions were received.

17 Patient Transport from Home to Hospital

The Panel received a presentation on missed appointments attributed to Patient Transport Services (PTS) within Kirklees. The presentation responded to queries raised by the Panel regarding the causes of missed appointments, responsibility for transport bookings, and eligibility criteria for PTS. It was noted that the definition of a missed appointment had been refined to include only inward journeys with specific abort reasons: wrong mobility, wrong address, failed journey, and Yorkshire Ambulance Service (YAS) delays. Journeys were excluded where the same patient had another successful inward journey on the same date.

Analysis of data from 1 January 2024 to 17 August 2025 revealed an average of nine missed appointments per week. The primary cause was incorrect mobility categorisation (60.6%), followed by YAS delays (17.1%), wrong address (13.4%), and failed journeys (8.9%). Most missed appointments occurred between 9am and 4pm on weekdays, aligning with peak transport activity. Hospital data showed that Huddersfield Royal Infirmary and Calderdale Royal Hospital accounted for the majority of missed appointments, though only 0.8% of total inward activity resulted in an abort. Similarly, the top 25 clinics accounted for 41.6% of missed appointment aborts, with Acre Mills Outpatients, Huddersfield Royal Infirmary Orthopaedics & X-ray, and Dewsbury District Hospital X-Ray Department being the most affected.

Apologies were received from Yorkshire Ambulance Service – Patient Transport Service. The Panel acknowledged the need for improved accuracy in mobility assessments and transport coordination to reduce missed appointments and raised the following questions:

Q1. There has been an increase and decrease in missed appointments from January 2024 to August 2025 which has not returned to zero, what is the reason for it being so low in January 2024 and what is the reason for the increases/decreases between January 2024 and August 2025?

Q2. Is there a clear escalation route for patients who experience repeated transport related issues?

Q3. What measures are put in place to ensure timely communication between transport providers and healthcare services when bookings for patient transport are made or changed?

Q4 In terms of providing transport, are there certain illnesses that are not being cared for?

Q5. What is the criteria for a patient to receive patient transport?

Q6. Has there been any recent changes to patient transport in terms of contract of provider?

Q7. What is meant by ‘wrong mobility’, which equates to 60% of missed appointments?

Q8. How is it possible for patient transport to get the wrong address of patients?

Q9. Could the raw data of missed appointments be provided in percentages along with numbers which would make the statistics more meaningful?

Q10. Who is responsible for ensuring the patient transport ambulance staff are physically fit to perform their duties to ensure that particular journeys are not aborted?

Q11. Who is responsible for maintaining records of patients who have physical disabilities?

Q12. What are the underlying reasons for missed appointments in the different areas of Huddersfield Royal Infirmary? Is there an underlying problem?

Q13. What is meant by a failed Journey?

Q14. Who is responsible for booking the transport at an initial appointment?

Q15. Are there any known inequalities in access to patient transport? ie disabilities, rural areas, English not first language?

Q16. What steps have been taken to ensure that services are inclusive, accessible and person centred?

Q17. Are there any patients who live in deprived areas that are disproportionately affected by missed appointments or missed journeys?

Q18. Are there any cost to patients for patient transport services?

Q19. How many patient transport journeys does Huddersfield Royal Infirmary arrange each week?

The Chair of the panel advised that questions would be forwarded to Yorkshire Ambulance Service-Patient Transport Service for a response, which would be published with the minutes. On receiving a response if the panel raised further questions, Patient Transport Services would be invited to a future panel meeting in which attendance was expected.

RESOLVED:

1) That the presentation be noted
2) That questions raised by the panel would be forwarded to Yorkshire Ambulance service – Patient transport service for a response, and would be published with the minutes
3) That Yorkshire Ambulance Service-Patient Transport Services would be invited to a future panel meeting if required, on receipt of responses to questions.

18 Access to GP's

The Panel received a presentation on Access to General Practitioners (GP's).

Catherine Wormstone - Director of Primary Care, Kirklees Health and Care Partnership provided an overview of GP workforce data and access challenges across Kirklees. It was reported that there were approximately 250 full-time equivalent (FTE) GPs in post, including salaried GPs, partners, locums, and trainees. Recruitment remained a challenge, particularly in areas of high deprivation, with practices relying on flexible staffing models such as locums, Physician Associates (PAs), and Advanced Nurse Practitioners (ANPs). Several schemes were in place to attract and retain GPs, including the GP Retainer Scheme, sponsorship for international medical graduates, and the Flexible Staff Pool. Additionally, 29 practices were identified as GP training sites, contributing to workforce sustainability.

The presentation highlighted the evolving roles of PAs and ANPs in general practice. PAs were employed across both general practices and Primary Care Networks (PCNs), performing clinical duties under GP supervision. ANPs, employed in over 20 practices and via PCNs, were qualified to prescribe medication, manage undiagnosed conditions, and refer patients to secondary care. Access methods for patients included telephone, in-person, and online consultations, with practices required to maintain online access during core hours from 1st October 2025. The Pharmacy First initiative was also outlined, enabling pharmacists to treat seven common conditions without GP involvement, thereby improving patient access and reducing pressure on general practice.

Modern General Practice Access was introduced as a national model aimed at improving patient experience and operational efficiency. This included structured triage, care navigation, and better use of multi-professional teams. Transition funding had been provided to 55 of 64 practices in Kirklees, with additional support offered to the remaining practices. Patient survey data from 2025 indicated varied satisfaction levels across PCNs, with improvements noted in ease of contact and appointment wait times. NHS 111 call data showed consistent monthly volumes, peaking during late afternoon hours, although the reasons for calls and their relation to GP access remained unclear.

Questions and comments were invited from Members of the Health and Adults Social Care Scrutiny Panel, and the following was raised:

- A comment was made expressing concern about the increasing shift toward digital access, highlighting that some individuals, particularly older people, may struggle due to limited technological skills or access.
- A question was raised regarding the role of Physician Associates (PA) in general practice, specifically around their involvement in diagnosing illnesses. It was clarified that Physician Associates must work under the supervision of a General Practitioner and were not permitted to operate independently, in line with updated guidance from the Royal College of General Practitioners.
- Further clarification was requested on the difference between Physician Associates and Advanced Nurse Practitioners (ANP). It was explained that ANPs were qualified nurses with advanced clinical training, including prescribing rights, while PAs may come from non-clinical backgrounds and

currently could not prescribe, though future training may include this capability.

- A question was raised about how the number of GPs in Kirklees compared to other areas with similar populations. It was acknowledged that most areas faced challenges in recruiting sufficient GPs, particularly in high-demand locations. Kirklees was noted to be actively pursuing recruitment and retention strategies, including protected time events, support networks, and incentives aimed at newly qualified GPs.
- Comments highlighted the importance of increasing the number of training practices in Kirklees, which was seen as a successful approach to retaining GPs post-training. It was noted that many trainees chose to remain in the area once qualified. A further question explored the destinations of GPs who left practice, with responses indicating that some relocate abroad for lifestyle or financial reasons, while others pursue opportunities in countries with less regulatory scrutiny.
- Questions were raised about rising patient list sizes and the impact on practices serving ageing and deprived populations. It was explained that the Additional Roles Reimbursement Scheme had expanded the range of professionals available in general practice, with 17 roles now accessible to practices and PCNs. Social prescribing link workers were highlighted as particularly effective in supporting patients. Regarding the national GP Patient Survey, it was confirmed that the 25% response rate in Kirklees was consistent with other areas and considered statistically valid when used alongside other feedback sources such as complaints and compliments.
- The Panel asked why Dewsbury and Thornhill consistently ranked lowest in-patient satisfaction surveys. It was explained that although the area often appeared at the lower end within Kirklees, significant improvements had been made year-on-year, particularly when benchmarked across West Yorkshire. Factors such as population demographics and language barriers were acknowledged, and the PCN was recognised for its efforts in improving access and engagement.
- Concerns were raised about GP appointment availability and telephone access at 8am. It was noted that practices had introduced online request options and invested in cloud-based telephony systems, including dedicated call-handling teams, which had significantly reduced call wait times and improved patient experience.
- Concerns were raised about NHS 111 call volumes at 8am, with members noting the pressure on phone lines and the need for improved access solutions.
- The Panel queried the impact of digital access on patient privacy and independence, particularly for those relying on family support.
- Concerns were raised about the limited uptake of Physician Associates (PAs) in general practice, with some practices reluctant to employ them due to the additional workload placed on supervising clinicians and questions around the efficiency of the role.
- The Panel expressed unease about the lack of clinical background required for PAs, noting that the two-year training programme may be insufficient for the level of patient interaction involved. It was highlighted that patients may not be aware they are not seeing a qualified doctor, which could lead to confusion and concern. Concerns were also raised about ANPs managing

undiagnosed conditions, with members seeking reassurance that appropriate safeguards were in place. It was acknowledged that while ANPs had advanced training, they referred patients to GPs when cases fell outside their scope, ensuring patient safety was maintained.

- The Panel discussed the importance of skill mix in general practice, recognising the value of professionals such as pharmacists and ANPs in managing complex cases. It was emphasised that these roles were not intended to replace GPs but to support them, and that national frameworks govern the scope and development of roles like PAs.
- The Panel questioned whether data was available on the outcomes of patients seen by non-GP clinicians, including whether they later required GP follow-up or experienced delayed diagnoses. It was explained that such data may exist at practice level through appraisals and performance reviews but was not currently available in a centralised format.
- Questions were raised about the uptake and impact of the Pharmacy First scheme in Kirklees. While specific local data was not available, it was noted that approximately 98% of pharmacies in Kirklees offered the service, and uptake was believed to be high. Members welcomed the scheme and acknowledged its potential to reduce pressure on GP services.
- Clarification was requested on why nine GP practices had not accepted support to transition to the Modern General Practice Access model. It was explained that some practices felt their current systems worked well for their patients, while others were uncertain about the implications of total triage. There was no requirement to adopt the model, and no clear correlation with performance levels were identified.
- Concerns were raised about the impact of national pharmacy closures on the Pharmacy First scheme. It was confirmed that Kirklees had a robust process for assessing the impact of closures, with recent changes balanced by new pharmacy openings. Outcomes were monitored centrally through national data systems and patient satisfaction surveys.
- The Panel queried the rise in missed appointments (DNAs) and asked whether analysis had been done to understand the reasons. It was suggested that some DNAs may be due to patients forgetting follow-up appointments or recovering before the scheduled date, and that difficulties in cancelling appointments could also contribute. It was also confirmed that DNA rates had decreased compared to previous years, with practices using digital reminders and monthly reviews to monitor and reduce non-attendance.
- The Panel queried the training provided to staff handling appointment triage, particularly for online bookings. It was explained that practices used sophisticated software with built-in algorithms to flag urgent cases, and triage was carried out by a mix of trained administrators, GPs, paramedics, and Physician Associates depending on the practice.
- A question was asked about the current status of home visits. It was confirmed that home visits still occurred but were increasingly carried out by ANPs or paramedics who reported back to GPs, allowing for more efficient use of GP time within practices.

RESOLVED:

1) That representatives be thanked for their attendance and presentation.
2) That the Access to GP’s report be noted.

19 Work Programme 2025/26

The Panel reviewed the work programme for 2025/26.

RESOLVED- That the work programme be noted.