



## NOTICE OF MEETING

**Health Overview and Scrutiny Panel**  
**Thursday 29 September 2016, 7.30 pm**  
**Council Chamber, Fourth Floor, Easthampstead House, Bracknell**

### **To: The Health Overview and Scrutiny Panel**

Councillor Phillips (Chairman), Councillor Tullett (Vice-Chairman), Councillors G Birch, Finnie, Hill, Mrs Mattick, Mrs Temperton, Thompson and Virgo

### **cc: Substitute Members of the Panel**

Councillors Allen, Mrs Angell, Brossard, Harrison and Peacey

### **Observer:**

Mark Sanders, Healthwatch

### **Non-Voting Co-optee**

Dr David Norman, Co-opted Representative

ALISON SANDERS  
Director of Corporate Services

### **EMERGENCY EVACUATION INSTRUCTIONS**

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- 4 Do not re-enter the building until told to do so.

If you require further information, please contact: Greg O'Brien  
Telephone: 01344 352308  
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Published: 5 September 2016



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Bracknell**

Sound recording, photographing, filming and use of social media at meetings which are held in public are permitted. Those wishing to record proceedings at a meeting are however advised to contact the Democratic Services Officer named as the contact for further information on the front of this agenda as early as possible before the start of the meeting so that any special arrangements can be made.

**Note:** *There will be a private meeting for members of the Panel at 7.00 pm in Meeting Room 1, 4<sup>th</sup> Floor, Easthampstead House.*

**AGENDA**

Page No

**1. Apologies for Absence/Substitute Members**

To receive apologies for absence and to note the attendance of any substitute members.

**2. Minutes and Matters Arising**

To approve as a correct record the minutes of the meeting of the Health Overview and Scrutiny Panel held on 30 June 2016.

5 - 12

**3. Declarations of Interest and Party Whip**

Members are requested to declare any Disclosable Pecuniary Interests and/or Affected Interests and the nature of those interests, including the existence and nature of the party whip, in respect of any matter to be considered at this meeting.

Any Member with a Disclosable Pecuniary Interest or an Affected Interest in a matter should withdraw from the meeting when the matter is under consideration and should notify the Democratic Services Officer in attendance that they are withdrawing as they have such an interest. If the Interest is not entered on the register of Members interests the Monitoring Officer must be notified of the interest within 28 days.

**4. Urgent Items of Business**

Any other items which, pursuant to Section 100B(4)(b) of the Local Government Act 1972, the Chairman decides are urgent.

**5. Public Participation**

To receive submissions from members of the public which have been submitted in advance in accordance with the Council's Public Participation Scheme for Overview and Scrutiny.

- |     |   |           |
|-----|---|-----------|
| 6.  | <b>Healthwatch Bracknell Forest</b><br>To give Members the opportunity to raise questions on the 2015-16 Annual report of Healthwatch Bracknell Forest.   | 13 - 34   |
| 7.  | <b>The Patient's Experience</b><br>To consider the current information from the NHS Choices website, for those NHS Foundation Trusts providing most NHS services to Bracknell Forest residents.   | 35 - 40   |
| 8.  | <b>General Practitioner Patient Survey</b><br>To consider the results of the GP Patient Survey for Bracknell Forest GP Practices, published in July 2016.   | 41 - 48   |
| 9.  | <b>A Review of Whether there is sufficient General Practitioner Capacity in Bracknell Forest to meet future Demands</b><br>To adopt the report of the Panel's Working Group which reviewed whether there is sufficient General Practitioner capacity in Bracknell Forest to meet future demands.  | 49 - 104  |
| 10. | <b>The Joint Strategic Needs Assessment and Health and Wellbeing</b><br>To receive updates from the Executive Member and Council Officers on:<br><br>(i) the Joint Strategic Needs Assessment<br>(ii) progress in implementing the Health and Wellbeing Strategy<br>(iii) the outcome of the Peer review of the Health and Wellbeing Board. |           |
| 11. | <b>Departmental Performance</b><br>To consider the parts of the Quarter 1 2016/17 (January to March) quarterly service report of the Adult Social Care, Health and Housing department relating to health.   | 105 - 126 |
| 12. | <b>Executive Key and Non-Key Decisions</b><br>To consider scheduled Executive Key and Non-Key Decisions relating to Health.   | 127 - 130 |
| 13. | <b>Member Feedback</b><br>To receive oral reports from Panel members on their specialist roles since the last Panel meeting.  |           |

### **Date of Next Meeting**

The next meeting of the Health Overview and Scrutiny Panel has been arranged for 12 January 2017.

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**HEALTH OVERVIEW AND SCRUTINY PANEL  
30 JUNE 2016  
7.30 - 9.05 PM**



**Present:**

Councillors Phillips (Chairman), Tullett (Vice-Chairman), G Birch, Finnie, Hill, Mrs Mattick, Mrs Temperton and Thompson

**Co-opted Member:**

Dr David Norman, Co-opted Representative

**Also Present:**

Richard Beaumont, Head of Overview & Scrutiny

Dr Lisa McNally, Consultant in Public Health

Gill Vickers, Director of Adult Social Care, Health & Housing

Councillor Ian Leake, Chairman of the Overview and Scrutiny Commission

Andrew Morris OBE, Chief Executive, Frimley Park NHS Foundation Trust

Councillor Sarah Peacey

**Apologies for absence were received from:**

Councillor Virgo

**56. Election of Chairman**

**RESOLVED** that Councillor Ms Phillips be elected Chairman of the Health Overview and Scrutiny Panel for the 2016/17 Municipal Year.

**Councillor Phillips in the Chair**

**57. Appointment of Vice-Chairman**

**RESOLVED** that Councillor Tullett be elected Vice-Chairman of the Health Overview and Scrutiny Panel for the 2016/17 Municipal Year.

**58. Minutes and Matters Arising**

**RESOLVED** that the minutes of the meeting of the Panel held on 14 April 2016 be approved as a correct record and signed by the Chairman, subject to a correction of the spelling of 'collaborative' in the ninth paragraph of minute 48 [Bracknell Urgent Care Centre].

**59. Declarations of Interest and Party Whip**

There were no declarations of interest nor any indications that members would be participating while under the party whip.

60. **Urgent Items of Business**

There were no items of urgent business.

61. **Public Participation**

There were no submissions under the Council's Public Participation Scheme for Overview and Scrutiny.

62. **Heatherwood Hospital Redevelopment**

Sir Andrew Morris OBE, Chief Executive of Frimley Health NHS Foundation Trust, attended the meeting and briefed the Panel on plans to redevelop Heatherwood Hospital. He explained that the existing buildings at Heatherwood were no longer fit for purpose and it would cost some £23m to restore and maintain them. Instead it was proposed to provide a brand new planned care centre offering a better environment for patients and staff, and a clear future role for Heatherwood Hospital.

The proposal was to develop new facilities providing six operating theatres offering general surgery and most specialties but mainly orthopaedics. There would be 40 in-patient beds (and an eight bed private patient space to generate income) together with 22 day case spaces and endoscopy facilities. This would ease pressure on the extremely busy sites at Wexham and Frimley. It was intended to site the new facilities on part of the woodland behind the existing buildings (subject to planning permission) with the majority of those existing buildings to provide a site for redevelopment with housing, which would generate a substantial capital receipt to part fund the development. The Trust was in detailed discussions with the Royal Borough of Windsor and Maidenhead about the proposals since they involved development in the Green Belt.

The proposals also included the redevelopment of the existing 'Block 40' of the hospital to provide new administrative offices for the Trust, together with dedicated space for education and training. In addition there was potential for provision of a primary care hub which will offer GP and other specialist care delivered outside of a hospital setting. The total estimated cost of the redevelopment was £77m and relied upon around £35m being raised from the sale of land for housing, the remainder being a loan from the Department of Health.

Arising from questions posed by members, Sir Andrew indicated:

- The generally positive feedback to the proposals following a consultation open day at Ascot Racecourse.
- The support from local GPs to the provision of a GP hub at Heatherwood and the success of GP hubs operating in the Surrey Heath area, particularly in relation to reducing emergency admissions to hospital.
- Given a favourable outcome to the dialogue with Windsor and Maidenhead, it was hoped to submit a planning application for the proposals in the autumn 2016, a start on site in June 2017 and completion in the summer of 2019.
- If the proposals were not approved, it was unlikely that it would be possible to retain any facilities for surgery at Heatherwood and probably only outpatient services would continue. That would also require an expansion of surgical facilities at the Frimley and Wexham hospitals.
- 

The Panel thanked Sir Andrew for his presentation and wished him every success in bringing the proposals to fruition.

**63. Berkshire Healthcare Trust**

The Panel received the outcome of the recent inspection of the Berkshire Healthcare NHS Foundation Trust by the Care Quality Commission (CQC). The overall assessment rating for the Trust was 'Good' and a summary of the findings from the CQC report was attached to the report. It was understood the Inspection had been thorough and included visits to many of the Trust sites and facilities across Berkshire. A member and officer had attended the 'Quality Summit' held by the CQC following the inspection.

The Panel was pleased to note the report.

**64. The Patient's Experience**

The Panel considered a report presenting current information from the NHS Choices website, for the NHS Foundation Trusts providing most secondary and acute NHS services to Bracknell Forest residents. The information included details of NHS Choices users ratings, Care Quality Commission (CQC) inspection ratings, recommendations by staff (for a friend or relative), infection control and cleanliness data, and a mortality rate indicator.

The Panel was informed that since the information was compiled, the CQC had issued an overall 'Good' rating for Wexham Park hospital. The Panel noted the report.

**65. Quality Accounts 2015/16**

The Panel considered the comments on the Quality Accounts sent by the Panel to the Royal Berkshire NHS Foundation Trust, Frimley Health NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust and the South Central Ambulance NHS Foundation Trust.

Department of Health Guidance stated that the Quality Accounts submitted by NHS providers, being a measure of the quality of the service delivered to local communities and stakeholders, should contain observations of Overview and Scrutiny Committees. Officer drafts of the comments had been circulated to Panel Members for endorsement before submission to the respective Trusts for consideration.

The Royal Berkshire NHS Foundation Trust and the Berkshire Healthcare NHS Foundation Trust had responded to the Panel answering questions and in a number of cases adding additional information to the Quality Account as requested by the Panel. Their responses were appended to the report.

The Panel noted the report and appendices and thanked the Head of Overview and Scrutiny for his work in drafting the comments for the Panel.

**66. Departmental Performance**

The Panel considered the Quarterly Service Report of the Director of Adult Social Care, Health & Housing covering the period January to March 2016 in relation to those matters concerning health. The Panel welcomed the new Director, Gill Vickers, to the meeting, acknowledging that the report had been prepared before she had taken up her post.

With reference to the Department performance indicators:

- Three indicators for 'Delayed transfers of care' were showing red and performance was declining. Further work was being done to pinpoint the reasons for delay eg. failure to put in place a domiciliary care package promptly or delay in social worker assessment.
- Further investigation was also being undertaken into indicator L180 – 'Time taken for ForestCare customers to receive the service from enquiry to installation' where although this was showing green, performance had declined.

Arising from questions and discussion the following points were noted:

- Additional information on NHS Health Checks showed good performance, generally the best in Berkshire and above the national average. The smoking quit success rate was 78%, well above the 60% target.
- Although the numbers of older people needing support in residential and nursing care who were unable to continue to fund their support was increasing, every assistance was being given to self-funders to make their money go further.
- The new community team structure for Older People and Long Term Conditions was continuing to settle in, which it was hoped would contribute to bringing down the above average sickness rate. Staff would continue to be monitored to seek ensure they were correctly placed to manage their work successfully and progress would be reported at a future meeting.
- The changes at ForestCare were aimed at giving the service the flexibility it needed to expand to provide emergency personal care to customers where this was required. This was being introduced with appropriate recruitment and training measures to ensure staff had the necessary skills to deliver the enhanced service.
- The Year of Self-Care had been a great success with very good rates of participation. The benefits of a locally chosen programme had been confirmed with very good feedback and the pleasing involvement of many local companies. Success rates were being monitored through the existing range of performance indicators.
- Arising from concerns about the level of domiciliary care available for the community, steps had been taken to boost recruitment and ways of establishing more of a career path for carers were being looked into.

The Panel noted the report.

**67. Executive Key and Non-Key Decisions**

The Panel received and noted the schedule of Executive Key and Non-Key Decisions relating to health.

**68. Overview and Scrutiny Bi-Annual Progress Report**

The Panel received and noted the Overview and Scrutiny progress report setting out the activity and developments over the period December 2015 to May 2016.

**69. Working Group on GP Capacity**

The Panel received a progress report on the work of the Working Group reviewing General Practitioner (GP) capacity. The Working Group aimed to hold two more meetings and complete its work in order issue a draft report to the meeting of the Panel in September. The Chairman said that if there was to be any slippage on that date, it would need to be reviewed by the Panel.



## 70. **Member Feedback**

Panel Members provided a number of oral updates on their specialist roles.

Councillor Hill – NHS England had been considering issues for international recruitment in the wake of the referendum result. There was uncertainty over future arrangements for EU residents coming to work in the UK and what effect the Transatlantic Trade and Investment Partnership (TTIP) between the US and the EU would now have.

Councillor G Birch – There were some particular concerns around the effect of the BREXIT vote on drugs in the NHS. Further information on this and on the Cancer Fund may be available by the time of the next meeting.

Councillors Thompson and Mrs Temperton – The Bracknell Health & Wellbeing Board had met on 29 June 2016 and consideration of the following items was noted:

- A presentation on the 'New Vision of Care' had been made illustrating the emphasis being placed on the importance of moving to a model of self-care. This relied on a collaborative approach to doing things differently and might be a useful presentation and discussion item for the Panel at a future meeting.
- The sustainability and transformation plan being formulated was an overarching plan for health and care services across a wide area including Bracknell Forest. These plans should not impede the introduction of any local projects or programmes coming forward in the meantime.
- The Emotional Health and Wellbeing Strategy was a very good policy promoting health in children and young people. This was coupled with a positive report on action and progress of CAMHS.
- A report entitled 'Families in a Strong Community' detailed work on providing a neighbourhood based programme of very early support and intervention for vulnerable families in Bracknell Forest.

Councillor Mrs Mattick – Berkshire Healthcare NHS Foundation Trust had recently held a staff awards ceremony which she had attended. A number of Board members were reaching the end of their term of office and new members would need to be appointed. Councillor Mrs Mattick had also attended the Dementia group at Frimley Park hospital.

Councillor Mrs Phillips – The Comprehensive Local Plan contained elements related to health on which comments were invited. Councillors Hill, Mrs Mattick and Mrs Temperton expressed an interest in assisting the Chairman to formulate comments on behalf of the Panel.

Councillor Mrs Phillips drew attention to the public consultation on a change to the out of hours service for GPs in Sandhurst. Some members of the Panel had met with the Practice Manager and, having reviewed the matter, were supportive of the proposed change. This would be communicated to the Clinical Commissioning Group.

**CHAIRMAN**

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**ACTIONS TAKEN : HEALTH OVERVIEW AND SCRUTINY PANEL MEETING**  
**30 JUNE 2016**

<b><u>Agenda Item</u></b>	<b><u>Action Required</u></b>	<b><u>Action Taken</u></b>
16. Member Feedback	Arrange meeting to consider making a Health O&S response to the Council's consultation on the Comprehensive Local Plan	Meeting held on 18 July. Response to consultation drafted, agreed with Panel Members, and dispatched on 22 July.
	Draft letter to the Clinical Commissioning Group giving the Panel's views on the proposed move of the GP Out Of Hours Service for the Sandhurst Group Practice	Letter drafted, agreed with Panel Members, and sent on 6 July.

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**healthwatch**  
Bracknell Forest

Annual Report 2015/2016



# This report is about the work of Healthwatch Bracknell Forest



This report is about the work we have done from April 2015 to March 2016



This report will tell you about what we will be doing next year



This report is for people that live in, use, or provide health and care services in Bracknell Forest

# Contents

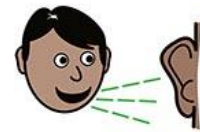
Page 3 Message from the Operational Lead



Pages 4 - 6 Who we are



Page 7 Listening to people who use health and care services



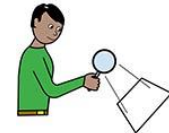
Pages 8 - 9 Giving people advice and information



Pages 10 - 13 How we have made a difference



Pages 14 - 15 Our work in focus



Page 16 Our plans for next year



Pages 17 - 19 Our people



Page 20 Our finances



Page 21 Contact us





# Message from the Operational Lead



Welcome to our annual report for 2015/2016.

We want to make sure that Healthwatch Bracknell Forest is a voice for all members of the community, so we have made our report easier to read this year.

It was a very busy year. People ask what I do as Operational Lead and the answer is - I sit in a lot of meetings.

We have also been busy visiting GP surgeries and meeting people who live and use health and care services in Bracknell Forest.

The staff have had lots of help and support from our volunteers and I would like to thank them for their time and hope they continue to work with us in the coming year.

Looking forward to next year we will finish visiting all the GP surgeries in the area and continue to represent you at the meetings we attend. We will continue to try and make the changes you tell us need to happen to make services better.

I hope you find the report interesting.

A handwritten signature in black ink, appearing to read 'Mark Sanders'.

**Mark Sanders**



# Who we are

Every local authority in England has a local Healthwatch. In Bracknell Forest your Healthwatch is made up of local groups and members of the public - a consortium.

Groups in the consortium:



Every year 3 members of the public are chosen, by voting, to join them. In 2015/2016 these were:



Louise Kirkham



Susan O'Sullivan



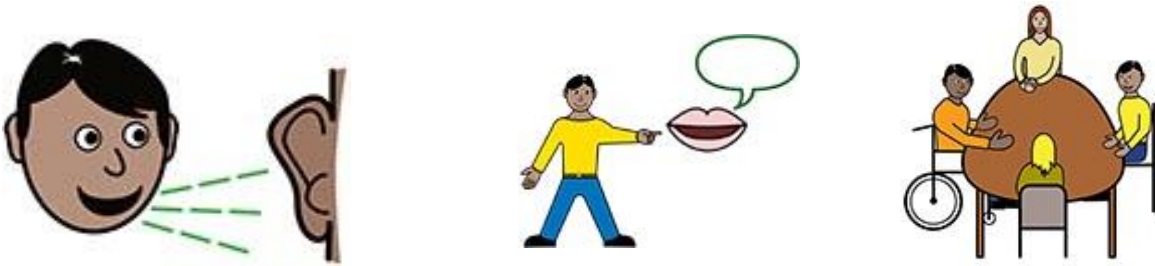
Peter Tobin

Healthwatch Bracknell Forest is based at The Ark's offices and had 4 members of staff during the year.

## Our purpose

To make health and care services work for the people who use them.

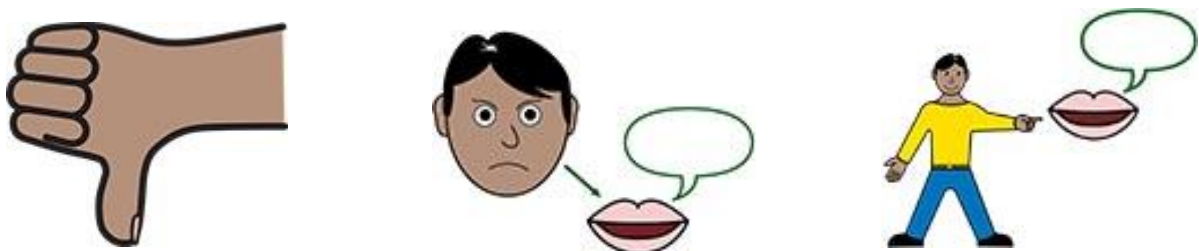
## How we do this



We listen to people who use health and care services, we tell the organisations that provide these services what people are saying and we represent the public at meetings about health and care services.



We provide information and advice about local health and care services to the public.



When things go wrong we can tell you how to make a complaint and, if you want or need support, refer you to local advocacy services.



We can ask for information from providers of health and care services.



We can visit health and care services. This is called an **Enter and View** visit.

### Our vision



Every voice counts, everyone matters

### Our priorities in 2015/2016

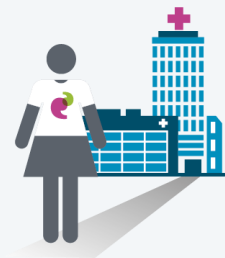
- 1 Letting people know about Healthwatch Bracknell Forest and the work it does, especially younger people and people who work in care.
- 2 Improving access to Primary Care services. Primary Care services include GPs and dentists.
- 3 Working with the patients at Broadmoor Hospital. This is a residential, high secure hospital for people with mental illness.
- 4 Improving access to hospital out-patient clinics.

# Listening to people who use health and care services

We talk to local people and organisations on social media



We have visited 17 local services and spoken to people



We have met lots of people at 53 community events



We have received 1,377 pieces of feedback about services



# Giving people advice and information



You can ask us for information and advice by:

- Visiting the office
- Talking to us at an event
- Telephone
- Email
- Visiting the website
- Letter
- Social media

During the year **348** people asked us for information and advice.



## Email bulletin

We sent people on our email mailing list health and care information every 2 weeks.

At the start of the year we had **306** people on our email mailing list. By the end of the year we had **1180**.

An excellent document yet again. Thank you!

Very helpful and provided a lot of useful information

## Website

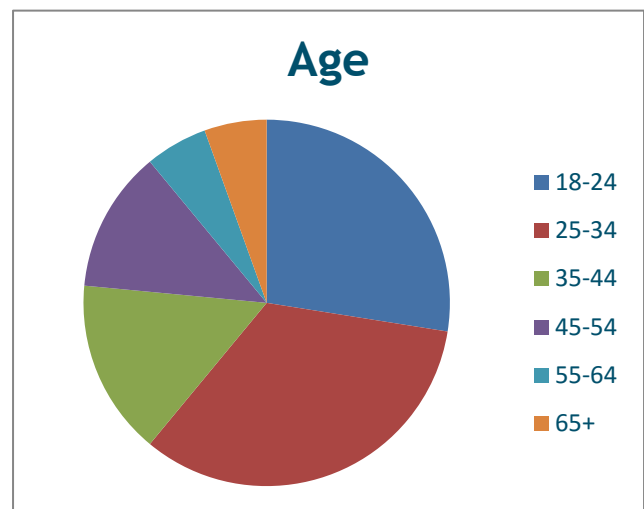
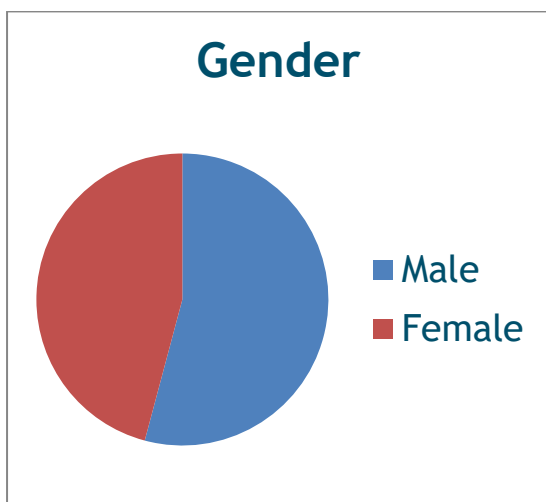
Our website has lots of information about us. It also has information about local health and care services.

We post news from other organisations such as Public Health.



8600 people looked at our website during the year. They looked at 40852 web pages of information.

Who visits the website?

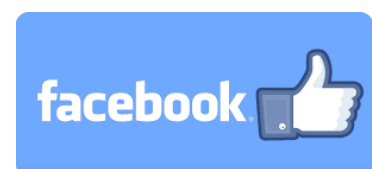


## Social Media

We 'tweeted' and 'posted' 412 times in the year

We interacted with 2011 people

We reached almost 35000 people



**Interacted** means people got involved. They might have re-tweeted to their followers, asked a question or started a conversation with us.

**Reached** means the amount of people who saw our posts.

# How we have made a difference

## Our reports and recommendations



After we have done an ‘Enter and View’ visit we write a report. This tells people about what we saw and what patients or people using the service have told us. We make recommendations (ideas) about how the **provider** of the service could make changes to make the service better for the people who use it.

**Providers** are the people or organisations responsible for the service. This could be a GP Practice, an NHS Trust, a company running a care home or the local authority.

We have written **15** reports and recommendations.



We also attend lots of meetings with **providers** and are able to give our recommendations to improve their services. This is why it is important for you to tell us about your experiences of health and care services, good and bad.

Some of the meetings we attend representing the public are:

- **Berkshire Healthcare NHS Foundation Trust Patient Experience and Engagement Group (PEEG)**  
Heads of Service (community services, mental health, district nursing) meet with Healthwatch Bracknell Forest and other patient representatives to talk about what has been working well for patients and to try to make things better when it has not worked so well. It meets every 3 months.
- **Better Futures for All**  
People from hospitals, the fire service, the local authority, GPs, the Clinical Commissioning Group (who pay for local health services), Healthwatch Bracknell Forest and patient representatives meet every month to talk about plans for new local services and how well other services are doing.



- **Learning Disability Partnership Board**

One of the Healthwatch consortium partners, Wokingham, Bracknell and Districts Mencap, are a member of this Board. They meet every 3 months and work with the local council and other local groups to make services and activities for people with learning disabilities in Bracknell Forest better.

129 **129 meetings attended this year!**

### Working with other organisations



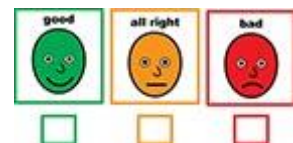
#### Bracknell and Ascot Clinical Commissioning Group (BACCG)

As well as going to meetings where we represent the voice of the public, we are also paid extra money to work with young people and extra money to help the Bracknell and Ascot Patient Assembly. We arrange their meetings, take their minutes and help them plan events.

#### Health Trusts

We work with Frimley Health NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust and West London Mental Health NHS Trust. As well as meetings we also read and comment on their **Quality Accounts** every year based on what the public has told us.

A **Quality Account** is a report about the quality of services by an NHS healthcare provider.



#### Local Authority

We give the local authority the public's feedback on the health and care services they provide and we also send out health messages on behalf of the Public Health team. We are a voting member of the Health and Wellbeing Board.



## Other local healthwatch and Healthwatch England

There are 150 local healthwatch organisations in England. We share information and work together and form a **network**.



We work very closely with our neighbouring healthwatch organisations and meet regularly. Berkshire has 6 healthwatch so we share some of the work. Healthwatch Bracknell Forest leads on the work with Frimley Health NHS Foundation Trust; other healthwatch pass on any patient feedback to us. Healthwatch Reading takes the leading role on work with Royal Berkshire NHS Foundation Trust.

We all share information with Healthwatch England so they can report on health and care services for the whole country. Healthwatch England also provides us with help and support.



### Care Quality Commission (CQC)

The CQC is an independent organisation that checks people get good, safe health and social care and it meets the rules set by Government. If a provider is not meeting the rules the CQC can take action against them to make them improve or, if necessary, close the service to keep people safe.

We provide the CQC with the feedback we have about services before they go and check them.

### SEAP

This organisation provides the NHS Complaints Advocacy Service. If you need to make a complaint to the NHS they can help and support you. We share information with each other to highlight problems with local services.





**Involve and local community groups**  
Involve help to support the hundreds of community sector groups in our area. During the year we ran two ‘Healthwatch Voices’ events together for groups. One was on Safeguarding Adults and the other on services available for unpaid carers.

Involve and Healthwatch Bracknell Forest have also been funded by BACCG to develop an online, interactive map of all the groups in the area. This should be available to the public later in 2016.



### **Bracknell Forest Safeguarding Adults Partnership Board**

Safeguarding is everyone’s business. As a member of the board we can alert our partners of potential problems in the community. All staff and volunteers of Healthwatch Bracknell Forest have to undergo Safeguarding Adults training.

### **Self-Care Week**



Self-care is all about people looking after themselves. In Bracknell the first Self-Care Week was in 2012. We are one of the project partners and a member of the Prevention and Self-Care Board. We help with planning the week and putting on the events.

Throughout the year we send out information about how people can look after themselves and manage long-term health conditions.

# Our work in focus

## Frimley Health NHS Foundation Trust



Frimley Health runs three hospitals - Wexham Park, Heatherwood and Frimley Park. The majority of people in Bracknell (70%) use Frimley Park.

Our Operational Lead, Mark Sanders, meets every month with Claire Marshall, Head of Patient Experience for Frimley Health.

At the monthly meetings we can tell Frimley Health what people in Bracknell Forest have been saying about the hospital and their experiences of being a patient or as a friend/relative of a patient.

These are some of the **outcomes** (results) of these meetings:

- The café and restaurant can now accept payment by debit card
- A change machine will be available
- There are signs in Nepalese in 3 important areas
- Visiting hours are now more flexible
- Family members can now book to see a doctor to discuss their relative's condition on ward G3 (this is a ward for people recovering from a stroke)

We are also working with Frimley Health on the bigger issues of discharge from hospital, **DBS checks** and Safeguarding Training.

**DBS checks** are checks made with the Disclosure and Barring Service. These checks can tell employers if someone has been in trouble with the police. There are different levels; some only include current criminal convictions, others cover anything that has happened in the past.



NHS Policy about who should have the checks, how often and at what level is unclear.

## Working with GP Surgeries

One of our priorities for 2015/2016 was:

**Improving access to Primary Care services. Primary Care services include GPs and dentists.**

This is a priority because of the amount of feedback we have had from the public. Many people have problems making an appointment with a GP when they need one.

Other issues people have told us about GP surgeries:

- Trouble getting through to the surgery by telephone
- Having to tell receptionists what the problem is
- Not knowing where to find information about health conditions like diabetes and high blood pressure
- Difficulties accessing the surgery if you use a wheelchair or walking stick
- Not being able to see the GP they want
- Privacy at reception



In the year we visited 10 of the 19 surgeries in our area. We then wrote a report and gave recommendations for each surgery. Some of the changes that have already been made include:

- Layout of waiting rooms to make them accessible
- Providing background noise
- Changes to appointment booking system
- Accessible reception desks no longer used for storage
- Changes to websites to make them 'user-friendly'
- Responses to patient feedback

We will be visiting the other 9 surgeries in 2016/2017.

# Our plans for next year

At our big public meeting in April 2016 we agreed our priorities for 2016/2017

- 1 Mental Health services
- 2 Dental care
- 3 Care homes
- 4 Care Act Advocacy

We will also continue to let people in the community know about Healthwatch Bracknell Forest and get their feedback on local health and care services.

We have a **Communications and Engagement Plan** that looks at how we let people in the community know about Healthwatch Bracknell Forest and how we talk to them. It is now 3 years old so this year we will be looking at it - in case we need to make any changes.



## Accessible Information Standard

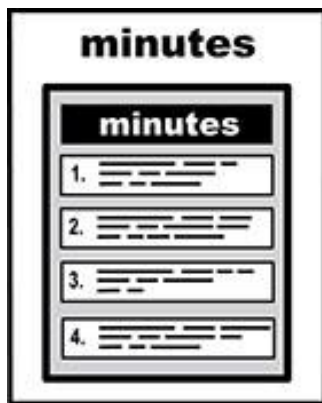
We will be working towards this during 2016/2017.

It means we will provide information in the ways that people have told us they need. This could be easy read, larger print or audio/visual.

# Our people

## Decision making

Every month members of the consortium, the 3 public members and Healthwatch staff meet. This is called the Project Management Board.



They talk about what the staff and groups have done, what feedback has been received from the public and members of their groups.

They make decisions about the work Healthwatch Bracknell Forest will do.

Members of the public can come to listen to the meeting and can read the minutes (notes) of the meeting on our website.

Our priorities are based on what **YOU** say.

## Volunteers

At the end of the year we had 27 volunteers.

There are lots of ways that people can volunteer for Healthwatch Bracknell Forest:



Put your name forward for the elections for Public Board members that takes place every April.



Become an Enter and View representative.



Become a Community Champion and help us tell people about Healthwatch Bracknell Forest.



All of our volunteers receive training. This training is done in a way that suits you and is accessible.

Contact us if you would like more information about becoming a member of the Healthwatch Bracknell Forest Team.

On the next page you can see some photos of the team in action.....







# Our finances

Income	£
Funding from Bracknell Forest Council to deliver local Healthwatch	100,122
Additional income from BACCG	29,526
<b>Total income</b>	<b>129,648</b>
<b>Expenditure</b>	
Operational costs	28,153
Staffing costs (including training)	63,136
Office costs	8,463
BACCG project costs	29,526
<b>Total expenditure</b>	<b>129,278</b>
Balance brought forward	370

**Income** is the money that we received to fund our work

**Expenditure** is the money we spent doing our work

**Balance brought forward** is money we can spend next year

# Contact us



## Registered Office address:

The Space, 20-21 Market Street, Bracknell, Berkshire,  
RG12 1JG



## Phone number:

01344266911



## Email:

[enquiries@healthwatchbracknellforest.co.uk](mailto:enquiries@healthwatchbracknellforest.co.uk)



## Website:

[www.healthwatchbracknellforest.co.uk](http://www.healthwatchbracknellforest.co.uk)

This annual report is available on our website and has been sent to Healthwatch England, CQC, NHS England, BACCG and Bracknell Forest Council.

We confirm that we use the Healthwatch Trademark (which covers the logo and Healthwatch brand) when carrying out our work as covered by the licence agreement.

If you require this report in a different format please contact us.

Thanks to  for the use of their image bank © LYPFT

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**TO: HEALTH OVERVIEW AND SCRUTINY PANEL  
29 SEPTEMBER 2016**

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**THE PATIENTS' EXPERIENCE  
Assistant Chief Executive**

**1 PURPOSE OF REPORT**

- 1.1 This report invites the Health Overview and Scrutiny (O&S) Panel to review the current information from the NHS Choices website, for the National Health Service Foundation Trusts providing most secondary and acute NHS services to Bracknell Forest residents.

**2 RECOMMENDATIONS**

**That the Health Overview and Scrutiny Panel:**

- 2.1 **Considers the NHS Choices information concerning the nearby NHS Trusts, at Appendix 1.**
- 2.2 **Determines whether to make any further enquiries based on the NHS Choices information.**

**3 SUPPORTING INFORMATION**

- 3.1 The Health O&S Panel has previously decided to obtain direct knowledge of the service user's perspective of public services, also on mortality rates in hospitals, through a regular flow of relevant and timely information about the quality of NHS services provided to Bracknell Forest residents. This is to include inpatient survey results and the NHS Choices information.

NHS Choices Website

- 3.2 NHS Choices ([www.nhs.uk](http://www.nhs.uk)) is the UK's biggest health website. It provides a comprehensive health information service, including more than 20,000 regularly updated articles. There are also hundreds of thousands of entries in more than 50 directories that can be used to find, choose and compare health services in England.

The site draws together the knowledge and expertise of:

- NHS Evidence, formerly the National Library for Health
- the Health and Social Care Information Centre (HSCIC)
- the Care Quality Commission (CQC)
- many other health and social care organisations

**ALTERNATIVE OPTIONS CONSIDERED/ ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS/ EQUALITIES IMPACT ASSESSMENT/ STRATEGIC RISK MANAGEMENT ISSUES / OTHER OFFICERS/ CONSULTATION – Not applicable**

Contact for further information







Richard Beaumont – 01344 352283

e-mail: [richard.beaumont@bracknell-forest.gov.uk](mailto:richard.beaumont@bracknell-forest.gov.uk)

NHS Choices users rating	Care Quality Commission inspection ratings	Recommended by staff	Open and honest reporting	Infection control and cleanliness	Mortality rate	Food: Choice and Quality
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**Heatherwood Hospital**  Add to shortlist








Tel: 01344 623333  
 London Road  
 Ascot  
 Berkshire  
 SL5 8AA  
 2.7 miles away | [Get directions](#)

 18 ratings <b>Rate it yourself</b>	 No rating <b>Visit CQC profile</b>	 Within expected range with a value of 80%	 As expected	 Among the best	 As expected in hospital and up to 30 days after discharge (0.9341)	n/a No relevant data available
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**Frimley Park Hospital**  Add to shortlist

Tel: 01276 604604  
 Portsmouth Road  
 Camberley  
 Surrey  
 GU16 7UJ  
 7.1 miles away | [Get directions](#)

 269 ratings <b>Rate it yourself</b>	 Outstanding <b>Visit CQC profile</b>	 Within expected range with a value of 80%	 As expected	 Among the best	 As expected in hospital and up to 30 days after discharge (0.9341)	 90.71% Among the best
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NHS Choices users rating	Care Quality Commission inspection ratings	Recommended by staff	Open and honest reporting	Infection control and cleanliness	Mortality rate	Food: Choice and Quality
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**St Mark's Hospital**  Add to shortlist

<p><b>Tel: 01628 632012</b>                  St Mark's Road                  Maidenhead                  Berkshire                  Berkshire                  SL6 6DU                  7.1 miles away   <a href="#">Get directions</a></p> <p> </p>	<p> 21 ratings  <a href="#">Rate it yourself</a></p>	<p><b>n/a</b>                  Not yet rated</p>	<p> Within expected range with a value of 74%</p>	<p><b>n/a</b>                  No relevant data available</p>	<p><b>n/a</b>                  No relevant data available</p>	<p><b>n/a</b>                  Not available for independent or specialist hospitals</p>	<p></p>
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**King Edward VII**  Add to shortlist

<p><b>Tel: 01753 860441</b>                  St. Leonards Road                  Windsor                  Berkshire                  SL4 3DP                  6.7 miles away   <a href="#">Get directions</a></p> <p> </p>	<p> 6 ratings  <a href="#">Rate it yourself</a></p>	<p><b>n/a</b>                  Not yet rated</p>	<p> Within expected range with a value of 74%</p>	<p><b>n/a</b>                  No relevant data available</p>	<p><b>n/a</b>                  No relevant data available</p>	<p><b>n/a</b>                  Not available for independent or specialist hospitals</p>	<p><b>n/a</b>                  No relevant data available</p>
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NHS Choices users rating	Care Quality Commission inspection ratings	Recommended by staff	Open and honest reporting	Infection control and cleanliness	Mortality rate	Food: Choice and Quality
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**Royal Berkshire Hospital**  Add to shortlist

<p><b>Tel: 0118 322 5111</b>                  London Road                  Craven Road                  Reading                  Berkshire                  RG1 5AN                  9.4 miles away   <a href="#">Get directions</a></p> <p> </p>	<p> 344 ratings  <b>Rate it yourself</b></p>	<p>                  Requires Improvement  <b>Visit CQC profile</b></p>	<p>                  Within expected range with a value of 74%</p>	<p>                  As expected</p>	<p>                  As expected</p>	<p>                  As expected in hospital and up to 30 days after discharge (0.9457)</p>	<p>                  94.71% Among the best</p>
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**Wexham Park Hospital**  Add to shortlist

<p><b>Tel: 01753 633000</b>                  Wexham                  Slough                  Berkshire                  SL2 4HL                  10.7 miles away   <a href="#">Get directions</a></p> <p> </p>	<p> 168 ratings  <b>Rate it yourself</b></p>	<p><b>n/a</b>                  Not yet rated</p>	<p>                  Within expected range with a value of 80%</p>	<p>                  As expected</p>	<p>                  Among the best</p>	<p>                  As expected in hospital and up to 30 days after discharge (0.9341)</p>	<p></p>
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NHS Choices users rating	Care Quality Commission inspection ratings	Recommended by staff	Open and honest reporting	Infection control and cleanliness	Mortality rate	Food: Choice and Quality
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<b>Prospect Park Hospital</b>							<input type="checkbox"/> Add to shortlist
<p><b>Tel: 0118 960 5000</b>                  Honey End Lane                  Tilehurst                  Reading                  Berkshire                  RG30 4EJ                  11.7 miles away   <a href="#">Get directions</a></p> <p>  </p>	<p>                  24 ratings  <a href="#">Rate it yourself</a></p>	<p>                  No rating <b>Visit CQC profile</b></p>	<p>                  Within expected range with a value of 74%</p>	<p><b>n/a</b>                  No relevant data available</p>	<p><b>n/a</b>                  No relevant data available</p>	<p><b>n/a</b>                  Not available for independent or specialist hospitals</p>	<p>                  96.97%                  Among the best</p>

Explanatory Notes

**NHS Choices User Ratings**

The proportion of the people who rated this hospital on NHS Choices who would recommend the organisation's services to a friend.

**Care Quality Commission Inspection Ratings**

As the independent regulator for health and adult social care in England, CQC check whether services are meeting their national standards of quality and safety.

**Recommended by Staff**

This measure shows whether staff agreed that if a friend or relative needed treatment they would be happy with the standard of care provided by the trust. The results are taken from the most recent national NHS staff survey.

**Open and Honest Reporting**

This is a new indicator that combines several other indicators to give an overall picture of whether the hospital has a good patient safety incident reporting culture.

**Infection and cleanliness**

This is a new combined (composite) indicator that describes how well the organisation is performing on preventing infections and cleaning. It is constructed from the existing data displayed on NHS Choices regarding the number of C. difficile and MRSA infections and patients' views on the cleanliness of wards.

**Mortality Rate**

Whether the rate of deaths for an NHS Trust is better or worse than expected for the Trust based on the type of cases treated. The adjusted mortality ratio reflects deaths in hospital and within 30 days of discharge.

**Food: Choice and Quality**

This indicator shows the results of the 2014 Patient-Led Assessments of the Care Environment, and shows a combined score for choice and quality of food.



**TO: HEALTH OVERVIEW AND SCRUTINY PANEL  
29 SEPTEMBER 2016**

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**GENERAL PRACTITIONER PATIENT SURVEY  
Assistant Chief Executive**

**1 PURPOSE OF REPORT**

- 1.1 This report invites the Health Overview and Scrutiny (O&S) Panel to consider the latest GP Patient survey results for Bracknell Forest GP practices.

**2 RECOMMENDATION**

**That the Health Overview and Scrutiny Panel:**

- 2.1 Reviews the latest GP Patient Survey results at Appendix 1**  
**2.2 Considers further scrutiny of survey themes or individual GP practices where the survey results are markedly different to the England average.**

**3 SUPPORTING INFORMATION**

- 3.1 The Health O&S Panel has previously decided to obtain direct knowledge of the service user's perspective of public services, through a regular flow of relevant and timely information about the quality of NHS services provided to Bracknell Forest residents. This is to include the periodic GP survey.
- 3.2 The GP Patient Survey is run every six months by Ipsos Mori for NHS England. It is designed to give patients the opportunity to comment on their experience of their GP practice. Every 6 months, over one million questionnaires are sent out to adult patients, randomly selected from all patients registered with a GP in England. The latest survey consisted of around 2.15 million postal questionnaires sent out to adults registered with GP practices in England across two separate waves, from July to September 2015 and again from January to March 2016. Over 836,000 patients completed and returned a questionnaire, resulting in a national response rate of 38.9%.
- 3.3 The survey results published in July 2016 are based on aggregated data collected from the two most recent waves of the survey. This is to create sufficiently large sample sizes to publish statistically robust results at GP practice level. Results are also published at national and Clinical Commissioning Group level. Data are weighted by age and gender so that results resemble the eligible registered list population of each practice and CCG.
- 3.4 The full results of the GP Patient survey are accessible on the NHS England website at <http://www.gp-patient.co.uk/>. The highlight results for the Bracknell Forest GP Practices are at Appendix 1, showing comparisons to the averages for the Bracknell and Ascot Clinical Commissioning Group area and the England average. The Appendix also shows the current inspection ratings by the Care Quality Commission.























































**ALTERNATIVE OPTIONS CONSIDERED/ ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS/ EQUALITIES IMPACT ASSESSMENT/ STRATEGIC RISK MANAGEMENT ISSUES / OTHER OFFICERS/ CONSULTATION – Not applicable**



















Contact for further information

Richard Beaumont – 01344 352283



















e-mail: [richard.beaumont@bracknell-forest.gov.uk](mailto:richard.beaumont@bracknell-forest.gov.uk)







**GP Patient Survey highlight results for GP Practices in Bracknell Forest, July 2016**

Binfield Surgery	Care Quality Commission rating – Good		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>What this practice <b>does best</b> <span>?</span></p> <ul style="list-style-type: none"> <li> <b>83%</b> of respondents usually wait 15 minutes or less after their appointment time to be seen <small>Local (CCG) average: 70%   National average: 65%</small></li> <hr/> <li> <b>93%</b> of respondents say the last nurse they saw or spoke to was good at treating them with care and concern <small>Local (CCG) average: 90%   National average: 91%</small></li> <hr/> <li> <b>76%</b> of respondents are satisfied with the surgery's opening hours <small>Local (CCG) average: 74%   National average: 76%</small></li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <p>What this practice <b>could improve</b> <span>?</span></p> <ul style="list-style-type: none"> <li> <b>43%</b> of respondents with a preferred GP usually get to see or speak to that GP <small>Local (CCG) average: 60%   National average: 59%</small></li> <hr/> <li> <b>66%</b> of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care <small>Local (CCG) average: 81%   National average: 82%</small></li> <hr/> <li> <b>71%</b> of respondents say the last GP they saw or spoke to was good at giving them enough time <small>Local (CCG) average: 85%   National average: 87%</small></li> </ul> </td> </tr> </table>		<p>What this practice <b>does best</b> <span>?</span></p> <ul style="list-style-type: none"> <li> <b>83%</b> of respondents usually wait 15 minutes or less after their appointment time to be seen <small>Local (CCG) average: 70%   National average: 65%</small></li> <hr/> <li> <b>93%</b> of respondents say the last nurse they saw or spoke to was good at treating them with care and concern <small>Local (CCG) average: 90%   National average: 91%</small></li> <hr/> <li> <b>76%</b> of respondents are satisfied with the surgery's opening hours <small>Local (CCG) average: 74%   National average: 76%</small></li> </ul>	<p>What this practice <b>could improve</b> <span>?</span></p> <ul style="list-style-type: none"> <li> <b>43%</b> of respondents with a preferred GP usually get to see or speak to that GP <small>Local (CCG) average: 60%   National average: 59%</small></li> <hr/> <li> <b>66%</b> of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care <small>Local (CCG) average: 81%   National average: 82%</small></li> <hr/> <li> <b>71%</b> of respondents say the last GP they saw or spoke to was good at giving them enough time <small>Local (CCG) average: 85%   National average: 87%</small></li> </ul>
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Crown Wood Medical Centre	Care Quality Commission rating – Good		
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<p><b>Crowthorne (New Wokingham Road Surgery)</b></p>	<p><b>Care Quality Commission rating - Good</b></p>
<p><b>What this practice <b>does best</b></b></p> <ul style="list-style-type: none"> <li>  <b>97%</b> of respondents find it easy to get through to this surgery by phone  <small>Local (CCG) average: 76%   National average: 73%</small> </li> <li>  <b>80%</b> of respondents with a preferred GP usually get to see or speak to that GP  <small>Local (CCG) average: 66%   National average: 59%</small> </li> <li>  <b>89%</b> of respondents describe their experience of making an appointment as good  <small>Local (CCG) average: 78%   National average: 73%</small> </li> </ul>	<p><b>What this practice <b>could improve</b></b></p> <ul style="list-style-type: none"> <li>  <b>81%</b> of respondents say the last GP they saw or spoke to was good at explaining tests and treatments  <small>Local (CCG) average: 88%   National average: 86%</small> </li> <li>  <b>84%</b> of respondents say the last GP they saw or spoke to was good at listening to them  <small>Local (CCG) average: 90%   National average: 89%</small> </li> <li>  <b>81%</b> of respondents say the last GP they saw or spoke to was good at treating them with care and concern  <small>Local (CCG) average: 85%   National average: 85%</small> </li> </ul>
<p><b>Crowthorne Heath Hill Surgery</b></p>	<p><b>Care Quality Commission rating - Good</b></p>
<p><b>What this practice <b>does best</b></b></p> <ul style="list-style-type: none"> <li>  <b>83%</b> of respondents find it easy to get through to this surgery by phone  <small>Local (CCG) average: 71%   National average: 73%</small> </li> <li>  <b>96%</b> of respondents say the last GP they saw or spoke to was good at listening to them  <small>Local (CCG) average: 88%   National average: 89%</small> </li> <li>  <b>89%</b> of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care  <small>Local (CCG) average: 81%   National average: 82%</small> </li> </ul>	<p><b>What this practice <b>could improve</b></b></p> <ul style="list-style-type: none"> <li>  <b>56%</b> of respondents usually wait 15 minutes or less after their appointment time to be seen  <small>Local (CCG) average: 70%   National average: 65%</small> </li> <li>  <b>77%</b> of respondents were able to get an appointment to see or speak to someone the last time they tried  <small>Local (CCG) average: 86%   National average: 85%</small> </li> <li>  <b>83%</b> of respondents say the last appointment they got was convenient  <small>Local (CCG) average: 90%   National average: 92%</small> </li> </ul>
<p><b>Easthampstead Surgery</b></p>	<p><b>Care Quality Commission rating – Inadequate</b></p>
<p><b>What this practice <b>does best</b></b></p> <ul style="list-style-type: none"> <li>  <b>76%</b> of respondents usually wait 15 minutes or less after their appointment time to be seen  <small>Local (CCG) average: 70%   National average: 65%</small> </li> <li>  <b>90%</b> of respondents find the receptionists at this surgery helpful  <small>Local (CCG) average: 85%   National average: 87%</small> </li> <li>  <b>91%</b> of respondents say the last nurse they saw or spoke to was good at treating them with care and concern  <small>Local (CCG) average: 90%   National average: 91%</small> </li> </ul>	<p><b>What this practice <b>could improve</b></b></p> <ul style="list-style-type: none"> <li>  <b>66%</b> of respondents would recommend this surgery to someone new to the area  <small>Local (CCG) average: 77%   National average: 78%</small> </li> <li>  <b>50%</b> of respondents with a preferred GP usually get to see or speak to that GP  <small>Local (CCG) average: 60%   National average: 59%</small> </li> <li>  <b>70%</b> of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care  <small>Local (CCG) average: 81%   National average: 82%</small> </li> </ul>

Evergreen Practice	Care Quality Commission rating – Good
<p><b>What this practice <b>does best</b></b></p> <ul style="list-style-type: none"> <li>86% of respondents with a preferred GP usually get to see or speak to that GP Local (CCG) average: 60%   National average: 59%</li> <li>91% of respondents find it easy to get through to this surgery by phone Local (CCG) average: 71%   National average: 73%</li> <li>84% of respondents describe their experience of making an appointment as good Local (CCG) average: 72%   National average: 73%</li> </ul>	<p><b>What this practice <b>could improve</b></b></p> <ul style="list-style-type: none"> <li>82% of respondents say the last nurse they saw or spoke to was good at listening to them Local (CCG) average: 90%   National average: 91%</li> <li>75% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care Local (CCG) average: 81%   National average: 82%</li> <li>79% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care Local (CCG) average: 84%   National average: 85%</li> </ul>
Forest End Medical Centre	Care Quality Commission rating – Good
<p><b>What this practice <b>does best</b></b></p> <ul style="list-style-type: none"> <li>71% of respondents usually wait 15 minutes or less after their appointment time to be seen Local (CCG) average: 70%   National average: 65%</li> <li>82% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care Local (CCG) average: 81%   National average: 82%</li> <li>84% of respondents say the last GP they saw or spoke to was good at treating them with care and concern Local (CCG) average: 84%   National average: 85%</li> </ul>	<p><b>What this practice <b>could improve</b></b></p> <ul style="list-style-type: none"> <li>30% of respondents with a preferred GP usually get to see or speak to that GP Local (CCG) average: 80%   National average: 59%</li> <li>61% of respondents describe their experience of making an appointment as good Local (CCG) average: 72%   National average: 73%</li> <li>76% of respondents were able to get an appointment to see or speak to someone the last time they tried Local (CCG) average: 86%   National average: 85%</li> </ul>
The Gainsborough Practice	Care Quality Commission rating – Good
<p><b>What this practice <b>does best</b></b></p> <ul style="list-style-type: none"> <li>94% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments Local (CCG) average: 84%   National average: 86%</li> <li>92% of respondents say the last GP they saw or spoke to was good at giving them enough time Local (CCG) average: 85%   National average: 87%</li> <li>92% of respondents say the last GP they saw or spoke to was good at listening to them Local (CCG) average: 88%   National average: 89%</li> </ul>	<p><b>What this practice <b>could improve</b></b></p> <ul style="list-style-type: none"> <li>78% of respondents find the receptionists at this surgery helpful Local (CCG) average: 85%   National average: 87%</li> <li>64% of respondents usually wait 15 minutes or less after their appointment time to be seen Local (CCG) average: 70%   National average: 65%</li> <li>68% of respondents are satisfied with the surgery's opening hours Local (CCG) average: 74%   National average: 76%</li> </ul>

Great Hollands Health Centre	Care Quality Commission rating - Requires Improvement
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p><b>What this practice <b>does best</b></b></p> <ul style="list-style-type: none"> <li> <b>90%</b> of respondents find it easy to get through to this surgery by phone <small>Local (CCG) average: 71%   National average: 73%</small></li> <hr/> <li> <b>74%</b> of respondents with a preferred GP usually get to see or speak to that GP <small>Local (CCG) average: 60%   National average: 59%</small></li> <hr/> <li> <b>84%</b> of respondents are satisfied with the surgery's opening hours <small>Local (CCG) average: 74%   National average: 76%</small></li> </ul> </div> <div style="width: 48%;"> <p><b>What this practice <b>could improve</b></b></p> <ul style="list-style-type: none"> <li> <b>78%</b> of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care <small>Local (CCG) average: 81%   National average: 82%</small></li> <hr/> <li> <b>93%</b> of respondents had confidence and trust in the last GP they saw or spoke to <small>Local (CCG) average: 95%   National average: 95%</small></li> <hr/> <li> <b>85%</b> of respondents say the last GP they saw or spoke to was good at listening to them <small>Local (CCG) average: 88%   National average: 89%</small></li> </ul> </div> </div>	
Ringmead Medical Practice	Care Quality Commission checks underway. Previous inspection in November 2013 concluded that all standards were being met
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p><b>What this practice <b>does best</b></b></p> <ul style="list-style-type: none"> <li> <b>96%</b> of respondents say the last nurse they saw or spoke to was good at explaining tests and treatments <small>Local (CCG) average: 88%   National average: 90%</small></li> <hr/> <li> <b>96%</b> of respondents say the last nurse they saw or spoke to was good at treating them with care and concern <small>Local (CCG) average: 90%   National average: 91%</small></li> <hr/> <li> <b>90%</b> of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care <small>Local (CCG) average: 84%   National average: 85%</small></li> </ul> </div> <div style="width: 48%;"> <p><b>What this practice <b>could improve</b></b></p> <ul style="list-style-type: none"> <li> <b>44%</b> of respondents usually wait 15 minutes or less after their appointment time to be seen <small>Local (CCG) average: 70%   National average: 65%</small></li> <hr/> <li> <b>46%</b> of respondents with a preferred GP usually get to see or speak to that GP <small>Local (CCG) average: 60%   National average: 59%</small></li> <hr/> <li> <b>65%</b> of respondents describe their experience of making an appointment as good <small>Local (CCG) average: 72%   National average: 73%</small></li> </ul> </div> </div>	
The Sandhurst Group Practice	Care Quality Commission rating - Good
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p><b>What this practice <b>does best</b></b></p> <ul style="list-style-type: none"> <li> <b>73%</b> of respondents with a preferred GP usually get to see or speak to that GP <small>Local (CCG) average: 60%   National average: 59%</small></li> <hr/> <li> <b>79%</b> of respondents usually wait 15 minutes or less after their appointment time to be seen <small>Local (CCG) average: 70%   National average: 65%</small></li> <hr/> <li> <b>78%</b> of respondents describe their experience of making an appointment as good <small>Local (CCG) average: 72%   National average: 73%</small></li> </ul> </div> <div style="width: 48%;"> <p><b>What this practice <b>could improve</b></b></p> <ul style="list-style-type: none"> <li> <b>85%</b> of respondents say the last nurse they saw or spoke to was good at treating them with care and concern <small>Local (CCG) average: 90%   National average: 91%</small></li> <hr/> <li> <b>85%</b> of respondents say the last nurse they saw or spoke to was good at explaining tests and treatments <small>Local (CCG) average: 88%   National average: 90%</small></li> <hr/> <li> <b>81%</b> of respondents say the last GP they saw or spoke to was good at treating them with care and concern <small>Local (CCG) average: 84%   National average: 85%</small></li> </ul> </div> </div>	

The Waterfield Practice	Care Quality Commission rating – Good
<p><b>What this practice <b>does best</b></b> ?</p> <ul style="list-style-type: none"> <li data-bbox="371 331 916 416">  <b>92%</b> of respondents were able to get an appointment to see or speak to someone the last time they tried  <small>Local (CCG) average: 86%   National average: 85%</small> </li> <hr/> <li data-bbox="371 461 916 546">  <b>74%</b> of respondents usually wait 15 minutes or less after their appointment time to be seen  <small>Local (CCG) average: 70%   National average: 65%</small> </li> <hr/> <li data-bbox="371 591 916 676">  <b>98%</b> of respondents had confidence and trust in the last nurse they saw or spoke to  <small>Local (CCG) average: 97%   National average: 97%</small> </li> </ul>	<p><b>What this practice <b>could improve</b></b> ?</p> <ul style="list-style-type: none"> <li data-bbox="1015 331 1525 448">  <b>76%</b> of respondents say the last GP they saw or spoke to was good at treating them with care and concern  <small>Local (CCG) average: 84%   National average: 85%</small> </li> <hr/> <li data-bbox="1015 492 1525 577">  <b>81%</b> of respondents say the last GP they saw or spoke to was good at listening to them  <small>Local (CCG) average: 88%   National average: 89%</small> </li> <hr/> <li data-bbox="1015 622 1525 739">  <b>76%</b> of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care  <small>Local (CCG) average: 81%   National average: 82%</small> </li> </ul>

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**HEALTH OVERVIEW AND SCRUTINY PANEL  
29 SEPTEMBER 2016**

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**A REVIEW OF WHETHER THERE IS SUFFICIENT GENERAL PRACTITIONER  
CAPACITY IN BRACKNELL FOREST TO MEET FUTURE DEMANDS**

**Assistant Chief Executive**

**1 PURPOSE OF REPORT**

- 1.1 This report presents the attached report resulting from the review of whether there is sufficient General Practitioner capacity in Bracknell Forest to meet future demands, undertaken by a working group of the Health Overview and Scrutiny (O&S) Panel.

**2 RECOMMENDATIONS**

**That the Health Overview and Scrutiny Panel:**

- 2.1 **Adopts the attached report and recommendations of the Working Group which reviewed whether there is sufficient General Practitioner capacity in Bracknell Forest to meet future demands.**
- 2.2 **Responds to the recommendations addressed to the Health O&S Panel.**
- 2.3 **Stands down the working group.**

**SUPPORTING INFORMATION/ALTERNATIVE OPTIONS CONSIDERED/ ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS/ EQUALITIES IMPACT ASSESSMENT/ STRATEGIC RISK MANAGEMENT ISSUES / OTHER OFFICERS/ CONSULTATION – Not applicable**

Contact for further information

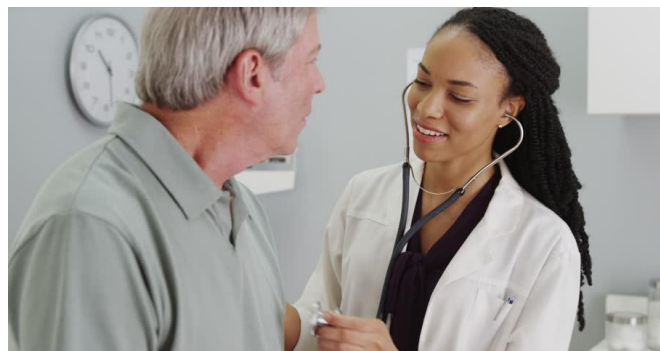
Richard Beaumont – 01344 352283  
e-mail: [richard.beaumont@bracknell-forest.gov.uk](mailto:richard.beaumont@bracknell-forest.gov.uk)

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**DRAFT 1.9.2016**

# **A review of whether there is sufficient General Practitioner capacity in Bracknell Forest to meet future demands**

**By a Working Group of the Health Overview and Scrutiny  
Panel**



**XX** September 2016

## Table of Contents

	Page Number
1. Foreword by the Lead Member	1
2. Executive Summary	2
3. Information Gathered	5
4. Conclusions and Recommendations	16
5. Glossary	25
Appendix 1 - The scoping plan for the review	26
Appendix 2 - Summaries of meetings	30
Appendix 3 - Information obtained from survey of GP Practices	44

## Acknowledgements

The Working Group would like to express its thanks and appreciation to the following people we met for their co-operation and time. Almost everyone we met thought our review was necessary and worthwhile, and some commended the Council's Overview and Scrutiny Panel for its initiative in carrying out this review. All those who have participated in the review have been thanked for their contribution, and sent a copy of this report.

The General Practitioners and their Practice staff serving the residents of Bracknell Forest

Juliet Anderson	Assistant Director for Education and Quality Workforce strategy and transformation (Health Education England)
Richard Mumford	Acting GP Dean, Oxford Deanery

### Bracknell and Ascot Clinical Commissioning Group

Dr William Tong	Chairman
Mary Purnell	Head of Operations

### Frimley Health NHS Foundation Trust

Jane Hogg	Integration and Transformation Director
Tina White	Programme Director, Sustainability and Transformation Plan

### NHS England South (South Central)

Dr Geoff Payne	Medical Director
Nicky Wadely	Programme Manager - Co-commissioning

### Bracknell Forest Council

Councillor D Birch	Executive Member for Adult Services, Health and Housing
Richard Beaumont	Head of Overview and Scrutiny
Andrew Hunter	Chief Officer: Planning, Transport and Countryside
Matt Lunn	Senior Planning Officer

## 1. Foreword by the Lead Member

- 1.1 The Health Overview and Scrutiny Panel formed a working group to examine the issue of GP capacity in the coming years.
- 1.2 At the outset the issue of sufficient GP capacity to meet the needs of residents in the future appeared to be fairly simple, one of the right numbers of practitioners in the right places, and establishing the process to make it happen. As all good scientists know one should never prejudge the outcome or you may miss the key insights, and this was no exception.
- 1.3 We discovered the NHS does not plan very far ahead, it is too busy fire fighting to deliver for today and tomorrow and possibly think about next year; which was a concern as Bracknell Forest has so much housing development planned we knew the number of residents will rise significantly with an aging demographic; and there is a lag to increasing capacity. We also discovered many GPs already feel at crisis point.
- 1.4 In serendipitous good timing the NHS announced the GP Forward View and the Sustainability Transformation Plan (STP) during our work.
- 1.5 These are indeed fortuitous developments and I hope that our findings will support the work that is being done to plan ahead and reshape primary care as part of those initiatives. In particular to support the desire to create a service for residents to make a same day appointment to see a GP or relevant practitioner to meet their needs and stem the flow of patients going to A&E, or becoming acute and needing more treatment in secondary care.
- 1.6 The theme running through our recommendations is collaborative working and flexibility. Services need to be delivered in a different way with the broader use of appropriate practitioners to relieve the pressure on GPs. The various NHS bodies and the Council need to work together to deliver the healthcare infrastructure and services required, and contributions from developers are needed too. Recommendations are based on what is in place today as the STP is still emerging and will clearly have a major impact.
- 1.7 This report is restricted by the time and resources available and the scope of this exercise has been limited to the services that GP practices typically provide, although it was clear through our work that the model of integrated care hubs with primary care, social care and mental health is the model for the future; and change at scale is necessary to enable the STP to deliver an efficient patient centred service for the needs of a growing and aging population.
- 1.8 I would like to thank my fellow councillors and co-opted members who worked on the review and especially to all the officers who supported us throughout the process. I would also like to thank the GPs who gave their time to help us understand the true situation in the area, and all the people who travelled to meet and inform us.

**Councillor Sarah Peacey**  
**Lead Working Group Member**

## 2. Executive Summary

2.1 Almost everyone needs to see their General Practitioner (GP) doctor from time to time. It is the 'front line' for National Health Service (NHS) primary care, with 90% of all NHS patient contacts occurring in general practice, and around 372 million GP consultations in England each year. It is also costly - a ten minute consultation with a GP is estimated to cost the NHS around £204, and GP Services in the Bracknell Forest and Ascot area cost some £14.5 million each year. For many people, their perception of the NHS is heavily influenced by how quickly they can get an appointment with their GP, and the quality of that service. We believe that residents of Bracknell Forest are interested to know whether there will be enough GPs to meet growing demands, most notably from the major new housing developments taking place and planned locally. The Health Overview and Scrutiny (O&S) Panel of Bracknell Forest Council therefore decided to carry out a review of whether there are enough GPs to meet the needs of Bracknell Forest residents, both now and looking ahead. This report summarises the outcome of that review, which took place between November 2015 and August 2016.

2.2 The remainder of this report is organised in the following parts:

Part 3 Gives information in respect of the factors affecting the sufficiency of GP capacity, and summarises how we set about our review.

Part 4 Contains the conclusions we have reached following our review, on which we have based a number of recommendations to the Council's Executive, NHS organisations, and the Health Overview & Scrutiny Panel.

At the end of our report is a glossary of terms used and three appendices containing detailed supporting information and summaries of the meetings we held.

2.3 Our overall conclusions are that:

- It is clear that the solution to meeting Bracknell Forest's growing needs for GP services is not simply to increase the number of Whole Time Equivalent GPs. The situation is complex, and major changes are underway.
- Our review bears out the response of Bracknell Forest GPs to a British Medical Survey in April 2016, where the majority said that their workload was 'often unmanageable'.
- In most respects, the evidence we collected confirmed our concerns about whether there is sufficient GP capacity, but we saw that some encouraging work is being done to make things better.
- Estimates of the additional GPs required to meet the needs of the Bracknell and Ascot area vary: The Oxford Deanery estimate that 6-7 extra GPs will be needed; our own estimate, based on housing growth and other forecasts is that around 11 extra GPs are needed by 2026; and the Royal College of GPs has forecast that Bracknell and Ascot needs 24 more GPs by 2020.
- We recommend below various improvements which we think would be of benefit.
- The information gained from this review should be of interest to all councillors

- The solutions to achieving sufficient GP resources have not yet been fully designed, and delivery is at an early stage. We therefore think that the Health O&S Panel needs to return to this topic to review progress, in due course.

2.4 Our recommendations to the Executive and the NHS are in part 4 of this report. They cover a variety of improvements which we believe are reasonable and necessary. The recommendations are as follows.

**We recommend to the Council's Executive that:**

- The Council should engage – both by Members and Officers - more proactively with the Joint Commissioning Committee (JCC), for example by attending all meetings or arranging a substitute as necessary.**
- The Health and Wellbeing Board (being the forum where the Council and the Clinical Commissioning Group (CCG) come together) should review what needs to be done to establish and maintain clear communication of health needs. This should include clear commitments in the Comprehensive Local Plan, and reference to healthcare facilities in the Community Infrastructure Levy Infrastructure Delivery Plan/ Regulation 123 List or Section 106 agreements.**
- Both the Comprehensive Local Plan, and the aims of the Health and Wellbeing Board should explicitly recognise the need to ensure that the necessary healthcare facilities will be in place to meet the demands of the expanding population.**

**We recommend that the Joint Commissioning Committee should:**

- Encourage Practices to have a good range of specialist interests and then make those services available to patients beyond their own List. This is in line with the Forward View and the STP, whereby the CCG should look to commission locally delivered services where appropriate, based around practices, clusters of practices, or integrated service delivery hubs.**
- Adopt a target, based on best practice, for the GP patient survey satisfaction survey question about the ease of making an appointment at a GP Practice. The JCC should openly and regularly monitor the achievement of that target by all GP Practices.**
- Re-state clearly and comprehensively who are the partner organisations involved in ensuring sufficient GP capacity, how they have a shared commitment to the task of ensuring there is sufficient GP capacity, and say how their performance is to be monitored and reported openly.**
- Systematically collect and publish data on workload and workforce, etc., to ensure that their plans are intelligence-led and timely.**
- Periodically publish information showing that they are aware of the changing population numbers – using figures agreed with the Council – showing that they are responding to forecast changing levels of demand.**
- Periodically publish information showing the changing pattern of long term conditions and that they are responding to changing levels of demand.**
- Do more to minimise the call on GPs' time through more health promotion and encouraging self care.**

- k. Devise a method to strategically capture different ways of working in GP Practices and best practice possibilities and circulate the information to all Practices.
- l. Explore the feasibility of Bracknell Forest having a GP 'Training Hub'. Also, to optimise patient care, the JCC should explore the feasibility of supplementary roles, for example introducing 'Physician Associates'.
- m. Continue its efforts to transfer appropriate work from GPs towards Nurses and Health Care Assistants; and with Health Education England and other partners seek to address any shortage of capacity in those professions locally.
- n. Consider how to improve capacity and economies by making fuller use of pharmacists and other appropriate professionals.
- o. Seek to minimise non-clinical contact, such as better signposting on GP Practices' websites and in surgery waiting rooms on where to go for help, which would help to divert people with non-medical issues elsewhere.
- p. Explore what initiatives could be taken to minimise the clinical time lost through some patients not turning up for their appointments.

We recommend that the Clinical Commissioning Group should:

- q. Ensure, through their commissioning of hospitals, and the Sustainability and Transformation Plan, that work is appropriately shared between GP Practices and hospitals.
- r. Explain the reasons for the delay in producing their Estates Strategy and give a firm date for its completion.

We recommend that the Health Overview and Scrutiny Panel should:

- s. Monitor the progress of the *Sustainability and Transformation Plan*, and the *General Practice Forward View*, robustly and regularly.
- t. Carry out a follow up to this review in 18-24 month's time, specifically to see whether the STP and the '*General Practice Forward View*' are being delivered successfully, and whether the pressure on GPs is at a sustainable level in the light of increased demand, particularly from new housing developments.

2.5 Members of the Working Group hope that this report will be well received and we look forward to receiving responses to its recommendations.

2.6 The Working Group comprised:

Councillor Peacey (Lead Member)  
 Councillor Mrs Mattick  
 Councillor Phillips  
 Councillor Mrs Temperton  
 Councillor Tullett  
 Councillor Virgo  
 Dr Norman (A co-opted Member of the Health O&S Panel, and a retired Bracknell GP)  
 Rachael Addicott (A co-opted Member, and a Senior Fellow at the Kings Fund)



### 3. Information Gathered

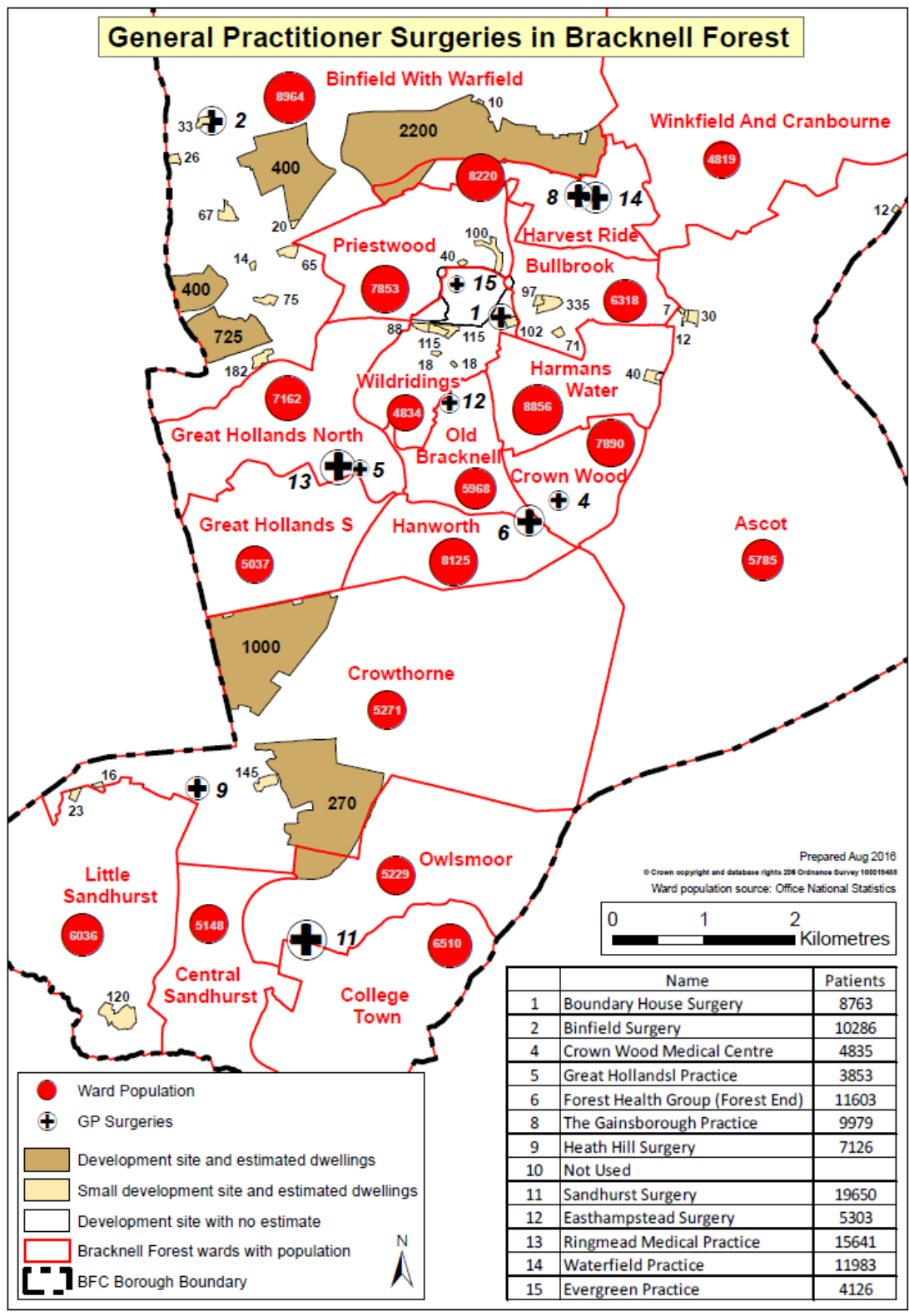
We set out in Appendix 2 of this report summaries of the meetings we held with a number of organisations whose role affects the sufficiency of GP resources. Appendix 3 summarises the information gathered from our visits to, and data collection from, 14 GP Practices serving most Bracknell Forest residents. Other key information we gathered is included in this part of the report. All those sources of evidence support the conclusions we have reached and the recommendations we have made in Part 4 of this report.

#### The National Context

- 3.1 In a report of May 2016 '*Understanding Pressures in General Practice*', the Kings Fund said that their analysis of 30 million patient contacts from 177 practices found that consultations grew by more than 15 per cent between 2010/11 and 2014/15. Over the same period, the GP workforce grew by 4.75 per cent and the practice nurse workforce by 2.85 per cent. Funding for primary care as a share of the NHS overall budget fell every year, from 8.3 per cent to just over 7.9 per cent. Pressures on general practice were compounded by the fact that the work is becoming more complex and more intense. This is mainly because of the ageing population, increasing numbers of people with complex conditions, initiatives to move care from hospitals to the community, and rising public expectations.
- 3.2 The Kings Fund also reported that Practices were finding it increasingly difficult to recruit and retain GPs. Many GPs reaching the end of their careers are choosing to retire early in response to workload pressures. They have also been affected by changes to the tax treatment of pensions which create disincentives to work when the lifetime allowance for pensions has been reached. Fewer GPs are choosing to undertake full-time clinical work with more opting for portfolio careers or working part-time. This is true for both male and female GPs. Trainee GPs are often planning to work on a salaried basis. This continues a longterm trend in which fewer doctors aspire to become partners in their practices. There are challenges too with recruitment and retention of other members of the primary care team particularly practice nurses and practice managers. This makes it difficult for some of the work of GPs to be taken on by other staff who are also in short supply.

#### The Bracknell Forest Context

- 3.3 What we learnt from our visits to GP practices showed a similar local picture to the national picture reported by the Kings Fund, above.
- 3.4 There are some 80 Full Time Equivalent (FTE) GPs in Bracknell Forest Borough. The following map of the Borough, at February 2016, shows:
- the population of each of the wards making up the Borough, in red circles (for example 8125 people live in Hanworth)
  - The number of patients at each GP Practice, and the surgery's location (for example, the Ringmead Medical Practice has 15,641 patients on their list, and they are located at the northern end of Great Hollands South)
  - The known housing development sites, with the estimated number of new dwellings (for example, 1,000 new dwellings are expected to be built on the former Transport and Road Research Laboratory site, west of Crowthorne).



Note – There are other GP Practices outside the Borough, providing services to Bracknell Forest residents, including Green Meadows, Magnolia House, Radnor House, Kings Corner and New Wokingham Road surgeries.

### **Why Did We carry out This Review?**

- 3.5 The Health Overview and Scrutiny (O&S) Panel decided to review whether there is sufficient GP capacity in Bracknell Forest because:
- We had not previously carried out a focussed review of this very important issue of whether there are enough GPs to meet residents' needs, both now and in the future
  - There were indications that the GP Practices were under a lot of pressure, and various factors looked likely to add to that pressure (we expand on this below)
  - We wanted to raise awareness and build members' understanding of the topic.
  - We wanted to see whether improvements were needed, and to make recommendations accordingly.

### **Approach of the Working Group**

- 3.6 The approach we took to our work was to meet a range of people inside and outside the Council with relevant knowledge and experience of the issue, and we supplemented this with research and analysis of our own, supported by our Overview and Scrutiny (O&S) officer. Our approach was all set out in detail in the standard scoping document for O&S reviews, at Appendix 1.
- 3.7 Early in the review, we realised that the position was much more complicated than simply the number of GPs, for example if GPs do not have sufficient Health Care Assistants then they will spend too much time doing tasks which could be safely entrusted to less qualified staff. We also came to realise during the course of our work that there was a 'generational change' afoot, with fewer doctors being willing to join a traditional GP Partnership Practice, with more doctors preferring salaried GP positions, or being a GP Locum, or pursuing a 'portfolio' career. Other significant developments which have a huge bearing on finding solutions to the pressures facing General Practice were found to be:
- The Sustainability and Transformation Plan. (see paragraph 3.29 below)
  - A major announcement by the Government in April 2016 '*General Practice Forward View*' (see paragraph 3.34 below).

### **Indications of Current and Future Pressure on General Practitioners**

- 3.8 There are a number of indications of the pressure currently facing GPs in Bracknell Forest, and a range of factors affecting the ability of GPs to meet the demands on their time, which collectively caused us concern. Insufficient resource for GP services has a clear impact elsewhere; for example, in England an estimated 5.8 million visits to Accident and Emergency or walk-in centres in 2012-13 occurred because patients had not been able to get an appointment or convenient appointment in General Practice.

#### **Does Bracknell Forest have enough GPs currently?**

- 3.9 There are a variety of sources of information, but they all point to there being too few GPs, currently. For example:

The Chairman of Bracknell and Ascot Clinical Commissioning Group (CCG) told us that, on the current formula, there are not enough GPs in Bracknell and Ascot. However, the current formula is not applicable for the future.

Analysis by *LG Inform* shows that in 2013/14:

	GPs per 10,000 population	GP Surgeries per 10,000 population
Bracknell Forest	7.1	1.1
Average for all English Unitary Authority areas (including areas of higher need)	8.5	1.5

Separately, the Royal College of GPs published research in 2016, calculating that Bracknell and Ascot needed 24 more GPs by 2020.

What is the Public's view about the ease of getting a GPs appointment?

- 3.10 The NHS periodically survey the views of millions of people who have accessed GP services. In the last published GP survey, 73% of Bracknell Forest residents said their overall experience of making an appointment was very good to fairly good, compared to an England average of 75%. The responses for individual GP Practices in Bracknell Forest ranged from 58% to 92%.

Is best use being made of GPs time?

- 3.11 As GPs are under pressure, it is important to make best use of their limited time. Recent research suggested that 27% of GP appointments could be avoided. NHS England estimated this to be 26%. Health Education England (HEE) told us that some people who frequently ask for a GP appointment do not always need GP, but other services. There was also evidence of a significant number of people not turning up for appointments – this wasted medical staff's time (though some doctors we met told us that it allowed them to catch up on other work) and denied the opportunity for other people to have those unkept appointments.

Do the Council's Planning policies and practices recognise and support the provision of sufficient numbers of GPs?

- 3.12 The Council's consultation over the new *Comprehensive Local Plan* includes very few references to health and there are no healthcare items in the Community Infrastructure Levy (CIL) 'regulation 123 list' (which lists the infrastructure needs of the Borough, which CIL monies are to be applied to). The Council also has the facility to include healthcare facilities when negotiating Section 106 agreements<sup>1</sup> with developers. We return to the Council's planning duties in paragraph 4.10 below.

What will be the impact of an increasing population?

- 3.13 A statistical release by the Office for National Statistics in November 2015 forecast a growth in Britain's population of 10 million to 74.3m over the next 25 years. The Council's *Core Strategy* to 2026 anticipates at least 9,041 additional dwellings being developed across the Borough. Applying the average of 2.4 people per dwelling, this

<sup>1</sup> Section 106 of the Town and Country Planning Act allows the Council and persons interested in land to agree contributions, arrangements and restrictions as *Planning Agreements* or *Planning Obligations*, in order to offset the costs of the external effects of development.

would equate to a population increase of some 22,000 people in the Borough. Applying the NHS assumption that one GP is needed for 1,850 people, this suggests that around 11 extra GPs are needed (we have around 80 GPs currently). The diagram on the following page illustrates by age band the planned population growth of nearly 20%, some 22,000 people to 2036.

What will be the impact of an increased aging population?

- 3.14 The November 2015 statistical release by the Office for National Statistics forecasts a large growth in Britain's population aged over 80 to more than 1/12 of the population. This disproportionately fast increase in the older population is also anticipated in Bracknell Forest (see diagram below). Increased age expectancy is of course to be welcomed, however age-related health conditions have a significant impact on NHS and Local Authority resources. Every GP Practice we met reported an increase, some large, in the number of frail elderly patients and complex long term conditions.

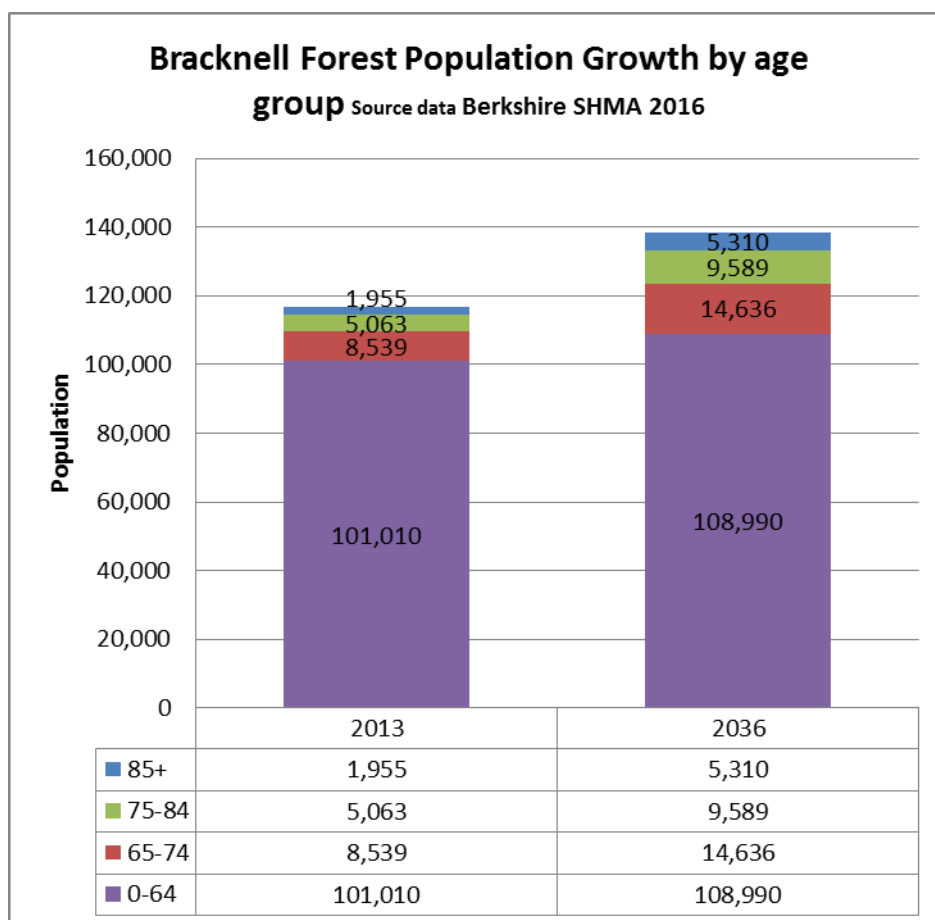
Is there a sufficient supply of new GPs to replace those who are leaving GP Practices?

- 3.15 The 'GP Taskforce' established by Medical Education England and the Department of Health (DoH) reported in March 2014 *'Despite the longstanding Department of Health policy to increase GP training numbers in England to 3,250 per annum, GP recruitment has remained stubbornly below this target, at around 2,700 per annum, for the last four years. This cumulative recruitment shortfall is being compounded by increasing numbers of trained GPs leaving the workforce, most significantly GPs approaching retirement, but perhaps more worryingly women in their 30s'*
- 3.16 This national picture was reflected locally, as most of the GP Practices we surveyed told us that GP retirements were in prospect, and they were struggling to fill vacant GP Positions (see Appendix 3, paragraphs A 3 -4).

Are organisational changes, such as co-commissioning helping or hindering solutions?

- 3.17 In recent years, the NHS has undergone huge organisational change, and it continues to do so, for example the change to 'co-commissioning' (where responsibility for commissioning GP services is transferring from NHS England to local Clinical Commissioning Groups). We were concerned that this might have blurred responsibilities for ensuring there are sufficient GPs, also that it is not uncommon for major change to cause performance to deteriorate, in the short to medium term. Furthermore, we were aware that NHS England, who have primary responsibility for ensuring an adequate supply of GPs, has had reductions in its own budget.

These concerns, listed above, which caused us to commence this review were later confirmed and reinforced by what we found during the course of our review.



ONS mid year estimates 116,567 population in 2013		2013	% of total pop	2036	% of total pop	Additional people by 2036	
SHMA estimates 138,559 population in 2036							
Growth rates of age range	0-64	7.90%	101010	86.65%	108990	78.68%	7980
	65-74	71.40%	8,539	7.33%	14636	10.57%	6097
	75-84	89.40%	5,063	4.34%	9589	6.92%	4526
(Growth rate age 65+ is 90%)	85+	171.60%	1,955	1.68%	5310	3.83%	3355
% Total population over 65			15,557	13.35%	29535	21.32%	13978
Total population			116567		138525		21958
65+ age range population growth is 63.7%							

### What Other Information Did We Gather In This Review?

#### Organisations with a Role in Providing Sufficient GP Capacity in Bracknell Forest

- 3.18 There is no single organisation responsible for determining and providing sufficient GPs for Bracknell Forest residents. The position is complex. GP Partnership Practices – the most common model currently in the Borough – are private businesses under contract to the NHS. They have a large degree of autonomy over the number of medical and other staff they employ, equipment and premises. Of the regional and national organisations, the following information has been taken from their websites.

- 3.19 NHS England (NHSE) leads the NHS in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care. NHSE shares out more than £100 billion in funds each year and holds organisations to account for spending this money effectively for patients and efficiently for the tax payer. A lot of the work NHSE does involves the commissioning of health care services, including the contracts for GPs, pharmacists, and dentists and they support Clinical Commissioning Groups (CCGs). Some CCGs have fully delegated responsibility for the commissioning and contract management of primary medical care.
- 3.20 Bracknell and Ascot Clinical Commissioning Group (CCG). Led by clinicians, CCGs are responsible for buying health services for the local area such as: Hospital services; Urgent Care services; Rehabilitation Care; most Community Health services; Mental Health and Learning Disability services. The CCG has been approved to enter into primary care joint co-commissioning arrangements with NHS England. This means that the CCG will have more say in local decisions, jointly with NHS England, about how primary care services are commissioned for the local populations. The CCG states that sharing this responsibility with NHSE will mean that the needs of the local population will be taken into account, in determining local health care services for the future. CCGs have always had the responsibility for quality improvement in General Practice contracts.
- 3.21 The Joint Commissioning Committee (JCC) is a joint meeting between the CCG and NHS England and is responsible for the joint commissioning of GP services and for the delivery of the local primary care strategy. The Council has a non-voting representation on the JCC. This committee meets in public and it commissions primary medical services, except those relating to individual GP performance management, which have been reserved to NHS England. This includes the following activities: General Medical Services, etc., contracts with GP Practices; decision making on whether to establish new GP practices in an area; and approving practice mergers. The stated key responsibilities of the JCC for the Bracknell and Ascot CCG area are to work together to:
- a) plan (including needs assessment) primary medical care services
  - b) undertake reviews of primary medical care services
  - c) co-ordinate a common approach to the commissioning of primary care services generally
  - d) manage the budget for commissioning of primary [medical] care services.
- 3.22 The GP National Recruitment Office was set up by the Committee of General Practice Education Directors in November 2002. It is the administrative body responsible for coordinating the nationally agreed and quality assured process for recruitment to GP Specialty Training Programmes in England, Wales, Scotland and Northern Ireland. One of their main roles is to assist Health Education England's (HEE) local offices and the deaneries to deliver a standard and robust recruitment and selection process that is reliable, valid and fair.
- 3.23 Health Education England (HEE) states that it ensures that the NHS workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place, now and in the future. HEE states they believe that the most important resource the NHS has is its people.
- 3.24 NHS Property Services Ltd manages, maintains and improves 3,500 properties, working with NHS organisations to create safe, efficient, sustainable and modern

healthcare and working environments. They are a limited company set up in April 2013, wholly owned by the Secretary of State for Health, to manage all the ex-Primary Care Trust estate not transferred to providers.

- 3.25 The Oxford Deanery, or the Oxford School of General Practice has as its purpose the training and development of a general practice workforce fit for the future, and the promotion of generalism and the role of primary care in the local NHS.
- 3.26 The Council's legal duties include operating a Health and Wellbeing Board (H&WBB), exercising its responsibilities as a Local Planning Authority, and delivering the Public Health function. The H&WBB is a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Board members are to collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future. The DoH intends that H&WBBs are a key part of broader plans to modernise the NHS to:
- ensure stronger democratic legitimacy and involvement
  - strengthen working relationships between health and social care, and,
  - encourage the development of more integrated commissioning of services.
- 3.27 We reviewed a report by a 'Task and Finish' group of the H&WBB of June 2015 on health infrastructure. This had been set up to avoid the risk of a fragmented approach to assessing and responding to the health infrastructure needs represented by housing growth and demographic change. This H&WBB report was limited in scope, and it does not appear to have been actively followed up since. The CCG told us that this work has informed bids which have been made to NHS infrastructure fund, and also the primary care transformation programme which forms part of the local STP.
- 3.28 On the Council's planning responsibilities, according to the National Planning Practice Guidance (NPPG) the built and natural environments are 'major determinants of health and wellbeing'. The NPPG defines a healthy community as a place that 'supports healthy behaviours and supports reductions in health inequalities'. This includes: helping to make active healthy lifestyles easy through the pattern of development, good urban design, and good access to local services and facilities. The Government's National Planning Policy Framework (NPPF) is based on the three pillars of sustainable development, which include a responsibility to "*create a high quality built environment, with accessible local services that reflect the community's needs and support its health, social and cultural well-being.*" The NPPG has a section called 'health and wellbeing'. This guidance instructs planners to consider health and wellbeing through both the plan-making and decision-making processes. The local plan should promote health, social and cultural wellbeing and support the reduction of health inequalities. Development proposals should consider the implications for provision of local healthcare infrastructure. The guidance also advises on whom planners should be liaising with to ensure that planning policies reflect the health needs and concerns of the local population. These include: CCG members and representatives of NHS England (which are listed as consultees for local plans), especially in relation to providing sufficient health infrastructure. Regulations under the Planning Act 2008 stipulate Medical Facilities and six other types of infrastructure which councils can use their Community Infrastructure Levy (CIL) receipts to fund. The Council also has the facility to include healthcare facilities when negotiating Section 106 agreements with developers. The CCG told us they would also welcome



discussions on the public estate with a view to creatively using public assets to improve health and wellbeing, in its widest context

### **Sustainability and Transformation Plan**

- 3.29 The Sustainability and Transformation Plan (STP) was launched in December 2015 as a major government initiative which holds out the prospect of radically improving the ability of GPs in Bracknell Forest to meet residents' health needs. This new approach aims to help ensure that health and care services are built around the needs of local populations. The nine 'must dos' for 2016/17 set nationally for every local system include:
- Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings. CCGs will additionally be expected to deliver savings
  - Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.
- 3.30 Every health and care system in England was required to produce a multi-year STP, showing how local services will evolve and become sustainable over the next five years – ultimately delivering the *Five Year Forward View* vision of better health, better patient care and improved NHS efficiency. To deliver plans that are based on the needs of local populations, local health and care systems in England came together in January 2016 to form 44 STP 'footprints'. The health and care organisations within these geographic footprints are working together to develop STPs which aim to help drive genuine and sustainable transformation in patient experience and health outcomes in the longer-term.
- 3.31 Bracknell Forest forms part of the Frimley Health and Care planning STP footprint, covering the population of 750,000 people registered with GPs in 5 CCGs: Slough; Windsor, Ascot & Maidenhead; Bracknell & Ascot; Surrey Heath and North-East Hampshire and Farnham. In addition to the CCGs, partners that make up the Frimley System include: five secondary care providers, five GP federations, two GP out of hours providers, two ambulance providers, three County Councils, and 7 District and Borough Councils, including Bracknell Forest Council. STPs footprints are not statutory bodies, but collective discussion forums which aim to bring together health and care leaders to support the delivery of improved health and care based on the needs of local populations. They do not replace existing local bodies, or change local accountabilities. STPs were to be submitted in June 2016, with a view to implementation starting in Autumn 2016.
- 3.32 The Frimley Health draft STP has five priorities for change:
- Making a further step change to improve wellbeing, increase prevention and early detection.
  - Significant action to improve long term condition pathways
  - Frailty pathways: providing proactive management of frail complex patients, having multiple complex conditions, reducing crises and prolonged hospital stays
  - Redesigning urgent and emergency care, including integrated working and primary care models providing out of hospital responses to reduce hospital stays
  - Reducing variation and health inequalities across pathways to improve outcomes and maximise value.

One of the enablers for this is 'Workforce'. One of the strands in that enabler is General Practice, and a significant change is envisaged as to how General Practice will work in future. The STP recognises that GPs have huge capacity problems currently. The STP will look at facilitating changes to the role of General Practitioner to help make it more attractive and to improve retention. For example, how to make fuller use of different staff in primary care rather than GPs being used to deal with many different tasks. STP work cannot force GPs to change their working arrangements, but the model preferred by STP leaders is to have hubs for out-of-hospital care. Some of these are already in place, with GPs working in an integrated team including social care and others.

- 3.33 The DoH has stated that the STP is all about working together to close the 'three gaps':
- The health & wellbeing gap, for example securing additional years of life by reducing deaths from conditions amenable to healthcare;
  - The quality & care gap, for example reducing the amount of time people spend in hospital
  - The financial gap, in terms of putting primary and secondary health care on a sustainable financial footing.

### **General Practice Forward View**

- 3.34 In April 2016, NHS England launched another major initiative entitled '*General Practice Forward View*'. This five year programme of work recognised the pressure on GPs, it aimed to stabilise and transform general practice, with commitments on investment (recurrent funding to increase by £2.4 billion annually, with a further 'turnaround' package of £500 million), workforce, workload, infrastructure, and care redesign. If delivered, this programme would address all the significant pressures which we saw facing Bracknell Forest GPs.
- 3.35 An update on the delivery of the '*General Practice Forward View*' in July 2016 stated that the NHS had decided:
- To release the first £16m of the new £40 million Practice Resilience Programme, a key part of the five-year General Practice Forward View, to help struggling practices across the country.
  - The first phase of the three-year, £30 million general practice development programme, which will give every practice in the country the opportunity to receive training and development support.
  - New funding to fully offset the rising cost of GP indemnity, and wider plans to reform indemnity arrangements
- 3.36 The NHS update stated that the *General Practice Forward View* built on recent developments, including an invitation to providers to tender for a new multi-year 'NHS GP Health Service' for GPs suffering from mental health issues like stress and burnout. It would also support GPs wishing to return to clinical practice after a period of ill health. Also, to support doctors who might otherwise leave the profession to remain in clinical practice NHS England had increased, through the Retained Doctor Scheme, both the money for practices employing a retained GP and the annual payment towards professional expenses for GPs on the scheme. NHS England said that it was also announcing further details of the 'Multispecialty Community Provider' (MCP) care model framework. It proposed the contract will be a multi-year contract with payment operating on the basis of a whole population budget. This new whole

population budget sits at the heart of the model. It is based on the GP registered list and covers a much wider range of primary and community-based services, and potentially aspects of hospital-based care. In practice, this means the MCP ultimately holding a single contract for all services in scope, including primary and medical community health, social and mental health services. It is intended that this greater level of flexibility will transform the way care is delivered. The framework, which will differ across the country to reflect the needs of local communities, includes better signposting, alternatives to face-to-face appointments and integrated access.

## 4. Conclusions and Recommendations

From its investigations, the Working Group (the Group) has drawn the following conclusions, on which we have based a number of recommendations to the Executive, to National Health Service (NHS) organisations, and to the Council's Health Overview and Scrutiny Panel.

### General

- 4.1 This has been an interesting review. In addition to carrying out a focussed scrutiny review of a very important issue for local residents for the first time, we think we have achieved our aims of:
- Raising awareness and building members' understanding of the topic
  - Exploring our concerns about whether there is sufficient GP capacity, with people at the heart of the issue, and through our own research
  - Using the evidence we obtained to identify possible improvements to alleviating the pressure on GPs.
- 4.2 Our overall conclusions are that:
- It is clear that the solution to meeting Bracknell Forest's growing needs for GP services is not simply to increase the number of Whole Time Equivalent GPs. The situation is complex, and major changes are underway.
  - Our review bears out the response of Bracknell Forest GPs to a British Medical Survey in April 2016, where the majority said that their workload was 'often unmanageable'.
  - In most respects, the evidence we collected confirmed our concerns about whether there is sufficient GP capacity, but we saw that some encouraging work is being done to make things better.
  - Estimates of the additional GPs required to meet the needs of the Bracknell and Ascot area vary: The Oxford Deanery estimate that 6-7 extra GPs will be needed; our own estimate, based on housing growth and other forecasts is that around 11 extra GPs are needed by 2026; and the Royal College of GPs has forecast that Bracknell and Ascot needs 24 more GPs by 2020.
  - We recommend below various improvements which we think would be of benefit.
  - The information gained from this review should be of interest to all councillors
  - The solutions to achieving sufficient GP resources have not yet been fully designed, and delivery is at an early stage. We therefore think that the Health O&S Panel needs to return to this topic to review progress, in due course.

### Major changes

- 4.3 The major changes afoot overshadow all of our conclusions and recommendations. Specifically:
- Time will tell if the vision set out in NHS England's, '*General Practice Forward View*' will be achieved in reality. We sincerely hope that it will be delivered, as it addresses all the causes contributing to maximising the supply of GPs and getting best use from their skills and experience (including expanding the workforce, new ways of working and investing in premises) which cause us concern. However, it seems to us to be a very ambitious programme, and the

NHS does not have the best track record in delivering major new initiatives entirely successfully.

- It also remains to be seen if the ‘*Sustainability and Transformation Plan*’ (STP) can be successfully designed, agreed upon by its numerous partner organisations, and delivered on time. Again, we sincerely hope that it will be, as in our view: it aims to increase quality and reduce costs; it addresses the inherent unsustainability of the current arrangements (where fewer new doctors entering general practice are willing to participate in the traditional Partnership model); and there is much to be gained by introducing multi-disciplinary primary healthcare ‘hubs’ and greater integration with local authorities’ social care work. However, we are mindful that: it, too, is a very ambitious plan; this will require investment, yet a key policy objective is to achieve financial savings; local authorities are under severe financial pressure due to reducing government funding and increasing demands for adult social care; and that most of the STP funding is being directed to the acute care sector rather than to primary care.

The success of these two initiatives is vital to achieving a solution to GP capacity, so **we recommend that the Health Overview and Scrutiny Panel monitors their progress, robustly and regularly.**

- 4.4 Notwithstanding the significance of these major changes, we still think it is worthwhile to record the outcome of our review, which we believe has led to some useful conclusions and recommendations. We have grouped our thoughts under the headings below, all of which are supported by the evidence in part 3 of this report, and Appendices 3 and 4.

### **General factors affecting whether there will be sufficient GP capacity**

#### The changing shape of General Practice

- 4.5 The apparent ending of the traditional Partnership model for GPs is a major change, which might be a painful transition for some doctors and patients. We were told that some individual practices will not be able to cope with the new type of operation. Instead, commissioners of GP services think that there needs to be a series of integrated hubs, with more collective working between GPs. The GPs would need to agree between themselves how to manage routine care and the various other demands. There would need to be a multi-disciplinary approach, with the GP as the clinical lead. This appears to be working well in Surrey Heath, and it gives a better, seamless service for patients. It will be important that all GPs are made aware of these changes and ‘won over’ to be supportive of them. We are satisfied that the Frimley Health STP team have this in hand.
- 4.6 In our survey of GP Practices, we learnt that around 60% of Practices had a specialist interest and saw patients from elsewhere, for a variety of treatments including minor surgery, dermatology and diabetes, for example. We consider that this is a valuable addition to the mainstream GP service, offering patients more localised and efficient treatments, and relieving pressure on Secondary care services. NHS England told us that services over and above the core provision of the GP contract need to be commissioned by the CCG from practices, as there is a payment issue which need to be formally agreed, particularly if there is an expectation of moving services and therefore contract from secondary care. **We recommend that the Joint Commissioning Committee should encourage Practices to have a good range of specialist interests and then make those services available to patients beyond their own List. This is in line with the Forward View and the STP,**

**whereby the CCG should look to commission locally delivered services where appropriate, based around practices, clusters of practices, or integrated service delivery hubs.**

#### Public confidence

- 4.7 The CCG Chairman acknowledged to us that, on the current formula, there are not enough GPs in Bracknell and Ascot. We believe this is simply untenable for such a vital service to residents. The latest (2014) survey of patients of GP services, in terms of whether their overall experience of making an appointment was very good to fairly good showed a great variation between the individual GP practices, and collectively the response was slightly lower than the national average. We consider that this survey response is a prime indicator of whether residents think there is enough GP availability to meet their needs, and that maintaining public confidence is essential. **We recommend that the Joint Commissioning Committee should adopt a target, based on best practice, for the patient survey satisfaction survey question about the ease of making an appointment at a GP Practice. The JCC should openly and regularly monitor the achievement of that target by all GP Practices.**

#### Roles and responsibilities

- 4.8 A number of different and autonomous organisations have roles to play in ensuring that there is enough GP Capacity (paragraphs 3.18 – 3.25). This complex structure is also changing, for example with the increasing role of the Joint Commissioning Committee (JCC). It seems to us that people inside the NHS find this confusing enough, and those outside have even less understanding. Neither can there be much confidence that the NHS has all the information it needs to make the right decisions on resourcing GP work: in a report of March 2016, the House of Commons Committee of Public Accounts (PAC) commented that the Royal College of General Practitioners said that the NHS has no system to track its medical workforce, so it does not know how many qualified GPs there are in total, or how many qualified GPs leave general practice, either to work in other parts of the NHS or to leave the profession altogether.
- 4.9 The CCG told us that the current system is very complicated. The Partnership model gave the best continuity of care for patients, and that is changing relatively quickly. Yet many people still want to see their own GP, and it is hard to change that mind-set. The CCG also told us that the position of NHSE and the CCG is to envision what the primary care provision should be locally, and that was not as simple as creating another surgery. It is also to be borne in mind that GP Practices are individual private companies, with a large degree of autonomy.

**We recommend that the Joint Commissioning Committee re-state clearly and comprehensively who the partner organisations are, how they have a shared commitment to the task of ensuring there is sufficient GP capacity, and say how their performance is to be monitored and reported openly.**

#### The role of the Local Authority

- 4.10 Building more houses inevitably means that more people will need GP services. Planning Officers were clearly aware of that need, but they told us that because the NHS organisations they engaged with (when producing the Local Plan and assessing planning applications) did not ask for extra health facilities, Planning Officers did not put much on health facilities in plans and policies. Planning Officers told us that the responsibility for this omission lies with the NHS, but we heard a very different

account from the CCG. By contrast - perhaps because it is a statutory function of the Council, with Education Officers being actively engaged with the Planning Function - there were very clear requirements for additional school places, which have been provided for in the Local Plan.

- 4.11 We consider that Planning Officers should have been more determined in pressing the NHS at a senior level to put forward the case for more health facilities, particularly to proceed in tandem with the major housing developments. This is, of course, not the whole solution as, along with the buildings, resources would need to be found by the NHS for the on-going revenue costs for the staffing, etc. of any new facilities. On the same theme, when we met the CCG, we encouraged them to take the opportunity of responding to the Council's consultation on its Comprehensive Local Plan (CLP), to ensure there is adequate recognition of the demand for health services. We note that the Health O&S Panel made similar points in its response to that consultation. The CLP has very few references to health, and no reference to the new integrated health and social care 'Hubs' envisaged in the STP.
- 4.12 From what we learned, it seemed to us that the Council has limited engagement with the Joint Commissioning Committee. Also, it appeared to be a missed opportunity that the Health and Wellbeing Board (H&WBB), having representatives from both the CCG and the Council, was not proactively engaged with health service providers in their duty to deliver the health infrastructure and GP services needed by residents. For example, they could try to ensure that the Council's spatial planning function is playing its part fully and constructively, and they could be a useful forum to shape the Council's and partners strategic input to the delivery of the STP.
- 4.13 For those Local Planning Authorities, like Bracknell Forest, which have adopted the Community Infrastructure Levy (CIL), there is a statutory requirement to produce a list of infrastructure projects that the council, as the CIL Charging Authority, may wholly or partly fund by the CIL. This is known as 'the Regulation 123 list'. The Executive Member for Health told us that it would not be appropriate to use receipts to support the provision of medical facilities, hence there was no reference to that in the Council's 'Regulation 123 list' or Infrastructure Delivery Plan. He explained that this was because GP Practices are profit-earning private businesses, and the Council should not be providing any private business with CIL funding. Besides, CIL funds were heavily in demand for new schools and other infrastructure requirements. We noted from our research that of the five other Unitary Authorities in Berkshire, one had not introduced CIL; three of the remaining four had included in their CIL 'Regulation 123' list a statement that CIL would be used to fund health infrastructure. The Council also has the facility to include healthcare facilities when negotiating Section 106 agreements with developers. The Working Group recognises the competing demands for CIL receipts, but considers that the Council needs to reassess its approach, as otherwise residents may well be left with insufficient health facilities. We should follow other authorities which are building health into their planning function and taking positive steps to assess their requirement. The evidence shows that there is an opportunity to take early action by taking forward the premises issues, e.g. a replacement for the Skimped Hill Practices, and a solution for the Binfield surgery, even though this is no one organisation's responsibility.

**We recommend to the Executive that:**

- **the Council should engage – both by Members and Officers - more proactively with the Joint Commissioning Committee, for example by attending all meetings or arranging a substitute as necessary.**
- **the Health and Wellbeing Board (being the forum where the Council and the CCG come together) should review what needs to be done to**



**establish and maintain clear communication of health needs. This should include clear commitments in the Comprehensive Local Plan, and reference to healthcare facilities in the Community Infrastructure Levy Infrastructure Delivery Plan/ Regulation 123 List or Section 106 agreements.**

## **Factors affecting demand for GP services**

### Understanding current and new demands

- 4.14 The '*General Practice Forward View*' document cites a recent international survey which revealed that British GPs are under far greater pressure than their counterparts, with rising workload matched by growing patient concerns about convenient access.
- 4.15 A report from the House of Commons Committee of Public Accounts (PAC) in March 2016 on Access to General Practice in England concluded that the Department of Health and NHS England did not have enough information on demand, activity or capacity to support their decisions on general practice. For example, the Department had not collected data on the number of consultations since 2008–09, and no data are collected on staff vacancies within practices. The Department said they had work underway to improve data on activity levels and staffing. The PAC recommended that the Department and NHS England should publish a plan for improving the information they have on demand, activity and capacity in general practice, including the minimum dataset they needed. The Government accepted the Committee's recommendation, subject to further work to test what was affordable and practicable. **We recommend that the JCC should systematically collect and publish data on workload and workforce, etc., to ensure that their plans are intelligence-led and timely.**

### Population growth

- 4.16 Bracknell Forest faces an exceptionally fast growth in its population - the planned population growth is nearly 20%, some 22,000 people to 2036. This will add greatly to the workload of primary care, particularly GPs. Most of the GPs we spoke to were quite stretched currently, and they were not confident that they could cope with this surge in demand, alongside the growth in the number of people with long term medical conditions needing their frequent attention. The Acting Dean of the Oxford Deanery (which trains GPs for the Thames Valley) told us that he estimated that Bracknell Forest needed around 6-7 additional GPs to meet the anticipated population growth from new housing over the next 20 years (based on an average List of 2,250 patients for each GP). He also said that It was more important to look at what the population needs, and what skills are needed to meet those needs – and that would not be confined to GP's skills.
- 4.17 This growth was already apparent when we visited the local GP Practices. Where comparator figures were available, this showed that the patient population had grown by 7% over the period 2008 to 2016. Only two GP Practices reported a reduction in patient numbers over that period, and the largest percentage growth was 18%. It is clear that the growth in patient numbers has been significant and fairly widespread. It seemed to us that the JCC was aware of the general movement but we would welcome reassurance that they 'have their finger on the pulse.' **We therefore recommend that the JCC should periodically publish information showing that they are aware of the changing population numbers – using figures agreed with**

**the Council – showing that they are responding to forecast changing levels of demand.**

- 4.18 The Council cannot control the number of people wishing to live in the Borough, and it is under an obligation to deliver new housing developments in line with the *Strategic Housing Market Assessment*<sup>7</sup>. However, it seems to us that the Council should be more pro-active in satisfying itself that the necessary healthcare facilities will be in place to meet the demands of the expanding population. **We recommend to the Executive that both the Comprehensive Local Plan, and the aims of the Health and Wellbeing Board explicitly recognise the need to ensure that the necessary healthcare facilities will be in place to meet the demands of the expanding population.**

Patients with long term conditions

- 4.19 The GP Practices told us they had a total of 45,691 patients with long-term conditions, a massive 39% increase on the 32,835 in 2008. This represents a big increase in the workload for GPs and other clinical staff. The Practices also told us that they had 25-50 patients each who are housebound with chronic conditions. It seemed to us that the JCC was aware of the general movement but we would welcome reassurance that they 'have their finger on the pulse.' Therefore, **we recommend that the JCC should periodically publish information showing the changing pattern of long term conditions and that they are responding to changing levels of demand.**

Encouraging people to take more responsibility for a healthy lifestyle and self-care

- 4.20 The demand on GPs time can be minimised if people take more responsibility for pursuing a healthy lifestyle (for example, the NHS spends a lot of time and money treating people with smoking-related conditions), and in people administering self-care sensibly for minor ailments. In terms of health promotion and prevention, the Council has a very effective Public Health function, and we particularly commend the current initiative of a self care awareness campaign. We have also seen evidence that the CCG has issued public information encouraging people to adopt healthy lifestyles. **We recommend that the JCC do more to minimise the call on GPs' time through more health promotion and encouraging self care.**

Transfers of care from the acute hospitals

- 4.21 The majority of the GPs we met were unhappy with their workload increasing due to more transfer of care to GPs and inappropriate 'delegation' of tasks from hospitals to GPs, which was often unfunded. Conversely, NHS England told us there were occasional complaints from the hospitals that people were being referred for treatment for conditions which should have been dealt with by their GP. It is to be hoped that this issue will be resolved through the 'whole system' approach of the STP, which involves both primary and secondary care working towards shared solutions, **We recommend that the CCG should ensure, through their commissioning of hospitals, and the STP, that work is appropriately shared between GP Practices and hospitals.**

## Factors affecting the supply of GPs

### Recruitment difficulties

- 4.22 Nationally, the target for recruiting and training GPs has not been achieved for some years, leading to difficulties filling GP vacancies. Most of the GPs we met were experiencing recruitment difficulties, even referring to 'a crisis situation' for Partner GPs, with difficulties also being experienced in recruiting Nurses & Health Care Assistants. We understand that there are many other areas of England facing more severe recruitment difficulties. The Oxford Deanery, which trains GPs in the Thames Valley, told us that it is a national decision as to how many GPs are trained, and in terms of need that is left to local demand.

### Different ways of working

- 4.23 Different ways of working are arising from necessity (for example increased delegation to Nurse Practitioners) or from centrally driven initiatives, most notably the STP. NHS England told us about some interesting alternatives to the traditional Partnership Practice, including: Partnership Practices considering closing can retain ownership of the building and rent it to the new service provider; procurement of five year contracts for provision of GP services; and federated GP practices which offered some advantages. Also, during our review we observed that the sharing of best practice was capable of improvement, between GP Practices: We learnt that the Practices have devised various useful arrangements to help in tackling demand, for example a whole day duty doctor system; more delegation to Nurse Practitioners; personalised lists; identifying pinch points, and auditing demand. **We recommend that the JCC should devise a method to strategically capture these different ways of working and best practice possibilities and circulate the information to all Practices.**
- 4.24 We learnt that, on qualification, GP trainees tended to stay in the same area as their training establishment. We also heard of an interesting development, whereby GPs can delegate certain medical procedures to a new post of 'Physician Associates'. **We recommend that the JCC should explore the feasibility of Bracknell Forest having a GP 'Training Hub'. Also, to optimise patient care, the JCC should explore the feasibility of supplementary roles, for example introducing 'Physician Associates'.**
- 4.25 From our survey of GPs, we noted that some GP's refer patients to other practices for specialist treatments. There is possible scope for making fuller use of these specialist skills, to give patients faster and more local treatment.

### Retention and re-employment initiatives

- 4.26 In our survey of GP Practices, all but one GP Practice were expecting GP retirements, some in the near future. The CCG informed us that a solution to this was not yet in sight. This will exacerbate the under-capacity problem the Borough already has, and this will be made worse by the further increase in demand which will arrive with the major new housing developments. This underlines the importance of NHS England's and others' efforts to improve the retention and re-employment of GPs, and to quickly find sustainable solutions to the pressure on GPs time.
- 4.27 We were encouraged to see that there is a clear commitment in the '*General Practice Forward View*' to increase the effort and resource for encouraging GPs to remain in place, and to encourage former GPs to return to Practice. Agency doctors are

expensive and cannot provide the same continuity of patient care as a permanent GP. NHS establishments in the acute sector run their own 'bank' of staff, and there may be a prospect of a similar initiative for GPs.

### **Making the best use of GPs time**

- 4.28 GPs time is in great demand, and it is costly. It therefore makes sense to make the best use of that time. On the basis of our review, we believe that further time savings are possible on the following aspects:
- a) Delegating Clinical work to appropriately qualified personnel. We asked the GP Practices how many clinical staff they employed, and the responses were: Nurses – from none to 5; and Health Care Assistants – from none to 4. Pharmacists, Nurses, and HCAs are a cost effective way of relieving the pressure on GPs time. **We recommend that the JCC should continue its efforts to transfer appropriate work from GPs towards Pharmacists, Nurses, and HCAs; and with HEE and other partners seek to address any shortage of capacity in those professions locally.**
  - b) Encouraging People to Consult Pharmacists. Pharmacists are highly skilled and it seems, under-utilised. Some changes are being made, for example to achieve economies by having community pharmacists administer inoculations. This has been a contentious issue locally, where we noted that one GP Practice had openly encouraged its patients not to get their influenza inoculations done by a pharmacist as that took money away from the GP Practice. This demonstrates that GP Practices' interests from the perspective of being private businesses do not always permit the most efficient way for the NHS to deliver medical services to the community. The CCG told us that this is defined in the GP Forward View around working with partners along with social prescribing and self care promoting patients responsibility and supporting non-registered members of the teams. **We recommend that the JCC should consider how to improve capacity and economies by making fuller use of pharmacists and other appropriate professionals.**
  - c) Signposting people to go elsewhere for non-clinical contact. Research by Citizens Advice in 2015 estimated that almost one-fifth of GPs' consultation time was spent discussing matters such as welfare, debt and personal relationships. The GPs we met told us that between 10% to 60% (with 20% being the most common response) of GPs time is used dealing with issues that could be more usefully addressed by someone else, including cases such as marriage difficulties. This corresponded with the 26% of 'avoidable GP contact time' which NHS England told us about. The CCG told us that they would like to see more building of resilience for communities and individuals, developing their assets to be able to self-manage with support when needed. **We recommend that the JCC seek to minimise this, such as better signposting on GP Practices' websites and in surgery waiting rooms on where to go for help, which would help to divert people with non-medical issues elsewhere.**
  - d) Minimising the number of cases where people fail to turn up for appointments. The GPs we met said that it was common to have some 'no shows' by patients for appointments, representing wasted GP time. They considered that this requires a solution from the Department of Health. Whilst 'no shows' can occasionally have some benefit, for example allowing a GP to catch up on an over-running list of appointments, they can waste time of Practice staff. We note that some local hospitals display information on the number of no-shows, explaining that this is wasteful, to encourage patients to stick to their appointment times. **We recommend that the JCC explore what similar**

**initiatives could be taken to minimise the clinical time lost through some patients not turning up for their appointments.**

- e) The need for Improved ICT is a recurring issue.
- f) More efficient patient pathways. All the GP Practices we met appeared to feel strongly that more can and should be done by other organisations to alleviate the pressure on GPs.

### **GP premises**

- 4.29 Having good quality buildings in the right place is important for the delivery of GP services. The majority of GP Practices we met did not wish to expand, though many saw a growth in demand for their services as being inevitable. Some practices would like larger premises, though they saw various obstacles to overcome.
- 4.30 At the outset of our review, we were encouraged to see that the CCG had reported to the Joint Commissioning Committee, on a system led estate strategy, in which it referred to amounts being provided to expand some GP Practices, that an Estates Forum was being established by the CCG, and that the CCG planned to have an 'Estates Strategy' written by mid 2016. The Group decided to meet the lead officer from NHS Property Services before the strategy was finalised. However, despite our repeated requests, we were not offered a meeting. Furthermore, the production of the Estate Strategy has over-run, and was still not available at the time of writing this report (10 August). **We recommend that the CCG explain the reasons for the delay and give a firm date for completion of their Estates Strategy.**

### **Follow-up To this Overview and Scrutiny review**

- 4.31 It is clear that the solutions to meet the growing demands on GP resources have not yet been fully developed, and implementation of those solutions will take some time. We believe that this is an important issue for residents, and it represents 'unfinished business' for the Health Overview and Scrutiny Panel. It will also be interesting to see the responses to the recommendations in this report, which we hope will bring commitments to make the improvements we have suggested. **We recommend to the Health O&S Panel that there is a follow up to this review in 18-24 month's time, specifically to see whether the STP and the 'General Practice Forward View' are being delivered successfully, and whether the pressure on GPs is at a sustainable level in the light of increased demand, particularly from new housing developments.**

## 5. Glossary

A&E	Accident and Emergency
BFC / 'The Council'	Bracknell Forest Council
CCG	Clinical Commissioning Group
CIL	Community Infrastructure Levy. A levy that local authorities can choose to charge on new developments in their area to fund infrastructure.
CLP	Comprehensive Local Plan
CQC	Care Quality Commission
DoH	Department of Health
FHT	Frimley Health NHS Foundation Trust
GP	General Practitioner
GPC	General Practitioners Committee
H&WB	Health and Wellbeing
IDP	Infrastructure Delivery Plan
HEE	Health Education England
JCC	Joint Commissioning Committee
KF	The Kings Fund
LEA	Local Education Authority
MCP	Multispecialty Community Provider
NHS	National Health Service
NPPF	National Planning Policy Framework
NPPG	National Planning Practice Guidance
O&S	Overview and Scrutiny
PAC	House of Commons Committee of Public Accounts
PCT	Primary Care Trust
PH	Public Health
RCGP	Royal College of General Practitioners
S 106	Section 106 of the Town and Country Planning Act
SHMA	Strategic Housing Market Assessment
STP	Sustainability and Transformation Plan
'The Group'	The Working Group of the Health Overview and Scrutiny Panel

## BRACKNELL FOREST COUNCIL

HEALTH OVERVIEW AND SCRUTINY PANEL  
NOVEMBER 2015

## WORK PROGRAMME 2015 – 2016

Terms of Reference for

**GP CAPACITY OVERVIEW AND SCRUTINY WORKING GROUP****Purpose of this Working Group / anticipated value of its work:**

- |  |
|--|
| <ol style="list-style-type: none"> <li>1. To explore the range of concerns indicating that there may be insufficient General Practitioner capacity to meet the needs of Bracknell Forest residents, in the future</li> <li>2. To ascertain the respective roles and responsibilities of the various NHS organisations connected with the provision of GP capacity, and to review their performance and coordination in that regard.</li> <li>3. To review whether Bracknell Forest Council is making a constructive and proper input towards addressing GP capacity needs.</li> <li>4. The anticipated value of the review is to conclude whether GP capacity needs have been properly identified and that sound plans are in place to meet those needs; and where they are not, to make recommendations accordingly.</li> </ol> |
|--|

**Key Objectives:**

- |   |
|---|
| <ol style="list-style-type: none"> <li>1. To gather information and build understanding of the factors affecting GP capacity, and the roles and responsibilities of NHS and other organisations with a part to play in delivering sufficient GP capacity.</li> <li>2. To directly gain the views of the Borough's GP practices on: the effectiveness of the current arrangements and future plans; and their individual circumstances, including succession planning.</li> <li>3. Through research and meetings, to reach conclusions on organisational collaboration, effectiveness and future prospects for the provision of adequate GP capacity</li> <li>4. To make recommendations as appropriate to the various organisations with a role in providing or influencing GP capacity.</li> </ol> |
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**Scope of the work:**

Everything with a direct bearing on the provision of adequate GP capacity to the residents of Bracknell Forest.
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**Not included in the scope:**

Anything outside the remit of the National Health Service or Bracknell Forest Council.
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**Terms of Reference prepared by:** Richard Beaumont

**Terms of Reference agreed by:** The Working Group

**Working Group structure:** Councillors Peacey (Lead Member), Phillips, Mrs Mattick, Mrs Temperton, Tullett and Virgo. Dr Norman

Rachael Addicott (Kings Fund) will provide advice to the Working Group throughout its review.

**Working Group Lead Member:** Councillor Peacey

**Portfolio Holder:** Councillor D Birch

**BACKGROUND:**

The Health O&S Panel decided to include this topic in its work programme for 2015/16 as it is concerned whether there will be sufficient numbers of General Practitioners to meet the GP primary care medical needs of Bracknell Forest residents, in the future. This concern is due to a combination of factors:

1. There are a number of organisations who have a role in relation to ensuring there are sufficient GPs, but it is unclear how well coordinated they are, and whether overall leadership and ownership of the issue is clear and effective. The advent of co-commissioning creates an opportunity to take a strategic approach to planning GP capacity/primary care
2. Bracknell Forest currently has fewer GPs per 10,000 population (7.1) than the average for all English Unitary Authority areas (8.5).
3. Britain’s population is forecast to grow by 10 million to 74.3m over the next 25 years, and the Borough’s housing developments (some 635 dwellings each year to 2035) indicate our population is likely to increase by at least 22,000 by the year 2026.
4. Increasing demand arising from long-term conditions including obesity, diabetes, mental health etc.
5. Britain’s population aged over 80 is forecast to rise rapidly to more than 1/12 of the population, putting additional demands on NHS and council services.
6. More GPs are leaving than entering the profession, and nationally it seems there is a ‘bulge’ of GPs reaching retirement age.
7. Recent research shows that 27% of GP appointments could be avoided.
8. The planned seven day opening of GP surgeries might divert resources away from times of peak demand for GP appointments.
9. It is unclear whether the Council’s Planning policies and practices recognise and support the provision of sufficient numbers of GPs.

**SPECIFIC QUESTIONS FOR THE PANEL TO ADDRESS:**

Questions will be raised as necessary to address the key objectives set out above. Additionally:

1. What is the Borough’s current GP capacity and scope to increase it?
2. What could be the options in Bracknell Forest for different/more efficient models of primary care?
3. Are all the decision makers attuned to the demands facing the Borough and actively/thoroughly addressing those demands?
4. What is the Council’s role in its Planning and other functions affecting GP capacity, e.g. Local Plan, Land assembly, S106 developer contributions, Community Infrastructure Levy, design of developments for health and wellbeing

**INFORMATION GATHERING:**

**Witnesses to be invited**

Name	Organisation/Position	Reason for Inviting
Rachael Addicott	Research Fellow Kings Fund	Subject expert



Practice Managers	GP Practices in Bracknell Forest (15 surgeries)	Assess existing capacity, succession planning, scope for expansion, views on alternative ways of working (particularly Vanguard and the New Vision of Care), and views on the overall issue of GP capacity
Dr Tong and Mary Purnell	Bracknell and Ascot Clinical Commissioning Group	To explore the role, responsibility and performance of each organisation in relation to providing GP capacity, and to seek their views on what, if anything, needs to change
TBC	NHS England (Primary Care Commissioning)	
TBC	NHS England Area Team	
James Page	NHS Property Services	
TBC	Health Education England	
TBC	Oxford Deanery	
Jane Hogg	Frimley Health Trust	To gain the views of the acute sector on GP structure and capacity
Andrew Hunter	Chief Officer: Planning & Transport	To review the role and performance of the Council's planning function, relating to GP capacity. To enquire how planning could input into infrastructure planning and what inputs they need from other functions.
Cllr D Birch	Executive Member for Health	To seek views on the scope of the O&S review and its conclusions/recommendations
John Nawrockyi	Director: Adult Social Care, Health and Housing	

### Site Visits

Location	Purpose of visit
GP Practices in Bracknell Forest	To interview GP Practice managers

### Key Documents / Background Data / Research

1.	Research of publications, e.g. Local Government Information Unit, and 'Town & Country Planning' on the topic (more documents to be identified)
2.	Possibly approaching the two MPs whose constituencies include Bracknell Forest, for their views on GP capacity
3.	Collection of relevant data from Office of National Statistics and NHS sources

### TIMESCALE

Starting: November 2015

Ending: July 2016

### OUTPUTS TO BE PRODUCED

1. A report containing recommendations to the NHS organisations and the Council's Executive

2. By publishing the report of the review and copying it to all Members, achieve wider sharing of information on various issues of interest and concern to Members, concerning the provision of GP services, to build knowledge and understanding.

#### REPORTING ARRANGEMENTS

Body	Date
Health Overview and Scrutiny Panel	29 September 2016

#### MONITORING / FEEDBACK ARRANGEMENTS

Body	Details	Date
Health Overview and Scrutiny Panel	Progress reports on Working Group's review	At each meeting of the Panel, next on 14 January 2016

## Summaries of Meetings

This section of the report summarises the meetings which we held. Richard Beaumont (Head of Overview and Scrutiny) provided officer support to the Working Group ('The Group') and attended all our meetings.

### Introductory Review Work

- 1 The Group met for the first time on **19 November 2015**, choosing a Lead Member, and receiving an introductory briefing from Richard Beaumont on possible key areas of focus for the review. The areas of focus were discussed and refined, and subsequently included in the scoping document for our review, which set out our objectives and approach in more detail (Appendix 1). A major decision by the Group was to seek to visit every GP Practice serving Bracknell Forest residents, to obtain information and views from them. This took a lot of their time and ours, but we believe it has given a very sound evidence base for our review and the conclusions and recommendations made in our report. We also committed to hold meetings of the various organisations with a role to play concerning GP capacity, to:
  - gain a clear understanding of each organisation's role
  - learn how each of the organisations is performing in that regard
  - obtain their views on what needs to be done to ensure there is sufficient GP capacity.
- 2 Other key issues identified at our first meeting were:
  - We recognised that the Vanguard Model<sup>1</sup> pilot might possibly lead to the whole care process changing.
  - One Member commented that residents at Jennetts Park ( a large new housing estate) had been promised a health facility. None had been provided, to date and it was not clear exactly what the facility would be. NHS England had decided that there should not be a GP surgery at Jennetts Park.
  - It was thought that the demands on GP's time could be significantly reduced if the number of 'no-shows' for appointments were to fall, also people not asking for GP appointments needlessly.

### Views of Kings Fund Representative

- 3 On **9 December 2015** the Group met **Rachael Addicott** (RA), a Senior Fellow of The Kings Fund (KF). The KF is a 'think tank' and research institute, highly regarded and seen to be very influential with the leadership of the DoH and NHS. The two main parts of its work are: delivering leadership development programmes; and policy work. The policy work mainly comprises short and long term research, providing analytical commentary, and generally helping people to understand the healthcare system and changes to it.
- 4 RA explained that increasing the number of GPs was not the only way to release more capacity. There is now much more flexibility than previously over different ways of working, contracting and related issues. The previous GP contract was prescriptive and unnecessarily restrictive, such that it had sometimes been used as barrier to innovation. The KF had suggested in 2013 that there was an opportunity for GPs to take greater

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<sup>1</sup> The new care models programme, one of the first steps towards delivering the [Five Year Forward View](#) and supporting improvement and integration of services.

responsibility for the procurement of primary care services. RA described how the care models in use now are more flexible and less restrictive than those used previously. For example, some GPs now work in acute settings, and when people present themselves at Accident and Emergency (A&E) they might be treated by a GP rather than hospital staff. Similarly, some hospital consultants work in GP settings, helping to improve the skills of GPs as well as working in outpatient sessions. This could lead to more specialisation by GPs. It also improved the patient experience (as they otherwise would have to attend a hospital outpatient session) and it reduced GP referrals to specialists.

- 5 RA expressed the view that the Department of Health (DoH) giving GPs more responsibilities had made the role less attractive to some people. We noted that GPs in Bracknell Forest had periodic training days, and some took a specialist interest in some fields of medicine (for example GPs now treated a lot of diabetes cases, whereas this used to be carried out mainly by hospitals), in a local GP network. RA said that the KF had concluded that the increased pressure felt by GPs is real, for example in not being allowed sufficient time to see patients. Consequently, moving work from the acute sector towards GPs might not be feasible. A cultural shift was taking place, with more GPs seeking to have a 'portfolio' career, for example by being a salaried locum, or working part-time. RA considered that this range of options should be promoted, to help to attract more people into the profession.
- 6 RA said that not enough was known about the impact on GP capacity of the drive to make people more responsible for their own health (there is a national focus on promoting self-management). Prevention was known to be effective in some cases, particularly where there are financial incentives. RA mentioned that walk-in clinics and increased use of pharmacies are part of the solution for achieving sufficient GP capacity. However, some GPs are unwilling to pass over some of their work (e.g. influenza vaccines), or having more health care being delivered by Practice Nurses – it was necessary to bear in mind that GPs are running a business. RA added that work was being done on categorising patients, with the aim that GPs could specialise in – and be given longer appointment times for patients with - complex co-morbidities. We observed that a significant proportion of GP's time is spent on issues which are not medical, e.g. when patients wanted to discuss their emotional well-being in the context of marital problems.
- 7 Other key issues which arose in our discussion were:
  - The quality of the physical estate for GP Practices can have a bearing on GP capacity.
  - NHS England are producing a range of commissioning options. It is for the co-commissioning CCG to recognise the need for more GPs. The leadership responsibility on GP capacity is more unclear than before the major reorganisation of the NHS (when the responsibility lay with the Strategic Health Authorities).
  - GPs are feeling sensitive and under a lot of pressure, for example on integrated care.

### **Agreeing the Approach to the Review**

- 8 On **18 January 2016**, the Group met to consider and agree the scoping document, setting out the approach to the review (reproduced at Appendix 1). In line with standing arrangements, we invited comments on this from the Council's Executive Member for Health and the Director of Adult Services, Health and Housing. The rest of our meeting was spent panning in detail the approach to take to the visits to GP Practices, including the data we wished to collect and the questions we wanted to ask all the Practices. Two members of the Group attended a forum of Practice Managers on 26 January to explain

the purpose of this information gathering exercise, and to secure the support of the Practices to our carrying out this research. We were pleased to receive a positive and supportive reaction from that forum. We also decided to reassure the Practices that their responses would not be individually identified, only published in aggregate form. We also informed council officers at the Royal Borough of Windsor & Maidenhead, and Wokingham Borough Council, about visits to GP Practices in those Boroughs which had a high proportion of Bracknell Forest residents on their patient lists.

### **The Council's Planning Function**

- 9 On 7 March, the Group met **Andrew Hunter (AH), Chief Officer: Planning, Transport and Countryside, and Matt Lunn (ML), Senior Planning Officer**. The officers described the role of the Council's planning function, relating to GP capacity. This comprised two elements:

Plan Making, which included, for example, housing growth and the production of the Infrastructure Delivery Plan (IDP). Statutory consultees for the IDP included the Local Education Authority and the NHS, who were asked at each stage of the Plan making process what extra services would be needed to go alongside that growth. The Council did not always receive responses from Statutory consultees. The Council then made use of the responses in developing the Plan and local Planning Policies, and in assessing planning applications. ML added that in producing the IDP, officers had engaged with the then Primary Care Trust (PCT) on site allocations during the process leading up to drafting the planning policies for major sites. If the PCT had provided evidence/justification for an additional Doctor's surgery, that would have been incorporated in the plan and policies. However – and despite a number of communications – neither the PCT nor the CCG had flagged up any such need. This was in contrast to the response from the LEA, which used established and elaborate forecasting models for the impact of housing growth on school places; which in turn led to a requirement on developers to contribute towards the costs of schools expansion/ new schools. It was clear that housing growth presented new demands on healthcare, but officers' understanding was that the NHS did not want small Doctors surgeries based on major development sites, preferring instead that residents on those sites made use of the larger surgeries in key locations such as Bracknell town centre. Officers had not seen any NHS forecasting models, though the CCG had carried out a review which had concluded that Crowthorne needed more surgery capacity. The Group saw that review report, which did not examine the issue of GP capacity needs, across the whole Borough.

The Planning process cannot be used to remedy past issues, only to address current and future needs generated by development.

Assessing Planning Applications, which included consideration of the impact on health and primary care. Consequently, the Council could if necessary require a developer to contribute land or resources towards meeting any such assessed need. For example, the original Master Plan for the Peacock Farm (now named Jennet's Park) housing development had included a Doctors surgery<sup>1</sup>.

- 10 The main matters arising in discussion, and in response to Members' queries were:
- a) One Member commented that the original Healthspace proposal had included enhanced GP services, The Healthspace proposal had not progressed as planned, and this had contributed towards the under-capacity problem now.

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<sup>1</sup> The CCG told us that there was no Section 106 provision for this.

- b) As to whether the CCG were aware of the full extent of new developments, officers thought that the former PCT were well aware of the need to contact the Council if their strategy changed, and meetings had been held with the PCT. When developing the IDP, officers had asked a key local NHS officer if the NHS had any projects which needed funding from the Community Infrastructure Levy (CIL). We subsequently raised this issue with that officer (Appendix 2, paragraph 24g), who later told us that *'I cannot provide evidence, regarding the S106/CIL conversations as these have been at informal meetings. Planners have not been able to grasp the fact that primary care provision needs to be via larger hubs, to provide the necessary range of services, and that single handed practices are a thing of the past.'*
- c) The Council was not prevented from requiring a Doctor's surgery at the Blue Mountain site, if the need was justified and raised at an early point in the plan making process.
- d) Parts of the Warfield development are at an earlier stage than Blue Mountain, thus there is more opportunity to make requirements for community facilities there if required.
- e) One Member commented that residents at Jennett's Park had bought their houses on the understanding that there would be a medical facility there. Having to travel to their designated GP Practice at Skimped Hill is a problem for some residents. NHS England's representative at a meeting of the Health O&S Panel had said they saw no need for such a facility at Jennett's Park. That was at odds with the June 2005 Peacock farm Master plan (which included land for a Doctor's surgery<sup>1</sup>, following discussions with the then PCT).
- f) A Member commented that Ringmead was the nearest GP Practice to Jennett's Park, and the Practice had decided against operating a second satellite site there. Jennett's Park is populated mainly by young adults and their children. Children are not included in the calculation of GP list size.
- g) One member commented that the Binfield Practice had contemplated moving westward to a more central location to meet the future demands from residents of the Amen Corner and Blue Mountain sites. The Practice also wished to expand.
- h) With regard to the first stage application at Warfield, AH advised that at the pre-application stage, the CCG had said they preferred a central Bracknell GP provision, and they had not responded to the consultation at the planning application stage.
- i) The NHS need to understand the full extent of housing growth if they are to make informed decisions on additional surgeries. Improvements required much better demand forecasting information from the NHS. The Council's Planning team needed this information at an early stage if they are to be able to put requirements into the Local Plan and make the appropriate requirements on individual planning allocations.
- j) Planning Officers are quite flexible in looking to see how a provision can be met, for example through land-swaps. Opportunities can be present even after developments have commenced construction.
- k) GP Practices are private businesses, which can influence their views on new 'competing' practices. They would also be reluctant to create new GP capacity in advance of new housing developments becoming occupied.
- l) The increased demand for GP appointments was partly due to people responding to NHS publicity campaigns encouraging people to see their doctor over moles, etc.; as well as the growth in long-term conditions, particularly diabetes.

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<sup>1</sup> The CCG told us that there was no Section 106 provision for this.

m) CIL is usable only for infrastructure provision, and not the on-going revenue costs and other costs of running a GP Practice.

- 11 At this meeting, the Group also noted the declared roles of organisations having an involvement in providing sufficient GP capacity in Bracknell Forest, and looked at the themes emerging from the visits to GP Practices.
- 12 The Group met next on **7 April**. We took stock of progress, and the interesting themes emerging from the visits to GP Practices. We decided not to press for visits to two Practices which were unwilling to participate in the Group's research. We also reviewed three documents of interest:
  - An extract of the Planning Act 2008 regarding Community Infrastructure Levy for medical facilities
  - A Town and Country Planning article regarding '*Planning for Health Infrastructure – re-engaging with the NHS*'
  - A House of Commons Committee report '*Access to General Practice in England*', following which we asked for and received more information on the Prime Minister's GP Access Fund.

### **Health Education England and the Oxford Deanery**

- 13 On **21 April** the Group met **Richard Mumford** (RM), Acting GP Dean, Oxford Deanery, and **Juliet Anderson** (JA), Assistant Director for Education and Quality Workforce strategy and transformation (Health Education England).
- 14 RM said that nationally, 3,250 GP students were needed, but that target had not been met for some time, indeed the numbers had been declining to approximately the number of GP trainees several years earlier. RM described the training for GPs. Graduates from Medical School undertook a one year foundation course in a hospital; 1/3 of the second year was spent in community health and 2/3 in a hospital setting. Afterwards, students entered training in one of a range of specialties, one of which is GP training. Trainees then entered a competitive recruitment process; London is a popular location with trainees, as is the Thames Valley. There was 18 months training in secondary care, followed by training in a GP Practice. During that time, trainees had to pass exams and demonstrate competence in a range of areas.
- 15 JA said that her personal focus was on the non-medical workforce. HEE do a lot of work to encourage people – from as early as 11 years old – to take an interest in a medical career. HEE is keen to explore new ways of working, for example upskilling Receptionists and engaging more Nurse Practitioners, to take some of the load off GPs.
- 16 RM said that in order to address primary care workforce issues, NHS England, HEE, the General Practitioners Committee (GPC) and the Royal College of General Practitioners (RCGP) have produced a collaborative, ten point GP workforce action plan<sup>1</sup>. RM summarised this as:

#### ***Recruit***

##### **1. Promoting general practice**

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<sup>1</sup> This can be viewed at <http://www.bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-current-issues/workforce-10-point-plan>

2. Improving the breadth of training. This included a more flexible training programme (which was seen as being quite short, at three years)
3. Training hubs. Groups and Federations of GPs were growing, to share resources and review education arrangements. A new approach was being deployed in RB Windsor and Maidenhead, and HEE want to identify early adopters.
4. Targeted support. There had been limited take-up of this, to date.

### **Retain**

5. Investment in retainer schemes. The long-standing retainer scheme assisted part-time GPs to remain in touch. More funding for this had been in the Government's announcement on 21 April.
6. Improving the training capacity in general practice
7. Incentives to remain in practice. Trainees are actively supported by the Deanery.
8. New ways of working. JA described how one possible solution might be to copy the USA's successful deployment of 'Physician's Associates'. This would require a 2 year training course, delivered by GPs and hospital doctors. This would not suit all Practices, though two Associates were now working successfully in Reading. The point is that some of the activities carried out by GPs can be carried out sufficiently well and more economically by other professionals, such as Associates and Nurse Practitioners. Clinical Pharmacists are another possibility – with training in consultation skills, and as part of the GP team, they should be able to carry out some of the simpler GP consultations.

### **Return**

9. Easy return to practice. RM said this scheme was definitely achieving results. The national programme was aimed at people who had been out of Practice for 2 years, to return.
  10. Targeted investment in returners, which included specific financial incentives.
- 17 The main matters arising in discussion, and in response to Members' queries were:
- a) More females were applying for GP training than previously, but their overall participation rate was a lower proportion due to their lifestyle choices, e.g. on possibly having children.
  - b) There is a national programme of GP training, also a Performance List (with requirements concerning safety, registration, performance, etc.).
  - c) The traditional model of Partnership Practices was being overtaken by other employment models, particularly a greater usage of Locums. The Partnership option tends to be less attractive to young GPs, not least because of the financial outlay for them. Portfolio careers are more common today.
  - d) We queried how the HEE and Deanery determined supply and demand, at a time when Bracknell Forest seemed to be already under-resourced, and there is set to be large population growth. RM explained that it is a national decision as to how many GPs are trained, and in terms of need that is left to local demand). GPs tended to settle in the same area in which they had been trained, hence there was a drive to train doctors in areas that were 'under-doctored.' JA said that there have been enough people to fill the GP training positions in the Thames Valley, unlike some other parts of the country. HEE believes there are enough GPs in the Thames Valley. As the number of GP training places is determined nationally, it would be better to focus efforts on making local GP Practices more attractive places to work. RM estimated that Bracknell Forest needed around 6-7 additional GPs to meet the anticipated population growth from new housing over the next 20 years (based on an average List of 2,250 patients for each GP). It



- was more important to look at what the population needs, and what skills are needed to meet those needs – and that would not be confined to GP’s skills.
- e) HEE and the Deanery could not stop GPs leaving the profession, the emphasis needed to be on making it an attractive career, and help people to return to the profession.
  - f) HEE had been protective of some activities in the past, but changes are being made, for example to achieve economies by having community pharmacists administer inoculations.
  - g) Members thought it was unclear how it was decided nationally how many GPs are needed, and whether it took sufficient regard of the increasing workload, the ‘bulge’ of GPs approaching retirement age, and the fast-increasing population. JA saw this as the responsibility of the CCG.
  - h) If people took more responsibility for their own health, there would be less demand on GP’s time.
  - i) We noted an example of a local GP Practice where three partners had recently resigned, and the senior partner – who had been unable to fill the vacancies, despite extensive network contacts – referred to it as a crisis. JA referred to the importance of the ‘System Transformation Programme’, and which will result in changes; Bracknell Forest Council has one seat on the STP. Practices need to take the initiative, plan ahead, and consider doing things differently.
  - j) The growth in the number of Locums was due to market forces and individuals’ career choices. This is a national trend, one factor being that it offered a higher daily remuneration than GP Partners.
  - k) Voluntary organisations and experts’ groups can assist in relieving the pressure on GPs, for example the use of ‘Talking Therapies’. This extended into the social care field.
  - l) People are seeking diagnoses in different ways, for example there was a high usage of Google to self-diagnose sexual diseases.
  - m) Arguably, three years training was insufficient to become a GP, though 2 years medical training preceded that.
  - n) Recruiting GPs and Nurses from India had advantages, such as their good university system and nursing training. GPs have to undergo assessment in the UK before they are allowed to practice.
  - o) JA said that if there are difficulties in obtaining GP appointments, that should be followed up by CCGs.
  - p) Attracting people to a career as a GP is the responsibility of the wider community, and many organisations should play their part in that regard. Attractiveness of that career path is a complex issue.
  - q) We noted the view that a generational change was underway. Fewer partners, the growth in Locums and salaried GPs reduced continuity of care, and that Partners are more inclined to take pride in their Practice and give extra effort.
  - r) JA said that some people who frequently ask for a GP appointment do not always need GP, but other services.
  - s) RM observed that Bracknell Forest has distinct strengths, including a superb Out Of Hours service, and a high level of good GP training practices. RM also commended the Council taking an interest in the issue of GP Capacity – neither he nor JA had been invited to meet a Borough Council on this topic previously.
  - t) The transition to a patient-centred approach across organisational boundaries was already underway, for example in Buckinghamshire.

18 On **27 April**, the Group reviewed information obtained from the Royal College of GPs on their views about under-capacity, particularly their calculation that Bracknell and Ascot needed 24 more GPs by 2020. We took stock of what had been learnt from the review, to date, including a seeming lack of communication between the centre of the

Department of Health/NHS and GP Practices, also to some extent between GP Practices. The Group considered the recent major announcement by NHS England, '*General Practice Forward View*', and in particular the commitments made to increase recurrent funding for GP services by £2.4 billion annually by 2020/21, with a further £500 million for a turnaround package. We spent some time on: considering whether the direction of our review needed to be changed in the light of that publication; and on preparing the questions to ask the next organisations to be met by the Group.

### **NHS England and the Bracknell and Ascot Clinical Commissioning Group**

- 19 On **19 May**, the Group met representatives of:
- NHS England South (South Central): **Dr Geoff Payne (Medical Director)** and **Nicky Wadely (Programme Manager - Co-commissioning)**; and
  - Bracknell and Ascot Clinical Commissioning Group (CCG): **Dr William Tong (Chairman)** and, **Mary Purnell (Head of Operations)**.
- These two organisations make up the Joint Commissioning Committee.
- 20 GP delivered a presentation on the *General Practice Forward View*, acknowledging that GP capacity was a pressing and big issue, which was part of the wider issue about sufficiency of primary care. Numerous reports were available on the topic from various authors, and it was difficult to draw hard and fast conclusions. The total number of GPs in South Central had not changed much. The majority of Doctors leaving General Practice were males, and those joining General Practice are predominantly females. A high proportion of GPs who are not working are female. GP described how the 'Car-Hill' formula or GP remuneration did not favour Bracknell and Ascot's circumstances, though there was little evidence that remuneration was a significant problem in terms of recruiting and retaining GPs. NHS England recognised that the pattern of work was changing, for example the large increase in telephone consultations. The Care Quality Commission (CQC) regime was also known to be resource intensive for GP Practices. Some 26% of GP consultations were potentially avoidable, GP said that the emphasis needed to be on what GPs could stop doing; and that would be a challenge for many GPs to accept. Promoting patients' self-care is very important.
- 21 NHS England (NHSE) considered that four of the GP Practices in Bracknell & Ascot looked too small to be viable in the future. In terms of surgery premises, there is a 'mixed economy' at present, for example some Practices own their premises and others lease them. NHSE see owner occupation as being a barrier to system transformation. The GP capacity situation is complex, the current arrangements are no longer fit for purpose, and there is an appetite to change the arrangements. NHSE organise large infrastructure changes, and local solutions are the responsibility of the Joint Commissioning Committee (JCC) with the CCG. Population growth and the increase in complex, long-term multiple conditions made the finding of solutions much more challenging.
- 22 Dr Tong (WT) said that the current system is very complicated. The Partnership model gave the best continuity of care for patients. People want to see their own GP, and it is hard to change that mind-set. There were significant areas of high housing growth. The position of NHSE and the CCG is to envision what the primary care provision should be locally, and that was not as simple as creating another surgery. It will take time to reduce the 'disease burden'. Finding a solution to the GP Practices' estate required a partnership approach with the care sector, the ambulance and fire services. However, the buildings issue was less important than workforce issues and methods; for example the open-access physiotherapy facility had worked well. The change process would take time as: the NHS is a massive employer; there are internal business units and some competition; local hospitals perform very well; but there is recognition that an overall systems transformation is needed, to include local authorities. Whilst it was right for the

CCG to take on commissioning of primary care, there was a perception of a conflict of interest.

- 23 Mary Purnell (MP) delivered a presentation entitled '*Better Futures For All – Programme Update*', giving an overview of the schemes being trialled to transform primary care locally. MP emphasised that these schemes were being funded by non-recurrent funding, so their continuity could not be assured. The CCG saw the local workforce as the main challenge, which could be affected by competing demand for labour arising from the regeneration of Bracknell town centre. The CCG was working with the Council and others to promote the year of self care.
- 24 The main matters arising in discussion, and in response to Members' queries were:
- a) The model was changing away from Partnered GPs towards increased use of salaried GPs and Locums, and more newly qualified doctors were interested in a portfolio career. NHSE's focus was on what is in the patients' best interests. NHSE recognised that the Partnership model has strengths, but it was not the best/only model going forward. It was known that in some cases, it can cost a Practice more to employ a Locum than they can charge the NHS. Various different arrangements were being deployed, such as: Partnership Practices considering closing can retain ownership of the building and rent it to the new service provider; procurement of five year contracts for provision of GP services; and federated GP practices, which offered some advantages. NW commented that NHSE were currently working on a number of possible combinations of GP Practices. WT said that there was interest in a federation in Bracknell & Ascot, but the 15 Practices are independent and it is difficult to resolve the contractual position.
  - b) Interim arrangements were sometimes needed, for example NHSE had commissioned the Berkshire Healthcare Trust to temporarily operate a surgery. The GPs had effectively been salaried, and they could focus their efforts on clinical delivery rather than running the business. In another case, a GP Practice had decided to close; an interim provider had been engaged, and a multi-specialty community contract ('GP Plus') was now being explored – this should link to the STP and delivery of an integrated care pathway for patients.
  - c) One view was that salaried GPs could not offer as good patient service as a GP Partnership. GP observed that a generational change was taking place, with doctors having different views about work/life balance.
  - d) NW said that the Urgent Care Centre is an important element in Primary Care, and its role might be widened.
  - e) GP Practices could not be treated by NHSE as 'real' business akin to the private sector, as there is no real competition and there are too many constraints applied.
  - f) One Member commented that patients were not always happy to be seen by nurses instead of doctors but had come to terms with that. If patients receive good treatment quickly, they will be content.
  - g) Attention was drawn to the forthcoming consultation by the Council of its 'Comprehensive Local Plan'. Members encouraged the CCG to respond with the needs of the NHS locally, which might lead to some Community Infrastructure Levy (CIL) monies becoming available. MP said that the CCG would happily respond, but have been previously told that by the Council there are no funds available from either CIL or S.106, indeed, the CCG had been advised not to seek such funding, though there was no written evidence of that. In relation to the envisaged health facility at Jennetts Park, MP commented that no funds were provided to build or run that facility, the former Primary Care Trust had just been given an opportunity to buy a parcel of land at Jennetts Park.

- h) The CCG had found it cumbersome to get progress with the Royal Berkshire FT over making fuller use of the Brants Bridge site.
- i) The move to get Community and Practice nurses to work closer together was showing great promise.
- j) Bracknell & Ascot had not yet trialled the use of Physicians Associates (though this was in use in West Berkshire). The concept was more advanced in secondary care (for example in endoscopy), and it was not a well-worked model in primary care.
- k) On training for the new models of working, NHSE was trying to encourage HEE to think ahead, and a workshop was to be held to stimulate radical thinking.
- l) WT agreed that, on the current formula, there are not enough GPs in Bracknell and Ascot. However, the current formula is not applicable for the future. For example, it does not take account of the increased use of Nurse Practitioners, or the prospective greater use of Pharmacists. The figures do not reflect the position 'on the ground', where gaps are being filled; Practices are resilient, though it was clear that some cannot fill their vacant positions.
- m) GP commented that research showed that Nurse triage does not reduce the number of GP consultations. NW observed that the 'care navigators' and customer service receptionists are effective in reducing the demand on GPs.
- n) The growth in the number of Locums was partly due to them commanding high levels of remuneration, also because some doctors do not want a permanent role in one Practice. It was recognised that the GP career needed to be made more attractive. Some former GPs had been re-engaged as Locums.
- o) WT said that there was no solution yet to meeting primary care needs, but it was being worked on. Many factors were in play, including a 'drift away' of doctors.
- p) MP stressed that primary care capacity was only part of the picture. A whole-system response was needed, incorporating the local authorities' public health role, for example – MP added that Bracknell Forest's Public Health (PH) function is better supported than some other councils, and the CCG wanted to see that continue.
- q) Members observed that the sharing of best practice could be improved, between GP Practices.
- r) The standard contract with the Foundation Trusts dealt with the issue of inappropriate transfer of work from the secondary to the primary care sector. The CCG monitors that, to ensure that the workload is kept under control. GP emphasised that the important thing was to meet patients' needs in the most clinical and cost-effective way.
- s) The CCG's Estates strategy was still in draft form.
- t) The Group suggested that the Health O&S Panel should consider issuing a response to the Council's public consultation on the Comprehensive Local Plan. (The Panel subsequently issued a response to that consultation, in July 2016).

### **The Sustainability and Transformation Plan**

- 25 On **27 June**, the Group met **Jane Hogg, Integration and Transformation Director, Frimley Health NHS Foundation Trust (FHT)**, and **Tina White, Programme Director, Sustainability and Transformation Plan (STP)**, for the 'Frimley footprint STP', to gain an understanding of how the STP would assist in meeting the challenge of GP capacity.
- 26 Jane Hogg (JH) outlined the current position on the draft STP for the Frimley Health 'Footprint', the submission deadline being 30 June 2016. The STP involved the whole health and care system for a population of some 750,000 people, covering five CCGs' areas, and the local authority areas for Slough, RB Windsor & Maidenhead, Bracknell Forest, North East Hampshire & Farnham, and Surrey Heath. The Plan would involve many organisations and transform health and care for the population. The Plan looked at

local needs, and it aimed for significant change and improvement. The fact that there is just one acute provider Trust for the footprint was seen as a significant advantage. The STP was being led by that Trust's Chief Executive, but Ambulance Trusts, Local Authorities and others were working together on the programme, forming a wider leadership group of some 50 people.

27 JH described how the STP has a shared goal of achieving three principles:

- . Better health and wellbeing
- . Better care and quality
- . Better financial sustainability.

These principles were being pursued by taking a taxpayer's view of what was required, rather than each organisation applying its own perspective. There will be no change to each organisation's statutory responsibilities, but the emphasis was on collective responsibility. For example, managing long-term conditions such as diabetes would be done between organisations to ensure the right care is delivered in the right place; this should improve the speed, quality and efficiency of care.

28 JH explained that the STP submission is also a bid for a share of the £8.5 billion extra funding promised by the Government over the next five years, a portion of which will be used to make up a Sustainability and Transformation Fund. FHT has estimated that the share for the FHT STP footprint should be around £47million by 2021, which would be used to fund the changes needed to current arrangements.

29 JH described how the local STP priorities had arisen from stakeholder workshops. The team did not have all the answers to those priorities, but there was a shared commitment to find the best solutions, which would require different approaches to those currently in use. The STP gave a chance to find a common approach. In the past, many people had ideas but there was not a mechanism for a cross-sector approach and a shared commitment. Rather than have small pockets of improvement, the STP aims to achieve bigger change, at scale.

30 JH said that there was a strong correlation between loneliness/social isolation and medical need. Patients were not leaving hospital too early, instead the transition to living alone at home was too great. There is some support for people returning home, but it is not consistent, and needs further development. Some initiatives like this work well in some parts of England. However, there are many inconsistencies between health and social care, and domiciliary care is lacking in places. There is real difficulty in recruiting domiciliary care workers, and FHT was looking to develop their support for this group of workers, to build a more efficient workforce. The STP aims to achieve the right level of service to all patients.

31 JH explained that there is a national concern about not making the STP submissions public until decisions have been taken on them. It was likely that a re-submission would follow in September. This was a collaborative, strategic process, so FHT could not say with certainty what the final plan would look like. For example, FHT was working with local authorities on a common vision to re-shape care provision.

32 Matters arising in discussion, and in response to Members' queries were:

- a) The CCG had stressed to Members the need for a whole system approach and an integrated pathway. JH explained that within the STP there are five priorities for change, and within those one of the enablers is Workforce. One of the strands in that enabler is General Practice, and a significant change is envisaged as to how General Practice will work in future. GPs were being engaged on this, as they will need to work at a scale they are not accustomed to. The STP

recognises that GPs have huge capacity problems currently. The STP will look at facilitating changes to the role of General Practitioner to help make it more attractive and to improve retention. For example, how to make fuller use of different staff in primary care rather than GPs being used to deal with many different tasks, in a similar way that Nurse triage was used by some hospitals. STP work cannot force GPs to change their working arrangements, but the model preferred by STP leaders is to have hubs for out-of-hospital care. Some of these are already in place, with GPs working in an integrated team including social care and others. The STP would not 'reinvent wheels'. They wished to build on what is working well, and they were already working with the Oxford Deanery and other relevant organisations to provide a way of co-ordinating all parts of the system.

- b) The sharing of information and access to medical records was seen to be fundamental. The 'Digital Road Map' - electronic sharing of information in the interests of patients - was being pursued. Some information governance issues remained to be resolved. This five year programme of work was designed to create a core data set 'wrapped around' each patient.
- c) On the issue of GPs feeling that work was being transferred to them from secondary care, JH explained that one of the priorities is to reduce inequalities across care pathways. They recognised GPs' concerns (indeed, there were similar concerns in the opposite direction from secondary care providers), and this was being reviewed to see how it could be improved. There are some valuable relationships between primary and secondary care, and the STP aimed to build on the best of those relationships, to allow the clearest pathways for patients and the most effective clinical governance of those pathways. One priority was to increase self-care and early prevention, which should lessen the demand on GPs.
- d) There are two GP Practices on the Heatherwood hospital site, currently. FHT planned to re-provide these, whilst looking to have a more integrated service there. The GP Practices' agreement to that change would be needed, in line with the new national initiative on GPs.
- e) On the apparent ending of the traditional partnership model for GPs, JH commented that individual practices will not be able to cope with the new type of operation. Instead, there needs to be a series of integrated hubs, with more collective working between GPs. The GPs would need to agree between themselves how to manage routine care and the various other demands. There would need to be a multi-disciplinary approach, with the GP as the clinical lead. The Surrey Heath experience is that the hubs are improving care of the most vulnerable patients responsively, whereas in other areas work has increased; showing that this is an effective model in reducing demands on secondary care. That way of working gives a better, seamless service for patients. This was the local GPs' initiative, and that success needs to be learnt from and replicated elsewhere. STP work estimated that a hub might ideally have some 50,000 - 100,000 patients. Other Practices might be willing to join in on the new model if they can see that the Surrey Heath model is succeeding.
- f) On the resourcing of GP capacity, JH said that there is an element within the STP on General Practice, but the solution was more complex than that. GPs are a fundamental part of making things work better. The STP did not look at GPs in isolation, but as part of a cross-sector approach, from the perspective of getting the best patient-centred value for money services. Work had been done to assess needs, and how best to meet those needs, both locally and across the STP footprint. The STP priorities - which the GPs helped to shape - are aimed at delivering the changes needed. FHT are working closely with HEE and others to identify the milestones and the initiatives which need to be taken, and by whom.

- g) JH said that the STP leadership was actively engaging with GPs, though there were mixed views among the Bracknell and Ascot GPs about the STP. The nine Surrey Heath CCG area's GP Practices had been actively involved in developing the new ways of working. A catalyst for change could be the GP retirement 'bulge', as it was thought that more of the newly qualified GPs are content to be salaried. The STP programme recognised the need for more communication and continuing engagement.
- h) There will be costs of implementing the STP, and it will be challenging to get everyone to agree on the way forward.
- i) As part of the STP process, views were being sent in to inform the tendering process for the 111 Service (Non-emergency ambulance), the emphasis being on getting clinical input earlier in the 111 response.
- j) It was not known how long it would take to obtain a decision on the STP submission, or to obtain the funding. This also depended on the £8.5 Billion still being available.

### **The Council's Executive Member for Adult Services, Health and Housing**

- 33 On **22 July**, the Group met **Councillor Dale Birch, Executive Member for Adult Services, Health and Housing**, to hear about the roles of the Health and Wellbeing (H&WB) Board, the Public Health (PH) function and the Adult Social Care team in relation to meeting the challenge of GP capacity.
- 34 Councillor Birch (DB) described how the two worlds of Local Government and the NHS 'spoke different languages'. A panoply of different organisations had a role to play in relation to GP capacity, and the NHS saw that term as applying more to fitness to practice rather than the number of GPs. Recruitment and retention of GPs were central issues, and the problem of under-capacity had been known about for some time. The Council was not responsible for providing or training GPs, but had an interface with that primary health service. The H&WB Board used its influence – particularly in relation to the 'Better Care Fund' – to ask commissioners to allocate funding to priority areas, such as the Respiratory team. The Council did not get any closer to the issue of ensuring there were sufficient GPs.
- 35 The main matters arising in discussion, and in response to Members' queries were:
  - a) DB said that the NHS architecture and frequent staff changes made it unclear who was responsible for commissioning new GP surgeries.
  - b) On the consultation over the Comprehensive Local Plan (CLP), DB agreed that the Plan should say more about health, also the need for older people's accommodation, though the Plan had to be supported with evidence. He suggested that Health Overview & Scrutiny might wish to suggest that the Plan should allocate sites for healthcare, but he did not see a case for allocating Community Infrastructure Levy (CIL) for that purpose. DB explained that this was because GP Practices are profit-earning private businesses, and the Council should not be providing any private business with CIL funding. Besides, CIL funds were heavily in demand for new schools and other infrastructure requirements. Members commented that the CIL regulations include health on the list of permissible infrastructure; some other councils had allocated CIL funds towards meeting health infrastructure needs, and if Bracknell Forest Council was to exclude that possibility, this would not help to resolve the GP capacity issue.
  - c) DB said there was no clear understanding from NHS partner organisations about the facilities they wanted to have, and their locations. DB was a member of the Joint Commissioning Committee which has responsibility for the estates strategy (yet to be produced), but had not been able to attend many meetings owing to diary pressures.

- d) Members observed that there had been contradictory statements from the Council's Planning Officers on the one hand, and from the CCG on the other, regarding the inclusion of health infrastructure requirements in the local plan and in the CIL 'Regulation 123 list' of the various infrastructure usages CIL funds would be put to.
- e) DB expressed the view that the GP capacity issue would not be resolved solely by providing more buildings. The CLP might indicate where the new 'hubs' might be sited; the next issue could be how the hubs are to be funded – and it would be wrong for the GP Practice element to be funded by a Local Authority. Some elements of the hubs might be funded by other organisations, including the NHS acute sector.
- f) One Member commented that the rental arrangements for new GP Surgeries would not entail a profit for GP Partners, if CIL was used to support their creation. DB responded that the GPs could make a profit, if their surgery was chosen as a location for a hub and they owned the freehold.
- g) The integrated health and social care agenda was being pursued by the H&WB Board in various ways. Some success had been achieved, for example on delayed transfers of care (where funds had been pooled with the CCG to improve the reablement facility), an initiative to minimise unnecessary hospital admissions; and a working group on children's mental health. The Board did not have authority to allocate funds.
- h) DB saw it as unsatisfactory that the STP Partnership group lacked engagement with elected members, and he, together with the Executive Members for Adult Services in Slough BC and RB Windsor & Maidenhead had passed their concerns to the FHT Chief Executive. The STP team had formed a reference group to inform elected members of progress.
- i) On the adequacy of social care at the time of hospital discharge, DB said that the intermediate care function was under review. The number of delayed discharge cases due to councils had been over-stated. The Council has a hospital in-reach team, also a presence at A&E to identify cases where local authority care could be sufficient.
- j) DB encouraged the Working Group to recommend that everyone should engage with the common agenda. He mentioned that he had requested an LGA Peer Challenge to review the H&WB Board, including its relationships. DB added that the H&WB Strategy was produced and owned by five different organisations, so it was necessarily a high-level document.

### **Production of the Working Group's Report**

- 36 The Group met for the last time on **22 August**, when it considered and subsequently agreed its draft report, for presentation to the Health O&S Panel for its adoption.



### **Information Obtained From Survey of GP Practices**

During its review, Members of the working Group visited 15 GP Practices in, or adjacent to Bracknell Forest, all of which were providing services to Bracknell Forest residents, using a structured questionnaire and a request for factual data. We summarise below the information we obtained from these visits. This information has been used to inform our conclusions and recommendations in part 4 of this report.

### **Main Messages From GP Practice Questionnaires and Visits**

#### **A) Workforce:**

- 1. Does the practice have a pharmacist and in what roles e.g. medical review, repeat prescriptions?**

##### Responses

Only one of the GP Practices had a pharmacist.

- 2. Do you anticipate the workforce changing, if so how?**

##### Responses

A third of the GP Practices anticipated change, the remainder saw this as unlikely. Most of the change was due to: increasing workload; Nurses and Health Care Assistants taking on more demanding roles; and staff retiring (with a change away from Partner GPs towards Locums or other salaried doctors).

- 3. Are you expecting any GPs to retire in the 5 year and 10 year horizon?**

##### Responses

All but one GP Practice were expecting GP retirements, some in the near future. (The CCG informed us that a solution to this was not yet in sight).

- 4. How easy is it to recruit clinicians:**

##### **Partner GP**

Responses ranged from difficult to impossible, even a crisis situation. Some commented that prospective Partners are deterred by high house prices and the burden of buying in to the Practice.

##### **Salaried GP**

Responses ranged from difficult to next to impossible.

##### **Locum GP**

Responses Most Practices said this ranged from difficult to horrendous, and some Locums were unwilling to do all the work asked of them.

##### **Ancillary workers – Nurses & Health Care Assistants**

Responses ranged from not easy to very difficult. Some reported a shortage of District Nurses.

- 5. Do any GPs have a special interest?  
If so, do they see patients from other practices?**

Responses Around 60% of Practices had a specialist interest and saw patients from elsewhere, for a variety of treatments including minor surgery, dermatology and diabetes, for example.

## **B) Patients and Workload**

- a) If the practice has a steadily growing list of patients registered with QOF (Quality and Outcomes Framework<sup>1</sup>) -, to what extent do you think this is due to:**

**Increased prevalence  
Movement from secondary care**

Responses All but two Practices reported growing lists of patients, and the growth in QOF cases was seen to be mainly due to: a movement of treatment away from secondary care to primary care (e.g. early discharge from hospitals); population growth (particularly the elderly); and increased prevalence of chronic conditions. One GP commented that Primary Care delivers over 90% of patient care, but takes just 8.3% of the NHS budget.

## **C) Further issues on Workload**

- 1. Apart from the chronic conditions listed in QOF, have you seen a change in activity and demand in the past 10 years? If so, what do you think has been the main cause(s) of this change?**

Responses Causes were varied and included: increased list size; more elderly patients; increasingly complex conditions; increased expectations by patients (sometimes caused by secondary care doctors, the Government and media encouraging people to see their doctor); less self-reliance by patients and family support; increase in mental health issues particularly with young people, sometimes arising from drug misuse; more bureaucracy; a growth in the number of cancer and diabetes cases ; increasing obesity and inactivity; increased longevity but poorer quality of life for some; insufficient self-care.

- 2. Types of patients you see in the practice:  
a. Have you noticed an increase in patients reporting particular conditions in the past five years? (other than those in QOF)**

Responses Almost every Practice reported increases, mostly in mental health conditions. Other conditions included muscular-skeletal, diabetes and allergies.

- b. Have you noticed an increase in patients with multiple morbidities?**

Responses Every Practice reported an increase, and one commented that the standard 10 minutes allowed for an appointment was no longer adequate.

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<sup>1</sup> The Quality and Outcomes Framework (QOF) is an incentive programme for GP practice achievement. It rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services. It is a voluntary process for all surgeries in England. The indicators for the QOF change annually, with new measures and indicators being retired. For 2014/15, the QOF awards practices achievement points for: managing some of the most common chronic diseases, e.g. asthma, diabetes; managing major public health concerns, e.g. smoking, obesity; and implementing preventative measures, e.g. regular blood pressure checks.

**c. Have you noticed an increase in patients with long term conditions?**

Responses Every Practice reported an increase.

**d. Have you noticed an increase in frail elderly patients?**

Responses Every Practice reported an increase, some large. One commented that there was an increased prevalence of old people living alone.

**3. How many of your patients are housebound, and how many are housebound with chronic conditions?**

Responses The number of patients ranged from 25 to 50, and two Practices said that all the patients had chronic conditions.

**4. Do you have a greater role in palliative or end-of-life care?**

Responses About 80% of Practices said they do, and two worked closely with a voluntary body.

**5. In terms of your average working day, what percentage of GPs time is used dealing with issues that could be more usefully addressed by someone else? e.g. patient issues such as minor illnesses that don't need to be seen by a GP or nurse; medical issues that another practice member should deal with; social care issues**

Responses ranged from 10% to 60%, with 20% being the most common response. Examples of issues which do not need to be handled by a GP included: social care issues; requirements by the Care Quality Commission (CQC); minor illnesses; repeat prescriptions; sick notes; writing notes to Housing Associations. One GP commented that this left no time for higher level GP tasks such as clinical governance and teaching. NB – this was supported by the presentation from NHS England which said that 26% of GP appointments were potentially avoidable.

**6. Have there been any thoughts on expanding the roles of the practice nurse, HCA or pharmacist to reduce GP workload?**

Responses All but one Practice had made increasing use of nurses and HCAs, with success, and one was considering using a pharmacist for medication reviews. Some said that further progress was inhibited by difficulties in recruiting nurses.

**7. Have other services impacted positively/negatively on GPs work, if so how?**

Responses were varied and only one Practice reported that the changes had been positive.

**a. Can you talk about how changes in secondary care have impacted?**

Responses pointed to more transfer of care to GPs and inappropriate 'delegation' of tasks from hospitals to GPs (often unfunded), including comments: Post-operative follow ups and pre-operative assessments are pushed out to primary care; poor hospital discharge arrangements; Locums operating the 111 service telling patients to see their GP urgently; this causing GPs to have insufficient time to do what they think is important, such as minor surgery.

**b. Can you talk about how changes in community care or social care have impacted?**

Responses included a few positive comments (e.g. intermediate care/re-ablement having a positive impact), but most commented that the changes had added to the pressure on GP Practices, including: poor social care and fewer beds in secondary care means that sicker, more vulnerable, patients are now in the community needing significant GP input; more Child Protection conferences; more help being needed in the community, otherwise people tend to go to their GP; reduced availability of District Nurses.

**c. Other services, such as private hospitals?**

Responses varied, with most saying there was little or no impact. Some saw a positive impact of private hospitals, in terms of faster patient care and helpfulness to GPs. One Practice criticised private hospitals for often expecting primary care to carry out pre-operative and post-operative procedures, and tests.

**8. What are the biggest challenges for your practice in managing activity and demand?**

Responses were mixed. All pointed to increased demand and activity levels, arising from increased patient numbers, the increasing elderly population, multiple morbidities, and expectations by some patients. The most common challenges cited were staff shortages and recruitment difficulties, with other challenges seen as financial and site constraints, and bureaucratic demands.

**9. Are there any examples of how your practice manages activity and demand that have been helpful and you would like to share with us?**

Responses were mixed, with many referring to the increased use of triage, particularly by telephone. Other measures included: working harder; task lists; a whole day duty doctor system; more delegation to Nurse Practitioners; personalised lists; identifying pinch points, and auditing demand.

**10. Do you have any plans for extended hours?**

Responses All but two Practices operated some type of extended hours, and one Practice hosted the CCG's extended hours service each evening and on Saturday mornings. There were no further plans to extend opening hours.

**D) Plans for Expanding**

**1. Do you have any plans to expand:**

**The patient list –**

Responses Most said that their lists were expanding due to new housing developments, and some were concerned about their ability to cope, saying that they were not looking for new patients.

**GP WTEs –**

Responses Most said yes, but referred to recruitment difficulties, even to crisis point.

**Ancillary staff –**

Responses Two said no, but the majority saw a need to increase ancillary staff in line with increasing patient numbers.

### **Premises -**

Responses More than half said no, and those who wanted to expand premises saw constraints in doing so.

**2. What is the approximate size of the premises in M<sup>2</sup>?**

Responses The areas ranged from 180 M<sup>2</sup> to 900 M<sup>2</sup>.

**3. Is it possible to expand within the current premises?**

Responses Were evenly divided between yes and no. Most constraints to expansion related to the physical site.

**4. Would you like to move to new larger premises; expand the current premises; stay the same?**

Responses Slightly more than half the Practices would like to expand or move to larger premises.

**5. Would extended hours enable you to expand within existing premises?**

Responses The overwhelming majority said no, three said possibly, and one said yes.

**6. If you would like to expand, in what timeframe would you like to expand?**

Responses Most of the Practices which want to expand want to do so within the next two years, and some wanted to do so quickly.

**7. Do you have any funding commitment from NHS England?**

Responses Most of the Practices with planned expansions had received funding commitments from NHS England.

**8. Are there any inhibitors to your plans to expand?**

Responses were mixed. Issues included the availability and affordability of sites; financial constraints; and the need to obtain the agreement of other parties.

### **E) General Questions**

**1. Is there anything which any other part of the NHS, central government or the Council can or should do to help ensure we have enough GP capacity to meet the large increase in demand arising from new housing developments, longer life expectancy and other factors?**

Responses The most common request was for more GPs and GP training places. Other points raised included:

- a. Increase in other clinical staff, School Nurses and Community Health workers.
- b. Increased funding
- c. Better communications on test results from some hospitals
- d. Better support from the CCG and NHS England on premises
- e. Making General Practice more attractive to Junior doctors

- f. More health promotion, to encourage people to take more responsibility for their own health.
- g. Removal of unnecessary bureaucracy
- h. Support for smarter and more flexible working with IT solutions.
- i. Improve the working conditions of GP partners.
- j. Offer medical students becoming GPs to write off their student loan.
- k. Expand the NHS Bracknell & Ascot GP fellowship scheme.
- l. Take into account the increase of female and part time GPs replacing male and full time GPs when calculating total GP numbers.
- m. Addressing poor morale among GPs.
- n. Encourage returners back into being a GP.
- o. The Council should promote healthy lifestyles.

## 2. Are there any general points you would like to make?

Responses were mostly expressing concern about the long-term viability of General Practice. Specific points raised included:

- a. More of the NHS budget needs to move from secondary care to primary care.
- b. Need for future workforce planning, estates strategy,
- c. Need to put the value back in primary care as a career.
- d. GPs attend fewer child protection conferences as times are inconvenient and funding no longer provided for absence cover.
- e. Need to audit the effectiveness of the extended hours service.
- f. Increase in work of occupational therapist now more are kept in their own homes
- g. Locums need supervision and do not provide the continuity of care which patients need.
- h. There were many 'no shows' for appointments in February, representing wasted GP time. This requires a solution from the Department of Health.

### **Main Messages From GP Practice Data**

We also obtained the following data from the 15 GP Practices we visited.

#### **Workforce**

The clinical workforce in each GP Practice in Whole Time Equivalents was in the range:

GPs – from 1.5 to 11.5 Whole Time Equivalents (WTE), of which:

- GP Partners ranged from 1 to 9
- Salaried GPs ranged from none to 2.7
- Trainee GPs ranged from none to 1.5
- Only one Practice had a GP Fellow (Part time)

Nurses – from none to 5

Health Care Assistants – from none to 4

#### **Patient Population**

The GP Practices had Patient Lists totalling 139,872 people. This exceeds the Borough's population because we reviewed practices based just outside the Borough which provide services for Bracknell Forest residents.

The Practices had a broadly similar age profile, and the overall percentages were:

Aged Under 65: 85%  
65-74: 8%  
Over 75: 7%

### **Growth in Patient Population from 2008 to 2016**

Where comparator figures were available, this showed that the patient population had grown by 7% over the period 2008 to 2016. Only two GP Practices reported a reduction in patient numbers over that period, and the largest percentage growth was 18% (Crown Wood GP Practice).

### **Patients With Long Term Conditions**

The GP Practices told us they had a total of 45,691 patients with long-term conditions, a massive 39% increase on the 32,835 in 2008. The main conditions reported were:

Hypertension (14,651)  
Asthma (6,989)  
Diabetes (5,485)  
Coronary Heart Disease (3,086)  
Cancer (2,932)  
Chronic Kidney Disease (2,813)

For further information on the work of Overview and Scrutiny in Bracknell Forest, please visit our website on <http://www.bracknell-forest.gov.uk/scrutiny> or contact us at:

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# QUARTERLY SERVICE REPORT

## ADULT SOCIAL CARE, HEALTH & HOUSING

Q1 2016 - 17  
April - June 2016

**Executive Member:**  
Councillor Dale Birch

**Director:**  
Gill Vickers






Date completed:

## Contents




Section 1: Where we are now .....	3
Section 2: Strategic Themes .....	7
Value for money .....	7
People live active & healthy lifestyles .....	8
A clean, green, growing and sustainable place .....	12
Strong, safe, supportive and self-reliant communities.....	13
Section 3: Operational Priorities .....	14
Section 4: People .....	16
Section 5: Complaints.....	18
Annex A: Financial information .....	20
Annex B: Annual indicators not reported this quarter.....	21

## Key

### Actions

	Action is on schedule		Action has been completed
	Action may fall behind schedule		Action is no longer applicable
	Action is behind schedule	-	Not yet updated

### Performance indicators

	On, above or within 5% of target
	Between 5% and 10% of target
	More than 10% from target

## Section 1: Where we are now

### Director's overview

There was significant activity within the Department in quarter 1 with both ongoing projects and decisions being made both by the Executive and by the Director.

In April, a decision was made to award the contract for the Falls Prevention Advisory Service, commencing in July 2016. This will ensure that Bracknell Forest residents aged 65 and over can access an upstream, preventative falls service that can be individually tailored to the needs of the person in order to achieve reduced future risk of harm, reduced future risk of hospital admission, and reduced future need for specialist support.

In May, Adult Social Care and Housing Overview & Scrutiny Panel considered the Annual Complaints report 2015-16 for Adult Social Care and for Housing. There were more compliments than complaints received over the reporting period, although the number of both had declined. The issues behind complaints were often resolved as a result of learning from the complaint although the fall in complaints may lessen the Departments opportunities to learn in this way.

In June, a decision was made by the Executive to award the contract for the Support with Confidence Service commencing in October. This will ensure that a choice of support arrangements is available to individuals purchasing their own care through individual budgets, direct payments or through their own funds. Personalised assessment and support and direct payments will be the key focus for the department and the market and community assets will need to be developed to provide much wider choice.

The Department will be taking a paper to the Executive in July seeking endorsement of its plan to re-commission the Drugs Alcohol Action team services, in order for a new contract to be in place from the beginning of the next financial year.

The final assurance rating for the Bracknell Forest 2016 Better Care Fund (BCF) submission is expected shortly from NHS England. The provisional rating provided in April 2016 was "Assured", which was the highest rating from a possible range of "Assured; Assured with Support or Not Assured". Nationally there has been a delay in NHS England completing the verification process for submissions.

The BCF schemes continue to be closely monitored each month through the Better Care Fund Steering Group, with further scrutiny provided through the Programme Board. There will also be a review of the BCF schemes to ensure they are delivering our key strategic objectives and to identify any opportunities to join our initiatives with those of the other East Berkshire Authorities

Significant work has been undertaken to ensure safety and to improve Clinical Care at the Bracknell Urgent Care Centre. There is now a stable, multi skilled staff team in place and they have instilled a learning and development culture. Communications and governance have been improved and a new mechanism to report issues via the intranet sends alerts to managers to alert them of any significant issues at anytime. There has been large stakeholder engagement to enable these changes to take place.

In the first quarter, the Council purchased four properties for its temporary to permanent programme and 6 properties were purchased for Downshire Homes Ltd (DHL). Further purchases for DHL will take place early in quarter 2 and the Council will continue to investigate property acquisition, such as leasing, in order to increase the amount of accommodation available as temporary homes for homeless households.

Work for the Public Health team in quarter 1 has focused significantly on commissioning, including the completion of procurement processes for Health Visiting and mental health support for young people. The Health Visiting procurement will support a skill mix approach (as part of our workforce development planning) in order to help address the national and local recruitment issues. At the same time, the team have further extended the Back to Fitness Programme, which forms part of the Year of Self care. Back to Fitness is a community initiative that brings residents together to support each other in getting more active. As well as giving people new confidence in relation to physical activity, the project also aims to increase social contact and benefit participants' mental well-being.

## Highlights and remedial action

### Good performance

Delivery against the actions in the Service Plan is looking strong. Of the 45 actions, 8 have been completed either on schedule or ahead of schedule (Blue), 36 are on target (Green), and 1 may be delayed (Amber).

Of the 8 actions completed, 5 were completed ahead of schedule and 3 were completed according to schedule.

Waymead Short Term Care were recently awarded an overall good rating in a recent report by the Care Quality Commission inspectors.

### Areas for improvement

#### *Actions*

Action 1.7.01 (Implement savings as identified for 2016-17) is currently amber. Savings of £1.3m are required from social care budgets. Work is ongoing to review care packages where it is identified that needs have changed or where there are new ways of providing support.

*Indicators*

Indicator L178 (The number of household nights in non self contained accommodation) is currently red. The higher level of household nights in non-self contained accommodation in first quarter is a consequence of delay in completion of Downshire Homes property purchase. It was hoped all purchases would be complete by end of June that has proved not to be the case.

Indicator L179 (The percentage of homeless or potentially homeless customers who the council helped to keep their home or find another one) is currently red. There has been an increase in homeless presentations and the ability to prevent homelessness by helping customers find an alternative home in the private rented sector remains challenging.

Indicator L278 (The percentage of adult social care records in the Adult Social Care system that contain the person's NHS number is currently amber. The NHS Number batch file is ready for transfer. The outcome of first pass to review the success rate of matching is now awaited.

**Audits and Risks**

Every quarter the department reviews its risks in the light of events. In the last quarter two risks have increased. The first is the likelihood of a provider failing, or ceasing to trade, with concerns having been raised in respect of two care homes in the area, one of which has subsequently closed. The Council is actively working with those providers to gauge the likelihood of ceasing to trade, and putting in place contingency arrangements in the event that they do cease to trade. The second risk is in the Department's Resource Allocation System not being robust enough to enable the savings that are required to be made being made in a sustainable way. The Department will be exploring alternative models over the summer to address this.

**Budget position***Revenue Budget*

The greatest challenge for the department is identifying savings from existing adult social care packages through a process of review and 'right-sizing'. This process is in progress but the target is £1.3 million and so will be a significant challenge. There is also a particular challenge in the Community Team for Mental Health: Older Adults, where the full year effect of rising residential and nursing placements is placing a significant pressure on the budget.

A further potential pressure in Adult Social Care is the requirement to move residents due to provider failure to meet the Care Quality Commission's requirements. The Council currently supports 20 residents where this is the case at an average weekly cost of £596. Given that new placements are usually in the region of £800, this could have an adverse impact of approximately £0.2 million.

*Capital Budget*

As at Month 2 we are reporting outturn to budget, except for the £0.4 million for Dennis Pilcher House which will no longer proceed so the budget will be returned to Corporate. As this scheme is no longer proceeding, this has also freed up the Community Capacity Capital Grant which had been earmarked for the scheme. A key task for the department is to explore how this grant can now be used for the Older People Accommodation Strategy, possibly to help ease market pressures on unit prices referred to above under the revenue budget.

## Section 2: Strategic Themes



### Value for money











Action	Due Date	Status	Comments
<b>1.2 The cost, quality and delivery mechanism of all services will be reviewed by 2019</b>			
1.2.03 Review the contract arrangements for Clement House support service	31/05/2016		Monthly monitoring and data collection continues which will feed into future options. The current provider has an extension of contract until September 2016 with a further 6 months if required.
1.2.04 Review and retender the housing related support contract for single homeless people	31/03/2017		A project Plan for the retendering of the housing related support contract for single homeless people is in place. A Procurement Plan will be in place with the required authorisations by 1 March 2017
<b>1.3 We charge appropriately for services and seek opportunities to generate additional income</b>			
1.3.02 Revise local council tax reduction scheme to be based on income bands	30/11/2016		Modelling options on income band scheme to take place on 28/07/16, with a view to report to September Executive
<b>1.7 Spending is within budget</b>			
1.7.01 Implement savings as identified for 2016-17	31/03/2017		Savings of £1.3m are required from social care budgets. Work is ongoing to review care packages where it is identified that needs have changed or where there are new ways of providing support.
1.7.06 Agree financial plans with the CCG to submit to the Department of Health in respect of the Better Care Fund	31/04/2016		The 2016/17 Better Care Fund Plan has been agreed with the CCG and submitted and accepted by the Department of Health.



















## People live active & healthy lifestyles

Action	Due Date	Status	Comments
<b>4.3 Comprehensive Public Health programmes aimed at adults and young people, including smoking cessation, weight management and sexual health in place</b>			
4.3.01 Enhance the emotional health and wellbeing of children and young people through the commissioning of online counselling, structured sessions in schools and interactive social media projects	31/03/2017		Contract for online counselling extended until Sept 2016 and procurement of new service from 1st October in process. Completed delivery of 22 anti-stigma sessions to 494 primary and secondary pupils (started in Q4). Social Media work: completion of anti-stigma guide for parents and animations of primary school stories.
4.3.02 Develop a web-based self-care guide for adults and older people focusing on smoking, Falls Prevention Programme, a Strength & Balance Programme and Befriending Services	31/03/2017		The action has been completed.
4.3.03 Improve health outcomes for children and young people through the commissioning of school nursing, health visiting and targeted programmes on health related behaviour	31/03/2017		The recommissioning of the health visiting service has commenced to ensure continuity of service from 1st January 2017 until 31 March 2018. This will align the health visiting contract with the school nursing contract, which will allow time for local discussions around future public health services for 0 - 19 years and opportunities for integration. Decommissioned Family Nurse Partnership (targeted) service due to lack of cost effectiveness.
<b>4.4 Personal choices available to allow people to live at home are increased</b>			
4.4.01 Review current provision and undertake tenders for the Advocacy service	31/10/2016		Interviews for the advocacy tender held, all tenders evaluated, a preferred supplier has been identified and the award of contract is going through the formal awards process.
4.4.02 Review current provision and undertake tenders for the Support with Confidence service	31/10/2016		The existing provider was awarded the contract and performance will be monitored on an ongoing basis.
4.4.03 Review current provision and undertake tenders for Intermediate Care Clinical service	31/12/2016		Strategic discussions are ongoing.
4.4.04 Review current provision and undertake tenders for the Local Healthwatch	31/04/2017		Current provision has been reviewed and a recommendation will be made to the executive member on future options.
4.4.05 Register Forestcare with the Care Quality Commission to provide emergency personal care	30/06/2016		Application has now gone off to CQC. We expect to hear back within 3 months.
4.4.06 Promote the use of mobile lifeline technology through Forestcare	31/03/2017		Forestcare have been to several shows/ talks this quarter. We have also distributed leaflets across the borough.
4.4.07 Work with partners to implement Carers Commissioning Strategy, in line with the requirements of the Care Act	31/03/2017		The Joint Commissioning Strategy for Carers has been completed and published. The Carers Issues Strategy Group will continue to work on the implementation of the action plan.

Action	Due Date	Status	Comments
4.4.08 Implement new ways of working that promote independence and wellbeing by transferring and integrating the short term and long term care teams to provide a co-ordinated response to individuals	31/03/2017		The Community Team for Older People and Long Term Conditions is now one integrated team.
4.4.12 Forestcare responder service to be extended to provide emergency personal care	30/06/2016		The service has submitted its registration paperwork to the Care Quality Commission. Once we are approved we will be in a position to extend the responder service.
<b>4.5 Preventative activities such as falls prevention are increased</b>			
4.5.01 Develop Falls Risk assessment service to be provided by Forestcare	31/07/2016		This development work is ongoing.
4.5.02 Develop a department wide approach to prevention including primary care engagement, reablement and intermediate care	30/06/2016		The Better Care Fund steering group financially supports and monitors initiatives aimed at prevention, including increased capacity within the Community intermediate Care Services which aims to promote independence and right size on-going packages of care. The group has GP and CCG engagement. Helping You Stay Independent Guide 2016/17 has been published.
<b>4.6 Integration of council and health services care pathways for long term conditions is increased</b>			
4.6.01 Review the model of providing DAAT services and implement any improvement identified	31/03/2017		Review has been completed and we will be going out to procure the new model of service delivery in August
4.6.02 Review the effectiveness of the Breaking Free online element of the DAAT service by monitoring the number of people accessing the service in this way and the outcomes achieved	31/03/2017		The number of people using Breaking Free online has increased. 17 people are currently registered on the system and 82% of them have completed extended brief intervention.
4.6.03 Deliver a self-care programme raising awareness of self-care and self-management of long-term conditions and managing the use of A&E services	31/03/2017		During the first quarter of 2016/17 the following campaigns and projects have been carried out on behalf of the Bracknell Forest Prevention and Self-Care Board: • Helping You Stay Independent Guide 2016/17 • Choose Better Campaign • Re:hydrate Campaign In May 2016, the National Self Care Forum chose Bracknell Forest as joint winners of the first National Self Care Week Award.
4.6.04 Develop and publish an Older People's Strategy	31/03/2017		The strategy is on target to be completed. The needs analysis is currently being undertaken.
4.6.05 Host a peer review of the operational effectiveness of the Health and Wellbeing Board	31/03/2019		Health and Wellbeing Peer Review Completed
4.6.06 Contribute to the development of the outcomes set by the three Urgent Care Boards and support the delivery of services which promote independence, reduce delayed transfers of care and develop	31/03/2017		Task groups have been created to deliver the priorities agreed at the three Urgent Care Boards now referred to as System Resilience Groups. BFC have representation on all groups to ensure a Bracknell focus on schemes and plans being delivered. Progress on the outcomes of each group will be reported in the next quarter.

Action	Due Date	Status	Comments
hospital avoidance schemes			
4.6.07 Work with the Acute Trust and review the out of hours intermediate care services so that delays for people in hospital awaiting social care are minimised	31/03/2017		Work is ongoing to minimise delays of people waiting in hospital who are ready to be discharged.
4.6.08 Further develop the integrated care teams with the Clinical Commissioning Group and Bracknell Healthcare Foundation Trust to support people with complex care needs	31/03/2017		The cluster groups continue to meet to promote independence and prevention for people with a long term condition.
4.6.09 Review the implemented winter pressures plans	31/03/2017		Work will commence in August 2016.
<b>4.7 Accessibility and availability of mental health services for young people and adults is improved</b>			
4.7.01 Develop a strategy for providing information and advice on how carers and people in the community who may need support, can maximise their independence	31/03/2017		Carers are being supported by Signal for Bracknell Forest who provide information advice and signposting for carers. The service launched on 1 April 2016. The intake function with the Community Team for Older People and Long Term Conditions provides entry and access for information and advice.
4.7.03 Expand and enhance the Early Intervention in Psychosis service for Mental Health, making access and assessment quicker	31/03/2017		An Early Intervention in Psychosis service has been set up that will give people access to a NICE concordant service. One of the targets for this service is that people will be assessed and commenced onto appropriate treatment within 2 weeks of referral. They will also have access to Cognitive Behavioural Therapy and Family Interventions.
4.7.04 Deliver a new service model in the Community Team for Mental Health for Older Adults to ensure a smoother journey through care, support and treatment based upon everyone having a single identified Support Co-ordinator	31/03/2017		The implementation of the new service model continues and people now have an allocated worker.
4.7.05 Undertake a review of the Mental Health Service and implement the findings	31/12/2016		The review relates to the rapid improvement event (RIE) to provide assurance that the new ways of working are safe and effective, giving opportunity to adjust as required. There is currently an ATM from Time Square seconded across to mental health services at Church Hill House to assist with this process which ensures synergy of processes across adult social care.

Ind Ref	Short Description	Previous Figure Q4 2015/16	Current figure Q1 2016/17	Current Target	Current Status
OF1c.1a	Proportion of people using social care who receive self directed support (Quarterly)	100.0%	100.0%	98.0%	
OF1c.1b	Proportion of carers who receive self directed support (Quarterly)	100.0%	100.0%	98.0%	
OF1c.2a	Proportion of people using social care who receive direct payments (Quarterly)	22.7%	21.9%	No target set	
OF1c.2b	Proportion of carers who receive direct payments (Quarterly)	100.0%	100.0%	No target set	
L030	Number of lifelines installed (Quarterly)	204	199	200	
L031	Percentage of lifeline calls handled in 60 seconds (Quarterly)	97.46%	98.46%	97.50%	
L217	Smoking quit success rate (Quarterly)	80.9%	Figures expected in Q2	60.0%	
L218	Uptake of specialist weight management treatment programme (Quarterly)	173	245	100	
L277	Number of people receiving Falls Risks Assessments (Quarterly)	67	77	40	
L278	Percentage of adult social care records in the Adult Social Care IT System that contain the person's NHS number (Quarterly)	New for 2016/17	78.0%	85.0%	
L279	Number of young people who actively engage with KOOOTH (Quarterly)	135	Figures expected in Q2	115	
L280	Percentage of young people who receive a response from KOOOTH within 24 hours (Quarterly)	100%	Figures expected in Q2	95.0%	




## A clean, green, growing and sustainable place

Action	Due Date	Status	Comments
<b>5.2 The right levels and types of housing are both approved and delivered</b>			
5.2.01 Procure 31 units of accommodation to provide homes for care leavers, homeless households and people with learning disabilities	31/03/2017		10 properties have been procured during the first quarter
5.2.04 Establish Downshire Homes as a viable company providing homes for rent for homeless families	31/03/2017		Downshire Homes Ltd has been established as a company, and 4 homeless households are living in properties purchased by Downshire Homes Ltd.











Ind Ref	Short Description	Previous Figure Q4 2015/16	Current figure Q1 2016/17	Current Target	Current Status
NI155	Number of affordable homes delivered (gross) (Quarterly)	9	8	10	
NI181	Time taken in number of days to process Housing Benefit or Council Tax Benefit new claims and change events (Quarterly)	4	9	9	
L178	Number of household nights in non self contained accommodation (Quarterly)	1,455	1,019	793	
L179	The percentage of homeless or potentially homeless customers who the council helped to keep their home or find another one (Quarterly)	71.0%	79.0%	88.0%	




## Strong, safe, supportive and self-reliant communities

Action	Due Date	Status	Comments
<b>6.4 Safeguarding structures to safeguard children and vulnerable adults are well-established</b>			
6.4.02 Lead the Bracknell Forest Safeguarding Adults Partnership Board's development plan taking into account the board's statutory footing	31/03/2017		A new safeguarding adult partnership board strategic plan (2016-2019) has been formulated and this has been approved at the June Partnership Board meeting. In addition a sub group and task and finish group structure has been approved by the board. In addition to the Board's strategic plan, partner organisation's individual development plans have been collated for inclusion in the Annual report which will be progressed during the next quarter.

## Section 3: Operational Priorities

Action	Due Date	Status	Comments
7.1.01 Embed the new structure of the Older People & Long Term Conditions service, following the Workforce Development project	31/03/2019		Action has been completed.
7.1.02 Develop the Adult Safeguarding Programme following the appointment of an independent chair and business support for the board to enhance capacity all round	01/04/2019		The Adult Safeguarding programme will include a review and update of the current safeguarding audit process to ensure Care Act compliancy; best practice and that the person remains at the centre of the safeguarding procedures.
7.1.03 Enhance the Intermediate Care at home service in order to facilitate less reliance in future on bed based services and allow more people to go directly home	02/04/2019		Future service development is in the service modelling phase with options.
7.1.04 Implement Homeless Strategy Action Plan	31/03/2017		There are a number of actions in the Homeless Strategy Action Plan to be completed during 2016/17. The actions for the first quarter have been completed.
7.1.05 Enter into new partnership agreement with Department of Work & Pensions to support households moving onto Universal Credit	30/04/2016		Partnership agreement signed for 2016/17.
7.1.06 Commission and maintain a triage of high value health improvement services	03/04/2019		Year of Self Care (YOSC) and all subsequent health improvement services are functional and delivering at or above expectations.
7.1.07 Commission a range of effective health improvement services aimed at improving outcomes such as smoking, obesity and physical activity	03/04/2019		All commissioned health improvement services are currently active and performing at or above target. This includes but is not limited to; smoking cessation (smoking), Weight Management (Obesity) & Back to Fitness (Physical activity)
7.1.08 Recover overpayment of housing benefit for those people no longer in receipt of benefit, to be achieved via attachment of earnings	31/05/2017		Policy implemented to recover overpaid housing benefit via attachment of earnings.
7.1.09 Develop the Electronic Time Monitoring System (ETMS) by introducing new modules that will allow family members to track home care visits in real time, and provide key quality information on providers' performance	31/03/2017		Testing on the family portal continues with a live date of the end of July. The Provider Quality Portal is now live as at the end of June.
7.1.10 Use monthly budget monitoring reports to identify and address any emerging overspends promptly	31/03/2019		Budget monitoring is on track



<b>Housing - Benefits - Quarterly</b>					
<b>Ind Ref</b>	<b>Short Description</b>	<b>Previous Figure Q4 2015/16</b>	<b>Current Figure Q1 2016/17</b>	<b>Current Target</b>	<b>Current Status</b>
L033	Percentage of customers receiving the correct amount of benefit (Sample basis) (Quarterly)	97.9%	96.9%	98.0%	
<b>Public Health - Quarterly</b>					
L215	Delivery of NHS Health Checks (Quarterly)	770	Awaiting data	400	



## Section 4: People

### Staffing levels

	Establishment Posts	Staffing Full Time	Staffing Part Time	Total Posts FTE	Vacant Posts	Vacancy Rate
DMT / PAs	13	11	2	12	0	0
Older People & Long Term Conditions	141	83	58	115.39	18	11.32
Adults & Joint Commissioning	103	72	31	90.86	20	16.26
Performance & Resources	27	20	7	22.55	0	0
Housing	70	47	23	58.52	2	2.78
Public Health Shared	10	7	3	8.42	1	9.09
Public Health Local	5	5	0	5	1	16.67
<b>Department Totals</b>	<b>369</b>	<b>245</b>	<b>124</b>	<b>312.74</b>	<b>42</b>	<b>10.22</b>

### Staff Turnover

For the quarter ending	30 June 2016	3.73%
For the last four quarters	1 July – 2015 – 30 June 2016	14.07%

Comparator data	
Total voluntary turnover for BFC, 2014/15:	13.4%
Average UK voluntary turnover 2014:	12.8%
Average Local Government England voluntary turnover 2014:	12.7%

Source: XPerHR Staff Turnover Rates and Cost Survey 2014 and LGA Workforce Survey 2013/14

#### Comments:

The last quarter has seen the closure of Heathlands and the Public Health Resources team, bringing about a number of redundancies.

A Council-wide vacancy management protocol is now in place to help reduce the need for redundancies. The vacancy panel reviews all vacancies on a weekly basis to determine whether they can be filled by those “at risk” of redundancy, whether the vacancy will be advertised internally or externally. All ASCHH vacancies are considered by the Panel prior to being advertised.

**Staff sickness**

Section	Total staff	Number of days sickness	Quarter 1 average per employee	2016/17 annual average per employee
DMT / PAs	13	4	0.31	1.23
Older People & Long Term Conditions	141	321	2.28	9.11
Adults & Joint Commissioning	103	314	3.05	12.19
Performance & Resources	27	15	0.56	2.22
Housing	70	145	2.07	8.29
Public Health Shared	5	5	1	4.00
Public Health Local	5	5	1	4.00
<b>Department Totals (Q1)</b>	<b>369</b>	<b>817</b>	<b>2.21</b>	
<b>Totals (16/17)</b>	<b>369</b>	<b>4087</b>		<b>17.04</b>

Comparator data	All employees, average days sickness absence per employee
Bracknell Forest Council 14/15	5.2 days
All local government employers 2014	7.9 days
All South East Employers 2014	N/A

Source: Chartered Institute of Personnel and Development Absence Management survey 2014

Comments:

Older People and Long Term Conditions

There were four cases of Long Term Sickness during Q1. Out of these cases, two cases have now returned to work. Two cases are still to return, these are being monitored by Occupational Health.

Adults & Joint Commissioning

There were three cases of Long Term Sickness during Q1. Out of these cases, two cases have now returned to work. One case is still to return, this cases is being monitored by Occupational Health.

Housing

There has been one case of Long Term Sickness during Q1, they are yet to return and currently being monitored by Occupational Health.

## Section 5: Complaints and Compliments

### Compliments Received

17 compliments were received by the Department during the quarter, which were distributed as follows:

#### *Adult Social Care Compliments*

6 compliments were received in Adult Social Care. 4 were for the Community Team for Older People and People with Long Term Conditions, 1 was for the Autism Team and 1 was for the Mental Health Team.

#### *Housing Compliments*

11 compliments were received by Housing. 6 were received by Forestcare and 5 by Housing.

### Complaints Received

There were a total of 7 complaints received in the Department during the quarter, 2 in Housing and 5 in Adult Social Care. No complaints were received by Public Health.

### Adult Social Care Statutory Complaints

5 complaints were received this quarter in Adult Social Care and all were dealt with using the statutory procedures. No complaints were dealt with using corporate procedures.

Stage	New complaints activity in Q1	Complaints activity year to date	Outcome of total complaints activity year to date
Statutory Procedure	5	5	2 complaints were partially upheld 1 complaint was not upheld 2 were ongoing within timescales.
Local Government Ombudsman	0	0	-

### Nature of complaints, actions taken and lessons learnt:

Of the 5 complaints, 2 were about learning disabilities services, 2 were about older people and long term conditions services and 1 was about mental health services. 3 complaints were about the standard of service provided (lack of appropriate or timely support and the inaccuracy of a review), 1 was about access to services (in this case transition services) and 1 was about decisions made in relation to moving an individual.

There was a learning point about the need for care managers to demonstrate appropriate sensitivity in certain situations, and also to discuss appropriate recommendations with carers. Workers will also be reminded to ensure that all previous evidence is considered prior to making recommendations.

There has been a decrease in the number of compliments due to the decommissioning of the Heathlands Residential Home which contributed significantly to previous quarters' compliments.

There are regular meetings within Adult Social Care so that learning from complaints is disseminated and acted on. The data is collated and as the year progresses and is reported annually within the Complaints Report for Adult Social Care.

### Corporate Complaints

2 complaints were received in Housing this quarter for the Welfare and Housing Service.

*The following table excludes Stage 1 complaints and those complaints which are dealt with through separate appeals processes. It should also be noted that complaints which move through the different stages are recorded separately at each stage.*

Stage	New complaints activity in Q1	Complaints activity year to date	Outcome of total complaints activity year to date
Stage 2	2	2	1 partially upheld; 1 complaint is ongoing within timescales.
Stage 3	0	0	-
Stage 4	0	0	-
Local Government Ombudsman	0	0	-

### Nature of complaints, actions taken and lessons learnt:

Of the 2 complaints, 1 concerned the nature of advice provided in relation to assessing housing benefit and one referred to the time taken to assess an application for medical priority in relation to a housing application. The first case was partially upheld although further investigation has revealed there may be evidence of fraud. The second case was not responded at time of writing but initial investigation highlighted that management of the request had fallen down and the customer was not kept informed of progress or responded to in a timely manner. The solution to this is to ensure caseworkers manage the medical priority requests rather than it being undertaken separately and thus customers not informed of progress.

## Annex A: Financial information

ADULT SOCIAL CARE HEALTH & HOUSING BUDGET MONITORING - MAY 2016							
	Original Cash Budget	Virements & Budget C/fwds	Current approved cash budget	Spend to date %age	Department's Projected Outturn	Variance Over / (Under) Spend	Movement This month
	£000	£000	£000	%	£000	£000	£000
<b>Director</b>	(338)	169	(169)	16%	(169)	0	0
	(338)	169	(169)		(169)	0	0
<b>Adult Social Care</b>							
Community Mental Health Team	1,974	3	1,977	10%	2,217	240	240
Community Mental Health Team for Older Adults	3,695	177	3,872	27%	4,772	900	900
Internal Services: Glenfield	201	1	202	15%	202	0	0
Community Team for People with Learning Disabilities	13,431	4	13,435	11%	12,648	(787)	(787)
Internal Services: Waymead	761	5	766	12%	766	0	0
Older People and Long Term Conditions	6,419	662	7,081	15%	7,556	475	475
Assistive Equipment and Technology	343	0	343	21%	343	0	0
Internal Services: Heathlands	636	(15)	621	9%	621	0	0
Community, Response & Reablement	1,778	(790)	988	30%	865	(123)	(123)
Emergency Duty Service	58	6	64	654%	64	0	0
Safeguarding	254	1	255	18%	311	56	56
	<b>29,550</b>	<b>54</b>	<b>29,604</b>		<b>30,365</b>	<b>761</b>	<b>761</b>
<b>Housing</b>							
Housing Options	170	2	172	72%	146	(26)	(26)
Housing Strategy	224	2	226	-8%	169	(57)	(57)
Housing Management Services	(40)	0	(40)	3%	(55)	(15)	(15)
Supporting People	952	32	984	7%	854	(130)	(130)
Housing Benefits Administration	612	(1)	611	-6%	611	0	0
Housing Benefits Payments	108	2	110	17%	110	0	0
Other Housing	18	0	18	4%	18	0	0
Forestcare	31	4	35	-325%	35	0	0
	<b>2,075</b>	<b>41</b>	<b>2,116</b>		<b>1,888</b>	<b>(228)</b>	<b>(228)</b>
<b>Commissioning &amp; Resources</b>							
Drug & Alcohol Action Team	3	2	5	17%	5	0	0
Joint Commissioning	562	3	565	20%	565	0	0
Information Technology Team	279	1	280	28%	280	0	0
Property	73	0	73	287%	73	0	0
Performance & Complaints	183	2	185	12%	148	(37)	(37)
Finance & Appointeeships	562	3	565	14%	531	(34)	(34)
Human Resources Team	192	1	193	15%	193	0	0
	<b>1,854</b>	<b>12</b>	<b>1,866</b>		<b>1,795</b>	<b>-71</b>	<b>(71)</b>
<b>Public Health</b>							
Bracknell Forest Local Team	(18)	2	(16)	7%	(16)	0	0
	(18)	2	(16)		(16)	0	0
<b>TOTAL ASCHH</b>	<b>33,123</b>	<b>278</b>	<b>33,401</b>		<b>33,863</b>	<b>462</b>	<b>462</b>
<b>Memorandum item:</b>							
Devolved Staffing Budget			14,037	17%	14,037	0	0
<b>Non Cash Budgets</b>							
Capital Charges	368	0	368		368	0	0
IAS19 Adjustments	1,194	0	1,194		1,194	0	0
Recharges	2,865	0	2,865		2,865	0	0
	<b>4,427</b>	<b>0</b>	<b>4,427</b>		<b>4,427</b>	<b>0</b>	<b>0</b>

## Capital Budget

Cost Centre Description	Budget £'000	Expenditure to Date £'000	Estimated Outturn £'000	Carry forward to 2016/17 £'000	(Under) / Over Spend £'000	Current Status
<b>HOUSING</b>						
Enabling more affordable housing	2,340.5	691.3	2,340.5	0.0	0.0	Purchased three properties in 16/17, two more in progress
Help to buy a home (cash incentive scheme)	240.0	2.0	240.0	0.0	0.0	Four cases to complete at £60k each
BFC My Home Buy	347.5	157.1	347.5	0.0	0.0	One property has been completed.
Waymead flats	580.0	1.1	580.0	0.0	0.0	Complete.
Downshire Homes	6,466.0	1,205.0	6,466.0	0.0	0.0	Four properties purchased to date
Tenterton Guest House	65.0	3.0	65.0	0.0	0.0	For works on roof
<b>TOTAL HOUSING</b>	<b>10,039.0</b>	<b>2,059.5</b>	<b>10,039.0</b>	<b>0.0</b>	<b>0.0</b>	
<b>Percentages</b>		<b>20.5%</b>	<b>100.0%</b>		<b>0.0%</b>	
<b>ADULT SOCIAL CARE</b>						
Care housing grant	15.4	0.0	15.4	0.0	0.0	
Community capacity grant	506.9	0.0	506.9	0.0	0.0	Monies to be spent on Bridgewell / Santa Catalina
Older person accommodation strategy	400.0	0.0	0.0	0.0	400.0	Budget to be returned to Corporate
Improving information for social care	39.2	0.0	39.2	0.0	0.0	Integrating health and social care IT
IT systems replacement	208.4	0.0	208.4	0.0	0.0	Plans for budget need to be determined
<b>TOTAL ADULT SOCIAL CARE</b>	<b>1,169.9</b>	<b>0.0</b>	<b>769.9</b>	<b>0.0</b>	<b>400.0</b>	
<b>Percentages</b>		<b>0.0%</b>	<b>65.8%</b>		<b>34.2%</b>	
<b>TOTAL CAPITAL PROGRAMME</b>	<b>11,208.9</b>	<b>2,059.5</b>	<b>10,808.9</b>	<b>0.0</b>	<b>400.0</b>	
<b>Percentages</b>		<b>18.4%</b>	<b>96.4%</b>		<b>3.6%</b>	

## Annex B: Annual indicators not reported this quarter

### Council Plan indicators

Ind. Ref.	Short Description	Quarter due
<b>4. People live active and healthy lifestyles</b>		
OF1e	The number of adults with learning disabilities in paid employment as a % of adults with learning disabilities who receive a long-term service	Q2
OF1f	The number of adults with a mental health problem in paid employment a % of adults in contact with secondary mental health services	Q2

**TO: HEALTH OVERVIEW AND SCRUTINY PANEL  
29 SEPTEMBER 2016**

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**EXECUTIVE KEY AND NON-KEY DECISIONS RELATING TO  
HEALTH ISSUES  
Assistant Chief Executive**

**1 PURPOSE OF REPORT**

- 1.1 This report presents scheduled Executive Key and Non-Key Decisions relating to health issues for the Health Overview and Scrutiny (O&S) Panel's consideration.

**2 RECOMMENDATION**

- 2.1 **That the Health Overview and Scrutiny Panel considers the scheduled Executive Key and Non-Key Decisions relating to health issues appended to this report.**

**3 REASONS FOR RECOMMENDATION**

- 3.1 To invite the Panel to consider scheduled Executive Key and Non-Key Decisions.

**4 ALTERNATIVE OPTIONS CONSIDERED**

- 4.1 None.

**5 SUPPORTING INFORMATION**

- 5.1 Consideration of Executive Key and Non-Key Decisions alerts the Panel to forthcoming Executive decisions and facilitates pre-decision scrutiny.
- 5.2 To achieve accountability and transparency of the decision making process, effective O&S is essential. O&S bodies are a key element of Executive arrangements and their roles include both developing and reviewing policy; and holding the Executive to account.
- 5.3 The power to hold the Executive to account is granted under Section 21 of the Local Government Act 2000 which states that Executive arrangements of a local authority must ensure that its Overview and Scrutiny bodies have power to review or scrutinise decisions made, or other action taken, in connection with the discharge of any functions which are the responsibility of the Executive. This includes the 'call in' power to review or scrutinise a decision made but not implemented and to recommend that the decision be reconsidered by the body / person that made it. This power does not relate solely to scrutiny of decisions and should therefore also be utilised to undertake pre-decision scrutiny.



**6      ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS**

No advice was sought from the Borough Solicitor, the Borough Treasurer or Other Officers or sought in terms of Equalities Impact Assessment or Strategic Risk Management Issues. Such advice will be sought in respect of each Executive Forward Plan item prior to its consideration by the Executive.

**7      CONSULTATION**

None.

Background Papers

Local Government Act 2000

Contact for further information

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**HEALTH OVERVIEW & SCRUTINY PANEL****EXECUTIVE WORK PROGRAMME**

<b>REFERENCE:</b>	I062200
<b>TITLE:</b>	Drug & Alcohol Recovery Services
<b>PURPOSE OF REPORT:</b>	Following a formal tender exercise to agree to the awarding of a contract to a Prime Provider for drug and alcohol recovery services.
<b>DECISION MAKER:</b>	Executive
<b>DECISION DATE:</b>	15 Nov 2016
<b>FINANCIAL IMPACT:</b>	Revenue savings anticipated. Details to be incorporated into the report.
<b>CONSULTEES:</b>	None
<b>CONSULTATION METHOD:</b>	None

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