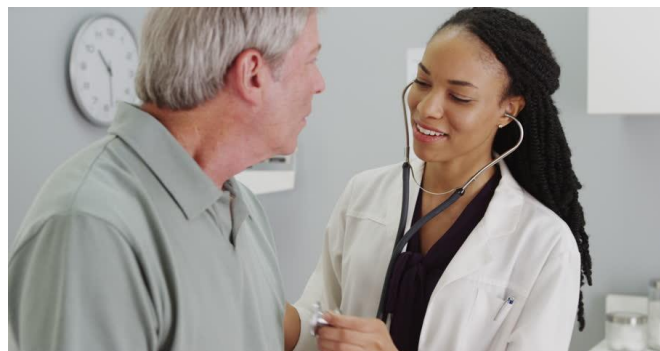


DRAFT 1.9.2016

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

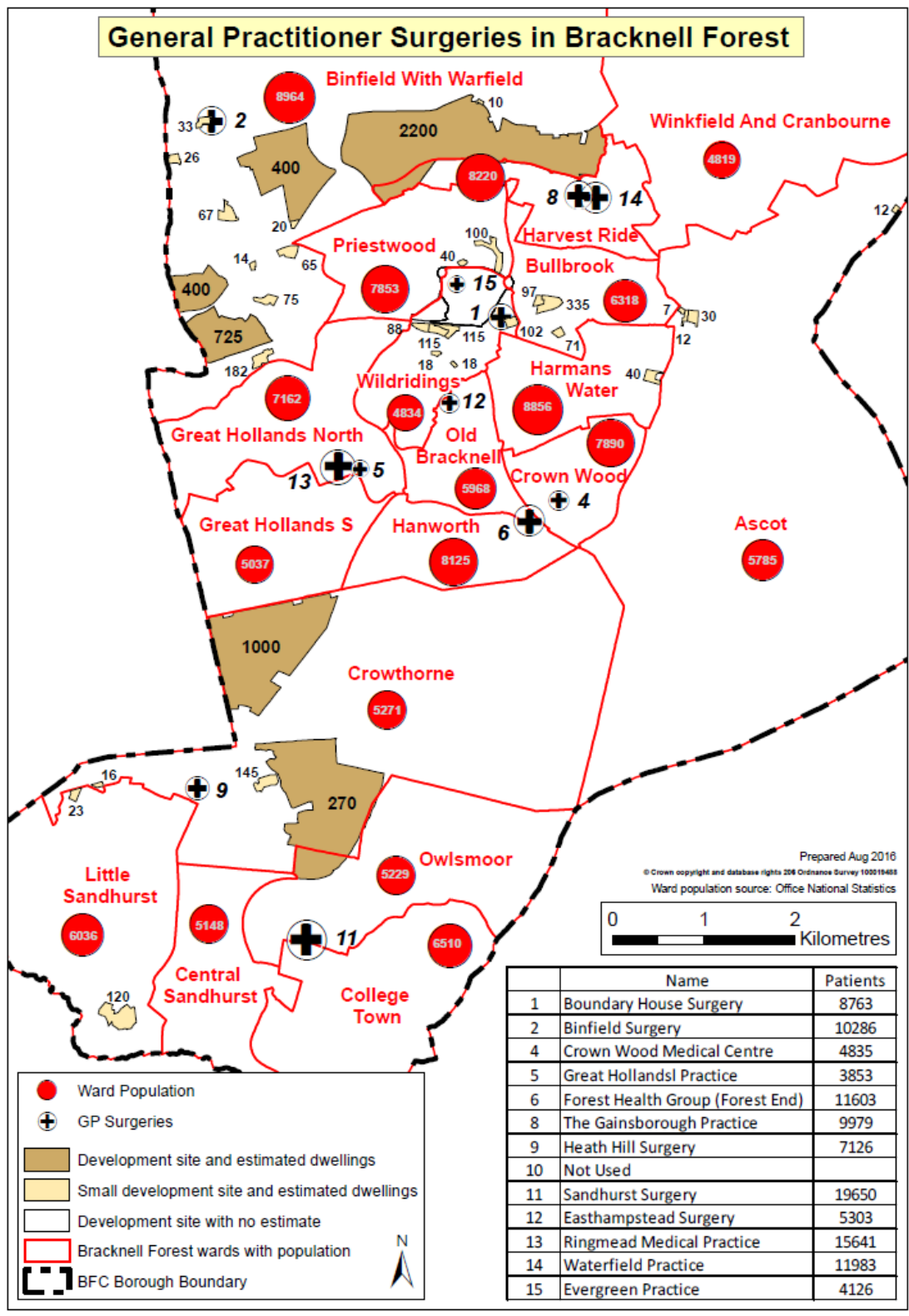
We set out in Appendix 2 of this report summaries of the meetings we held with a number of organisations whose role affects the sufficiency of GP resources. Appendix 3 summarises the information gathered from our visits to, and data collection from, 14 GP Practices serving most Bracknell Forest residents. 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 agreements¹ 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

¹ 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.

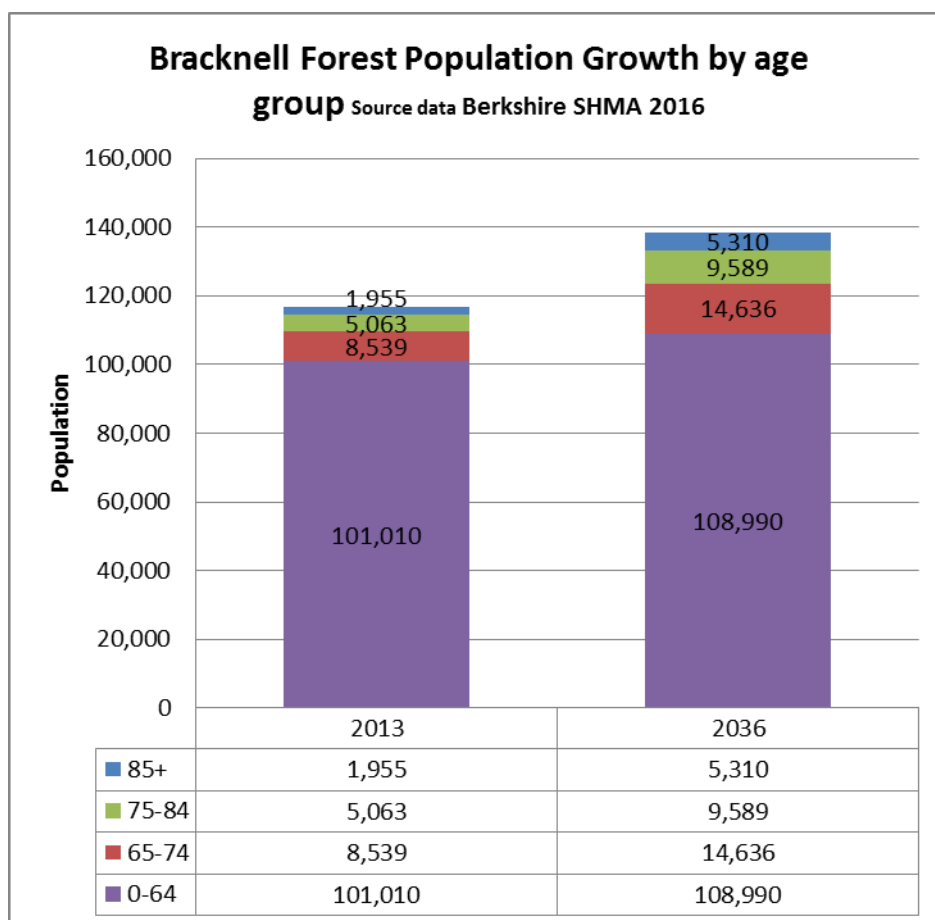
Is there a sufficient supply of new GPs to replace those who are leaving GP Practices?

- 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*⁷. 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"> 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 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. 3. To review whether Bracknell Forest Council is making a constructive and proper input towards addressing GP capacity needs. 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. |
|--|

Key Objectives:

- | |
|---|
| <ol style="list-style-type: none"> 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. 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. 3. Through research and meetings, to reach conclusions on organisational collaboration, effectiveness and future prospects for the provision of adequate GP capacity 4. To make recommendations as appropriate to the various organisations with a role in providing or influencing GP capacity. |
|---|

Scope of the work:

Everything with a direct bearing on the provision of adequate GP capacity to the residents of Bracknell Forest.

Not included in the scope:

Anything outside the remit of the National Health Service or Bracknell Forest Council.
--

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 Model¹ 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

¹ 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 surgery¹.

- 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.

¹ 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 surgery¹, 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.

¹ 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 plan¹. RM summarised this as:

Recruit

1. Promoting general practice

¹ 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 Framework¹) -, 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.

¹ 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 M²?

Responses The areas ranged from 180 M² to 900 M².

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:

Overview and Scrutiny, Chief Executive's Office, Bracknell Forest Council, Easthampstead House, Town Square, Bracknell, Berkshire, RG12 1AQ, or email us at overview.scrutiny@bracknell-forest.gov.uk or telephone the O&S Officer team on 01344 352283