London Borough of Barking and Dagenham

Notice of Meeting

THE EXECUTIVE

Tuesday, 3 August 2004 - Civic Centre, Dagenham, 7:00 pm

Members: Councillor C J Fairbrass (Chair); Councillor C Geddes (Deputy Chair); Councillor J L Alexander, Councillor G J Bramley, Councillor H J Collins, Councillor S Kallar, Councillor M A McCarthy, Councillor M E McKenzie, Councillor L A Smith and Councillor T G W Wade

Also Invited: Councillor Mrs V M Rush for Item 7

Declaration of Members Interest: In accordance with Article 1, Paragraph 12 of the Constitution, Members are asked to declare any direct/indirect financial or other interest they may have in any matter which is to be considered at this meeting

23.7.04

Graham Farrant
Chief Executive

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AGENDA

1. Apologies for Absence

2. Minutes - To confirm as correct the minutes of the meeting held on 20 July 2004 (circulated separately)

Business Items

Public Items 3 to 6 and Private Items 14 to 18 are business items. The Chair will move that these be agreed without discussion, unless any Member asks to raise a specific point.

Any discussion of a Private Business Item will take place after the exclusion of the public and press.

3. Urgent Action Provision (Pages 1 - 3)

4. Age Concern - Future of the Active Age Service (Pages 5 - 7)

5. **People Matter - Annual Statistics for 2003 - 2004 (Pages 9 - 11)**

6. **Fees and Charges: Planning Post Search and Other Enquiry Fees & Charges 2004 / 2005 (Pages 13 - 14)**

Discussion Items

7. **Draft Final Report of the Access to Primary Care Review (Pages 15 - 91)**

8. **Regeneration Best Value Review Improvement Plan - Quarterly Progress Report (Pages 93 - 105)**

9. **Bevan Avenue Building - Building Name (Pages 107 - 108)**

10. **Review of Void Performance 2004-2005 and Plans for 2005 - 2006 Onwards (Pages 109 - 125)**

11. **East London Transit (to follow)**

12. **Any other public items which the Chair decides are urgent**

13. **To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.**

Private Business

The public and press have a legal right to attend Council meetings such as the Executive, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972).

Discussion Items

None.

Business Items

14. **St Marys, Lexham House and Sebastian Court Security Works - Tender Acceptance and Budget Approval (Pages 127 - 130)**

Concerns a Contractual Matter (paragraphs 7 and 9)

15. **Term Contract for Electrical Repairs and Minor Works in Public Buildings and Schools (Pages 131 - 134)**

Concerns a Contractual Matter (paragraphs 7, 8 and 9)

16. Land Disposal Sites: Land Valuation for Site at Digby Gardens (to follow)

Concerns a Contractual Matter (paragraph 7)

17. Head of Procurement - Additional LSMR Post (restricted circulation, circulated separately)

Concerns a Staffing Matter (paragraph 1)

18. Staffing Matter (restricted circulation, to follow)

Concerns a Staffing Matter (paragraph 1)

19. Any other confidential or exempt items which the Chair decides are urgent

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THE EXECUTIVE

3 AUGUST 2004

REPORT OF THE DIRECTOR OF CORPORATE STRATEGY

URGENT ACTION PROVISIONS	FOR DECISION

This report is submitted in accordance with the Council's Constitution, specifically Article 1 (Member Meetings General), Paragraph 17.

Summary

To consider amending the Constitution by changing the Urgent Action Provisions to more accurately reflect the roles of Members in the decision making process.

The Council's procedures for dealing with urgent actions are laid down in the Constitution and require Chief Officers to formally consult with the Leader of the Council, and the Chairs of the Assembly and Scrutiny Management Board (SMB). The involvement of the Leader and Chair of the Assembly relates to the strategic and policy functions of the Executive and Assembly, whilst the involvement of the Chair of the SMB is to ensure any urgent actions taken remain the subject of scrutiny and to confirm the need for urgency.

Recommendation

Mindful of the Member's concerns, but in recognising the importance of involving Scrutiny in the process of approving urgent matters, it is proposed to clarify the roles of nominated Members in the Urgency Provisions. On that basis the Executive is being recommended to ask the Assembly to amend paragraph 17.1 of Article 1 (Member Meetings General), so that when urgent actions are taken by the Chief Executive or the relevant or Lead Chief Officer (under delegated power) it is made clear that consultation with the Leader of the Council and Chair of the Assembly is about the basis for taking the decision, whilst consultation with the Chair of the SMB is about recognising the need for urgency to take the decision.

For any urgent action the procedure will require that clearance be sought from the Chief Executive, Director of Finance, and the Monitoring Officer, or in their absence, their nominated deputies, prior to any consultation with Members. (see Appendix A for the revised wording of the paragraph that will appear in the Constitution)

The decisions taken under the urgent actions procedure will then be reported to the next Executive meeting, rather than the next appropriate meeting as currently worded. This will allow the opportunity through the Call In procedure for non-Executive Members to challenge the principles around why a particular decision was taken, albeit the actual decision could not be overturned.

The Call-in procedure as laid out in Article 5C of the Constitution will be amended accordingly.

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CONSTITUTION ARTICLE 1

MEMBER MEETINGS GENERAL

REVISED PARAGRAPH 17 – URGENT ACTION

17.1 In exceptional circumstances and where delay will be prejudicial to the interests of the Council, the Chief Executive or the relevant or lead Chief Officer, as appropriate, is authorised to take urgent action which is not otherwise delegated to them subject to:-

(i) ensuring the actions are cleared firstly with the Chief Executive (in the case of other Chief Officers), the Director of Finance and the Monitoring Officer, or in their absence their nominated deputies,

(ii) consultation with the Leader of the Council and the Chair of the Assembly on the specific reasons for taking the action, together with the Chair of the Scrutiny Management Board as to why the decision cannot wait until the next meeting of the Executive. Where, for any reason, it is not possible to consult with the said Members, then the Deputy Leader, the Deputy Chair of the Assembly and the Deputy Chair of the Scrutiny Management Board will deputise respectively. In the event that the necessary decision cannot be obtained through this procedure within 24-48 hours, then the matter may be dealt with, provided that at least 2 of the 6 Members are consulted, one of whom should be the Chair/Deputy Chair of the Scrutiny Management Board.

(iii) compliance with the Constitution and, in particular, relevant rules where appropriate, and

(iv) the decisions taken under the urgent actions procedure being reported to the next available meeting of the Executive.

17.2 Urgent actions taken under these provisions will be subject to call-in, allowing only the principles for making the decision to be challenged. In such instances the actual decision can not be overturned.

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THE EXECUTIVE

3 AUGUST 2004

REPORT OF THE DIRECTOR OF CORPORATE STRATEGY

AGE CONCERN - FUTURE OF THE ACTIVE AGE SERVICE	**FOR DECISION**

This report is submitted to the Executive further to previous discussions about the active age service..

Summary

This report outlines the results of a meeting between Age Concern Trustees and interested Members and asks the Executive to endorse the further work proposed at that meeting

Recommendation

The Executive is asked to endorse the way forward set out at in paragraph 2.2 of this report.

Reason

To clarify the further work required to explore the options for securing the active age service.

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1. History

1.1 The Director of Social Services submitted a report to The Executive on 26 November 2002 on the reshaping of elders day services. As a result a contract was agreed with Age Concern for a frail elders service and alternative funding would need to be found for the remaining active age service. In order to assist Age Concern in moving to a self funding active age service, on 22 July 2003, the Executive agreed to fund:

- the rents for the premises used by Age Concern to provide the Active Age Centres, for two years only (total £166,120); and
- a fundraiser for Age Concern (£24,000)

This funding would cease in March 2005.

1.2 The Executive on 18 May 2004 agreed to support the Daisy Chain Appeal in principle but without any financial commitment.

2. Meeting between the Council and Age Concern

2.1 A meeting between the Council and Age Concern took place on 13 July 2004. Councillors McCarthy (Chair), H Collins and Mrs Bruce were present. Officers attending were: John Tatam, Naomi Goldberg, Mick Beackon , Jim WIilson, Rob Tomlinson and Teresa Parish. Age Concern were represented by Doug Waters, Brian Devlin, Keith Chapman, Sam Mauger and Claire Ramm.

At the meeting, Officers gave a presentation which outlined:

- the implications for the Active Age Centres when funding for the rent ceases at the end of March
- the difficulties that Age Concern face because of uncertainties around the future of premises that they use for the Active Age Centres
- possible options available if the Active Age Centres are to continue

Members present questioned Age Concern about:

- their fundraising activities and problems they encountered with funding applications
- numbers using the centres
- Age Concern's ideas around developing Centres of Excellence and the use of Community Halls

Members and Age Concern both stated their ambition was to bring the Centres back to a five day a week service if possible.

2.2 It was proposed that:

1. Officers should work with Age Concern to identify premises including community halls where Active Age Centres can continue to be provided in the long term;
2. Where Community Associations have indicated that they may not have the capacity to take out leases themselves Officers would work with Age Concern to agree leases on Community Halls in partnership with the relevant Community Associations and Ward Councillors with the aim of avoiding closure of the centres and ensuring that community association activities could still take place;
3. A report should be submitted to the Executive in September setting out options for the future of the Active Age Service along with costings; and
4. Officers will clarify for Age Concern the likely future position for each of the premises they currently use in the light of the community halls' review.

3. Financial Implications

3.1 The Executive has previously agreed to cease financial support for the active age service from March 2005. Any financial implications of maintaining a full active age service will be included in the report proposed for submission to the Executive in September. If that report details any additional financial costs, these will have to be considered within the overall Budget Strategy and Budget Process for 2005/06.

Background Papers:

- Presentation made to Meeting with Age Concern – 13th July 2004
- Executive Minute 227 (26 November 2002) – Frail Elders Day Services
- Executive Minute 58(22 July 2003) – Age Concern Active Elderly Centre
- Executive Minute 401 (18 May 2004) Age Concern Barking and Dagenham

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THE EXECUTIVE

3 AUGUST 2004

REPORT OF THE DIRECTOR OF CORPORATE STRATEGY

PEOPLE MATTER: ANNUAL STATISTICS FOR 2003-2004 [BSC: 20 and 21]	**FOR INFORMATION**

Summary

This report gives statistics for training in the Staff Development Programme 2003-2004. It will be followed by a further report summarizing this year's analysis of learning and development needs, and plans for 2005-2006

Recommendations

Members are asked to note the statistics

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1. Introduction

It is good practice to ensure that Members are kept informed of the monitoring statistics for training. This report shows two years of figures, and notes trends.

2. The Statistics

TOTAL NUMBER OF ATTENDEES	
2002-03	2003-04
1,829	1,866

The total number of attendees who are registered disabled.

REGISTERED DISABLED	
2002-03	2003-04
23	41

The total number of attendees from Black, Asian, and Minority Ethnic Groups

Black, Asian & Minority Ethnic Groups		Unknown	
2002-03	2003-04	2002-03	2003-04
331	434	137	114

The total number of attendees who are resident in the Borough

RESIDENT IN BOROUGH	
2002-03	2003-04
534	519

The total number of attendees who are male/female

GENDER TOTALS			
2002-03		2003-04	
M	F	M	F
723	1106	633	1233

The Departments' total number of attendees

DEPARTMENT TOTALS												
2002-03						2003-04						
CECS?	HH	EAL	LES	SS	OTH	CS	FD	HH	EAL	LES	SS	OTH
466	546	289	264	233	31	178	209	422	463	217	339	38

The attendees' scale totals.

SALARY SCALE TOTALS															
2002-03								2003-04							
Sc1	Sc2	Sc3	Sc4	Sc5	Sc6	SO1	SO2	Sc1	Sc2	Sc3	Sc4	Sc5	Sc6	SO1	SO2
34	27	134	197	164	130	123	134	46	52	129	123	102	110	135	62
PO1	PO2	PO3	PO4	PO5	PO6	LPO R	OTH	PO1	PO2	PO3	PO4	PO5	PO6	LPO R	OTH
100	126	115	76	46	47	19	357	114	109	166	93	75	57	38	349
								LS MR	CO						
								80	26						

- The number of attendees continues to rise.
- There continue to be big increases in attendance by black and minority ethnic groups, and women.
- Attendance by people who are registered disabled has doubled.
- Attendance by some departments has risen, while others have decreased.
- There is an increase in attendance by staff on management grades. This is appropriate for a corporate programme which focuses on management development. Nevertheless, attendances by staff in lower grades remains high.

24. Conclusions

The statistics demonstrate that the Council's corporate staff development programme continues to show a positive trend in terms of equalities data, and in terms of coverage of all staff.

Background papers used in the preparation of this report:
None

People consulted in writing the report
The Leader
The Chief Executive
The Director of Corporate Strategy
Corporate Equalities and Diversity Adviser
The Head of Organisational Development and Employee Relations
Heads of Human Resources, Training Managers

Ref: 03-04 stats report

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THE EXECUTIVE

3 AUGUST 2004

REPORT FROM THE DIRECTOR OF REGENERATION AND ENVIRONMENT

PLANNING POST SEARCH AND OTHER ENQUIRY FEES AND CHARGES 2004/05	**FOR DECISION**

To this report concerns the setting of Charges, which is the responsibility of the Executive.

Summary
In accordance with the guidelines laid down by the Charging Policy Commission, this report proposes the Planning enquiry charges to be adopted for 2004/2005.

Recommendation
The Executive is recommended to approve the increased charges for Planning Post Search enquiries and Consultancy Fees for 2004/5 as detailed in this report.

Reason
To set the Planning Post Search and Other Fees and Charges for the forthcoming year in accordance with the principles of the Charging Policy Commission and to assist with the Council's Community Priority of *"Regenerating the Local Economy"*.

Wards Affected
This will apply to all Wards in the Borough.

Contact		
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1. Post Search Enquiries

1.1 Charges are made to solicitors or members of the public following a request for additional information resulting from Land Charges searches. Under the Local Authorities (Charges for Land Searches) Regulations 1994, as well as a charge for the initial search, Local Authorities are empowered to charge for any information requested as a result of the proposed sale of a property. This service was previously provided free of charge. However, as searches do not now include copies of decision notices, these inquiries have increased dramatically since that time. A charge was introduced in April 2001 and last revised to its current level in March 2003 to what was considered a reasonable charge for the service provided. The charge currently levied for this service is £33.00 (inclusive of VAT) where no site visit is required and £49.50 where it is required.

1.2 The projected cost of providing this service in 2004/5 is £35.00 for a non site visit and £55.00 if a site visit is required. This is a flat rate fee and not an hourly rate.

2. Consultancy Enquiries

2.1 This service is very similar to the post search enquiry procedure detailed above. This charge occurs when a consultant in preparing a report for private clients will request planning information from the Local Planning Authority. The Council currently charges for this work on an hourly basis at £60.00 per hour based on market rates. This rate has not changed since 2002.

2.2 It is intended to raise this rate to £70.00 per hour to reflect increased officer costs since this time.

3 Proposed Charges

3. Below are the current and proposed charges for Planning Post Search enquiries and Consultancy Charges for 2004/5. By implementing these changes the service will be recovering its full costs.

	Current Charge 2003/04	**Proposed Charge 2004/05**
Planning Post Search enquiries		
without site visit	£33.00 (inc. VAT)	£35.00 (inc VAT)
with site visit	£49.50 (inc VAT)	£55.00 (inc VAT)
Charges to Consultants	£60.00 per hour	£70.00 per hour

4. Consultation

The following has seen this report and are happy with the report as it stands.

Councillor H Collins, Lead Member for Developing Rights and Responsibilities with the Local Community and Providing Equal Opportunities and Celebrating Diversity (Income and Charging).
Bob Cooper, Interim Head of Finance, RED

Background Papers
Local Authorities (Charges for Land Searches) Regulations 1994.

- Executive Report and Minute 330 11 March 2003.
  Re: Planning Post Search and other Enquiry Charges.
- Assembly 4 July 2001
  Report of the Charging Policy Commission

End

Barking and Dagenham Health Scrutiny Panel (17 June 2004)

Scrutiny Management Board (30 June 2004)

Executive (20 July 2004)

Assembly (25 August 2004)

Draft final report of the Access to Primary Care Review: Summary	**For decision**

This report provides a summary of the Health Scrutiny Panel's review of access to local primary care services, the Council's first scrutiny of an externally provided service. The full review report is attached.

Final reports of scrutiny panels are presented to the Scrutiny Management Board (SMB), the Executive and the Assembly, as required by Paragraph 11 of Article 5b of the Council's Constitution. The SMB may ask questions, give advice and/or make suggestions but it has no power to alter the report. If it feels strongly about any issue not supported by the panel, it may refer this to the Assembly in a separate report. The Executive may ask questions and respond in a separate report to the Assembly, but may not influence or seek any amendment to the report. The Assembly, together with any members of the public, may ask questions. It will be asked to formally adopt the report and its recommendations. It may move changes to the recommendations in which case the Lead Member (or representative) will be given the opportunity to respond before a vote is taken.

Summary

1. Health Scrutiny

Since January 2003, councils have had the power to look into local health services on residents' behalf and recommend improvements - this is called 'health scrutiny.' The Council set up a special members' panel to carry out this work locally. The panel is led by Councillor Val Rush and meets in public session.

A key aspect of health scrutiny is in-depth reviews on issues of local concern. These involve seeking stakeholders' views, looking at relevant documents, visiting services and, at the end of the process, producing a report including recommendations for improvement. The National Health Service (NHS) bodies responsible for the area being reviewed then have to say, within a set period, what action they will take in response.

2. The Review

In spring 2003, the panel asked the community to suggest possible topics for the first in-depth reviews. The community identified access to primary care services, particularly those provided at their local doctors' surgeries, as one of the most important local health issues and so the panel chose this as its first topic.

Responsibility for these services is shared between Barking & Dagenham Primary Care Trust (PCT) and General Practitioner (GP) practices.

The panel wanted to gain an understanding of the key issues relating to access to primary care from the point of view of the community, front-line primary care professionals and the PCT. In addition to its discussions with the PCT, it therefore carried out the following consultation during the review:

- Consultation with the community

  The panel asked the public two main questions:

  (i) What is your experience of accessing primary care, especially general practice?
  (ii) What improvements would you suggest?

  The panel asked these questions through workshops at the Community Forums, the Forum for the Elderly and the Access Group. Over 250 residents took part. An article seeking residents' views also appeared in The Citizen.

  The panel also had access to a national patients' survey allowing it to compare the experience of Barking & Dagenham residents with those in the rest of the country.

- Consultation with front-line primary care professionals (PCPs)

  The panel asked three main questions:

  (i) What do you see as the key issues affecting access to primary care?
  (ii) What are the challenges you face?
  (iii) What do you feel would help improve services in the future?

  The panel asked these questions through meetings with GPs and practice nurses; approximately 40 PCPs took part. A letter seeking PCPs' views was also sent to all local practices.

3. The Report

Part 1 of the report provides information on the background to the review and the way it was carried out.

Part 2 looks in detail at the main areas covered by the review, namely resources for primary care (funding, primary care professionals, premises, primary care/secondary care, and the Primary Care Trust), opening times, appointments and waiting times, quality of services and receptionists. It also looks briefly at a number of the other issues touched on during the review.

The panel's recommendations are set out below, together with a summary of its key messages.

The panel's key messages and recommendations

[The timescale for each recommendation is shown in square brackets]

A. General recommendations:

1. That the report be sent to Barking & Dagenham Primary Care Trust (PCT) and the North East London Strategic Health Authority (SHA) for their formal response by 30 September 2004 [August 2004]

2. That the report be widely circulated and publicised as detailed in paragraph 8 of part 1 of the report [August/September 2004]

3. (i) That the panel meets in October 2004 to look back at the review and consider any lessons learned for future reviews, having asked those involved for their comments

(ii) That the panel considers a full progress report by the PCT on the implementation of the recommendations in March 2005 (six months after the deadline set for the receipt of responses from the PCT and the SHA).

4. That the PCT and local practices carefully consider the comments/suggestions put forward by the public/PCPs during the review and make any necessary improvements [September 2004 and ongoing]

B: Funding and need (Section 2.1 of the main report)

There are two critical health funding issues for Barking & Dagenham, both of which must be urgently resolved if the major health inequalities facing local people are to be tackled and a healthy future for the borough secured:

1. The under-funding of the Primary Care Trust

The PCT is under-funded by 10.7% (or £24.4m). The impact of this is particularly acute here due to the major health inequalities faced by local people who, on average experience 20% poorer health than the national average.

If the PCT was funded to the proper level, it would make a real difference to local people's lives. The long list of areas where investment has had to be held back include children's cancer and diabetes services, health-checks for the over 75s and Macmillan nursing support. If the shortfall is not closed, it will continue to be a significant barrier to service delivery and to improving the health of local people.

The Government has stated that the position will be addressed in the coming years; a more concrete assurance is required.

2. The impact of future population growth.

With the regeneration of the Thames Gateway, the borough's population is expected to grow by 40-60,000 in the next 10-15 years. The Government must therefore not only close the existing shortfall but also ensure resources keep pace with this growth.

Recommendations:

1. That the Council, SHA and PCT continue to lobby the Government to address the current funding shortfall without delay and ensure that future health funding keeps pace with population growth. We would expect the PCT to lead this process. [Ongoing]

2. That the PCT submits a report to each meeting of the Joint Health & Social Care Board setting out the progress being made on these issues and any proposals for further action [Ongoing, with first report in 3rd quarter of 2004/05]

3. That this report be sent to the Minister of Health to support this process [August 2004]

4. That the Council works with the SHA, the PCT and other partners to agree a set of projected population figures to 2020 [October 2004]

C: Primary care professionals (Section 2.2)

1. Shortage of Primary Care Professionals (PCPs).

- For many years, there has been a shortage of PCPs in Barking & Dagenham. To meet the national average staff/patient ratio, the borough would need around 20 additional GPs and 5 additional practice nurses (figures are whole time equivalent (wte)).

- The PCT has been working very hard to address this problem through a wide range of recruitment initiatives. Last year, it made a net gain of nearly 8 wte GPs. This work is, however, hampered by turnover, a problem which is likely to continue: although there is now no mandatory retirement age for GPs, many doctors are currently over or approaching 65.

- We acknowledge the PCT's efforts, along with the difficulties involved, and congratulate it on the significant inroads it has made so far. However, as the PCT itself makes clear, the pressure and drive must be maintained.

2. The work of PCPs.

- PCPs not only have a high workload but also have to cope with 'human pressures' like dealing with rude and aggressive customers. Locally, the challenges are heightened by the difficulties facing primary care services. The community owes these professionals a debt of gratitude for the efforts they are making on our behalf.
- We also looked at the steps being taken to reduce the pressures: for example, developing the role of other PCPs so they can take on some of the tasks traditionally carried out by GPs or practice nurses and addressing "work/life balance" issues.

Recommendations:

1. That the PCT implements robust arrangements to monitor the set outcomes expected of GP practices under the new General Medical Services (nGMS) contract (the new contract for primary care medical services which came into effect on 1 April 2004) and to take corrective action where practices are not meeting these outcomes [October 2004 and ongoing]

2. That all PCPs, including support staff, receive an appraisal during 2004/05 [March 2005]

3. That the PCT gains benefit from the vast knowledge of the primary care workforce by conducting a PCP suggestion survey and/or implementing a PCP suggestion scheme [December 2004]

4. That the PCT establishes an awards scheme for recognising outstanding service by GPs, other PCPs and indeed practices (we suggest that nominations could come from three directions: the public, the PCT and from PCPs putting forward their own staff) and that these awards be presented at the Ceremonial Council [December 2004]

D: Premises (Section 2.3)

Key messages:

- A large number of local practices are in old, unsuitable premises: 76% are currently below the required standards, impacting adversely on the environment for patients and staff and causing access problems.

- This is being addressed through two main routes:

  - the Local Improvement Finance Trust (LIFT) programme, a capital investment programme run by a public/private sector partnership. The first 7 LIFT schemes, involving new buildings and enhanced services, will all be underway this year and further schemes are in the pipeline.
  - Improvement schemes put in place by the PCT and individual practices. Despite limited funding and other barriers, 4 premises have been replaced and 7 refurbished in the last few years.

- We congratulate the PCT, the Barking & Havering LIFT Company (LIFTCo) and the practices involved for the strides they have made in improving primary care premises but, as all parties acknowledge, there is still a considerable way to go: even when the currently programmed schemes are complete, 25% of premises will still need refurbishment or replacement to bring them up to standard.

Recommendations:

1. We strongly encourage those practices who require improvements to (a) work with the PCT to secure capital funding and (b) make the investment required to fund any shortfall (although we do recognise the difficulties practices face in this respect - see paragraph 2.3.10) [Ongoing]

2. (i) That the PCT and LIFTCo consult the Barking & Dagenham Access Group on all developments to primary care premises. This consultation must take place at all stages of any such development: the Group should be involved in formulating the initial proposals and their advice should continue to be sought right through until the work is completed and signed off. Although their services are outside the scope of this review, we suggest that the other local NHS (National Health Service) bodies - Barking, Havering & Redbridge Hospitals NHS Trust (BHRT) and the North East London Mental Health Trust (NELMHT) - also consult the Access Group in this way. [Ongoing]

(ii) That practices take up the Access Group's offer to visit surgeries and offer advice on

access issues [Ongoing]

3. That LIFT Co, the PCT and practices take special heed when planning/implementing improvements of the feedback from the public and PCPs on this issue, particularly on access, waiting rooms, facilities for children and space for consultation [Ongoing]

E: Primary and secondary care (Section 2.4)

Key messages:

One of the ways in which the Government is trying to reduce the pressure on secondary (hospital) care is by looking to primary care to share more of the load. We support this approach in principle, but have the following concerns:

- The first part of the approach is reducing inappropriate use of secondary care services. Where this results from a lack of responsibility on the part of the patient, this must be stopped. However, as the report shows, it sometimes results from patients being unable to gain timely access to a PCP.

- The second part is getting more work done, where appropriate, in a primary care setting. However, faced with problems including shortages of funding and staff, local primary care services are finding it difficult enough to deliver their core service without having to take on additional responsibility.

- Our main concern is the SHA's proposals for meeting the current and future needs of North East London. They plan to use existing hospitals to focus on complex care, develop further 'Treatment Centres' to support diagnostic and planned treatment, and to significantly expand and remodel primary and community facilities. However, despite the projected population growth they do not intend to build a new hospital. Although we have listened to the SHA's arguments, we have grave doubts as to whether the region can support this population growth without such a hospital. As it is, the local hospital trust will, by 2005/06, be 300 beds short, even with the new Oldchurch Park hospital.

- The PCT has recently secured capital funding for a new Walk-In Centre at Barking Hospital (integrated with the current Minor Injuries Unit) which will provide enhanced primary care services. We support this proposal, but feel it needs to be more imaginative in scope if it is to meet the needs of local people and compensate for the lack of Accident & Emergency (A&E) provision in the Borough, especially given the projected population growth.

Recommendations:

1. That the SHA reviews its proposal not to build a new hospital in the Thames Gateway region [October 2004]

2. That the PCT reviews the scope of the proposed Walk-In Centre at Barking Hospital [October 2004]

F: The Primary Care Trust (Section 2.5)

Key messages:
We received complaints from GPs that the PCT didn't keep them informed, didn't return calls, were always in meetings and didn't provide feedback. The PCT, while acknowledging there is always room for improvement, felt that GPs did not appreciate that officers' jobs took them away from their desks.

Recommendation:
That the PCT discusses with GPs the issue of communications and puts any necessary improvements in place [November 2004]

G: Opening times (Section 3)

Key messages:

- Under the nGMS contract, which came in on 1 April 2004, practices have to make services available between 8.00am and 6.30pm from Monday to Friday. Before, a typical practice might have opened until 8.30 pm on a weekday, with a half day on Thursday and emergency surgery on Saturday morning.

- One of the aims of the change is to address the work-life balance of PCPs. We are sympathetic with this aim. However, local people are calling for flexible opening times that meet their needs, including evening and Saturday surgeries, and these needs must be met.

Recommendations:

1. That the PCT tenders for the provision of evening and weekend GP services that adequately meet the needs of local people [October 2004]

2. That the PCT monitors the operation of the new contractual hours [Ongoing]

3. That the PCT informs the public of the new arrangements [October 2004]

H: Appointments and waiting times (Section 4)

Key messages:

- Appointments are measured by two national performance indicators: the percentage of patients able to be offered an appointment to see (i) a GP within 48 hours and (ii) a PCP within 24 hours. In the last year, there has been a huge, sustained improvement in local performance against these indicators, the first figure rising from 86% to 100% and the second from 65% to 100%. This is the result of extremely hard work by the PCT and individual practices and we congratulate them on their achievement.

- We feel patients should see their usual GP if at all possible, given the benefits of continuity. However, this does not seem to be the current thinking in the NHS (the wording of the indicator is, after all, "access to **a** GP," not "the patient's usual GP").

- The ease of obtaining an appointment varies considerably across the borough. The PCT is currently rolling out a best practice toolkit to local practices; we hope this

resolves this issue but urge the PCT to monitor progress carefully.

Recommendations:

1. That the PCT adopts a policy that patients see their usual GP wherever possible and, with practices, takes action to promote this [November 2004 and ongoing]

2. That the PCT monitors the implementation of the best practice toolkit (the 'Advanced Access Programme') [Ongoing]

3. That the PCT collects figures on the number of patients who refuse a 24/48 hour appointment [December 2004]

4. That the PCT discusses with GPs the latter's concerns regarding the Access Satellite Clinic at Abbey Medical Centre and the Minor Ailments Scheme (see paragraph 4.5 of the main report).[October 2004]

I: Quality of services (Section 5)

Key messages:

- In the national patients' survey, Barking & Dagenham performed poorly on service quality issues and about 60% of the public comments we received were negative. We found it difficult, however, to get an accurate picture because the primary care performance targets focus on quantity more than quality; we were pleased to note, therefore, that more quality-based targets are likely to be introduced in the future.

- The introduction of the nGMS contract should lead to improvements in service quality. All local practices have signed up to its 'Quality and Outcomes' framework, which sets out a broad range of quality-based performance indicators.

- Also on a positive note, a number of local practices have set up patients' participation groups (PPGs) and all practices are now required to carry out an annual patient questionnaire

- The public feedback shows that there are wide variations in service quality locally. The PCT needs to work with local practices to create a seamless service across the borough so that patients can expect the same high standards wherever they go.

Recommendations:

1. (i) That all local practices establish a PPG to help them identify necessary service improvements (we accept that it may be difficult for every practice, particularly the smaller ones, to set up their own group and that, in these cases, it may be appropriate for two or three practices to "share" one group so they can spread the work between them). [March 2005]

(ii) That the PCT supports this process by formulating standard terms of reference for the groups and ensuring adequate reporting lines are in place between the groups and the PCT, Patients' Forums, Health Scrutiny and so on [December 2004]

2. That practices feedback the results of their patient questionnaires to their PPGs and the

PCT as a matter of course [Ongoing]

J: Receptionists (Section 6)

Key messages:

Residents' comments ranged from "receptionists are wonderful" to "receptionists are stand off-ish and gas to each other." On the common complaint that "you can't get by the receptionist", GPs commented that "it's not their fault - we are simply too busy to take more appointments." GPs and the public alike commented on the rudeness receptionists sometimes have to put up with from patients. A number of comments referred to the difficulties stemming from the volume of telephone enquiries and suggestions included customer care training/guidelines for receptionists.

We recognise that, as one resident put it, "receptionists have a lot to go through and a difficult job." We feel that they would benefit from further support in terms of training and guidance; something must also be done about the telephone situation.

Recommendations:

1. That all practices ensure they have proper arrangements in place for the recruitment and induction of receptionists (including a job description, person specification, formal interviews, references and induction programmes) [December 2004]

2. That all practices send their receptionists on a recognised customer care training course, unless they have recently attended one, and ensure their training is kept updated [March 2005]

3. That the PCT produces customer care guidelines for distribution to all practices [December 2004] (or, if there is something readily available, distributes this immediately)

4. That the PCT and practices review the comments made about telephone enquiries and take appropriate action [November 2004]

K: Public information on primary care services (Section 7)

Key messages:
The public feedback included calls for better publicity, including information on opening times and so on, and a suggestion that an article be included in The Citizen each month focusing on a particular health issue or service area.

Recommendations:

1. That the PCT and practices include regular articles on their services in The Citizen (although their services are outside the scope of this review, we suggest BHRT and NELMHT do the same). [Ongoing]

2. (i) That GP practices and other primary care facilities provide clear information to the public on the following:

(a) opening and consultation times (these should be clearly displayed outside the building, in addition to the places recommended under (ii) below)

(b) any charges levied for services (these should be clearly displayed at reception, in addition to the places recommended under (ii) below)
(c) the quality standards that they are aspiring to achieve under the Quality and Outcomes Framework
(d) other key information on their services, including arrangements in place for appointments, repeat prescriptions and so on

(ii) That this information be made available to the public through a variety of methods, including practice leaflets, notice-boards and websites and in appropriate languages and formats (e.g. Braille, audio tape, large print and so on)

(iii) That GP practices ensure they are fulfilling their obligations under the Freedom of Information Act

(iv) That the PCT closely monitors progress with (i) (ii) and (iii) and provides guidance and support as necessary, particularly in terms of the provision of information in appropriate languages and formats

L: The role of the public (Section 8)

Key messages:

- The role of the public. We urge all residents to play their part in helping to ensure local primary care services run smoothly by acting responsibly and making appropriate use of them. We received complaints both from the public and PCPs about the problems caused by patients not turning up for appointments and so on.

- The "non-medical" work of GPs. By this, we mean activities like signing passport applications and filling in non-medical forms on behalf of patients, all of which places an additional burden on GPs. Some GPs charge for this work; we would like to see greater transparency in relation to these charges.

Recommendations:

1. The role of the public:

(i) That the PCT, working with practices and their public participation groups, devises and implements an ongoing public information campaign to encourage appropriate use of primary care services [November 2004 and ongoing]

(ii) That the Council supports the above by offering space in The Citizen and slots at Community Forums. [Ongoing]

2. GPs' "non-medical" work:

(i) That the Head of Customer First and the PCT investigate what they can do to alleviate the burden of GP's non-medical role. We feel the Council should be able to deal with the Council-related queries currently being referred to GPs, that the PCT may be able to deal with more issues centrally (for example, through the Health Information Shop and Patient Advice & Liaison Service (PALS)) and that the Voluntary Sector also has an important role to play. [November 2004]

(ii) That the PCT recommends the Local Medical Committee to encourage local practices to formulate and then sign up to a standard, local list of charges for "non-medical" work. The agreement should also cover associated administrative arrangements (for example, the issue of receipts for such work). The PCT would then publish the list of charges and the details of the practices who had signed up to it. [October 2004]

M: Prescriptions (Section 9)

Key messages:
The public feedback included complaints about long waits for repeat prescriptions and associated bureaucracy. GPs' complaints included patients insisting that they filled out their prescriptions when this could quite easily be arranged by the receptionist.

Recommendations:

1. That practices carry out an annual check of all long-term prescriptions to ensure their continued effectiveness [Ongoing]

2. That the PCT looks at the possibility of introducing a credit-card style system for prescriptions as used in a well-known high street chemist [December 2004]

N: Referrals, tests and results:

Key messages:
The feedback from both the public and health professionals was that, too often, these processes take too long and are hampered by 'red tape.'

Recommendations:

1. That the PCT generally reviews and addresses the concerns/suggestions put forward on this matter in conjunction with BHRT and other relevant NHS bodies [December 2004]

2. That the PCT specifically:

(i) pursues the suggestion raised by the Practice Nurses Forum that nurses be empowered to make referrals where appropriate (we have been advised that this is already possible in some cases) [November 2004 and ongoing]

(ii) investigates and reports back to GPs (and the panel) on their complaint that they are being asked to double-check the need for referrals with hospitals even when they know these are necessary [November 2004]

(iii) finds a solution to the problems faced by patients living at home on their own [November 2004]

O: Home visits and out-of-hours services (Section 11)

Key messages:
Barking & Dagenham scored poorly on these areas in the national patients survey. The public's feedback to the panel included complaints about difficulty in obtaining home visits.

Recommendation:
That all practices reflect on how far the comments made by the public apply to them and make any necessary improvements and that the PCT supports them with this as necessary [October 2004 and ongoing]

P: Locums

Key messages:

- The use of locums is too high, although it is hoped this will decrease as more permanent GPs are recruited.
- Locums do not provide the same level of service as the GPs they are being brought in to cover: this is an unacceptable situation and must be addressed.

Recommendation:
That the PCT and practices work together to ensure that locums cover the whole service provided by the GP they are being brought in to cover [November 2004]

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- **Background Papers used in the preparation of this report:**
- Health Scrutiny Panel papers and minutes
- Improving health and wellbeing through public health partnership: Annual Report 2002/03 (Council/Primary Care Trust, 2003)
- A guide to the NHS for members and officers of health scrutiny committees (Department of Health, November 2003)
- Planning Health Services North East London – Thames Gateway Development (Strategic Health Authority letter to Secretary of State for Health dated 12.12.03)
- Barking and Havering LIFT Strategic Services Development Plan (2002)
- Report on performance against the Local Delivery Plan targets for Quarter 3, 2003/04 (Report to Primary Care Trust Board, 26.02.04)
- Under Capitation (Report to Joint Health & Social Care Board, 30.3.04)
- New GMS and PMS contract: calculation of aspiration payments for the quality and outcomes framework (Department of Health letter to PCT Directors of Finance dated 2.12.03)

If you would like to inspect or have further details about the background papers, please contact the Democratic Support Officer.

Barking & Dagenham Health Scrutiny Panel

Review of Access to Primary Care: Draft Final Report

May 2004

Part 1: Background information

1. Introduction

1.1 This part provides information on the background to the review and the way it was carried out.

2. Background to the review

Health scrutiny

2.1 In January 2003, councils were given a new power to look into local health services on residents' behalf. This is called 'health scrutiny' and its overall aim is to act as a lever to improve the health of local people.

2.2 Barking & Dagenham Council set up a standing 'Health Scrutiny Panel', made up of 6 councillors, to carry out this work locally. Until May 2004, the panel had two main roles:

- Scrutiny: conducting in-depth scrutiny reviews on issues of local concern. These reviews involve seeking stakeholders' views, looking at relevant documents, visiting the services under review and, at the end of the process, producing a report including recommendations for improvement. The National Health Service (NHS) bodies responsible for the area being reviewed then have to say, within a set period, what action they will take in response.

- Overview: including responding to consultation from local NHS bodies on major service changes and generally keeping up to date/raising questions about health issues currently facing the local community.

2.3 Health scrutiny is a complex and wide-ranging area and, as a result, the panel has had a very high workload. To ease this situation, the Scrutiny Management Board (SMB), which has overall responsibility for scrutiny, has agreed to change the way health scrutiny operates. From May 2004, the existing panel will be responsible for overview and the SMB will appoint separate, time-limited panels to carry out in-depth reviews. This will also allow more Members an opportunity to get involved in this important area of work.

The Access to Primary Care Review

2.4 In the spring of 2003, the panel asked the community to suggest possible topics for its first in-depth reviews. The community identified access to primary care services, particularly those provided at their local doctors' surgeries, as one of the most important local health issues and so the panel chose this as its first topic.

2.5 The second review is of local Speech & Language Therapy services, another area identified by the community as key, and will conclude in September 2004.

3. Scope of the review

3.1 The panel agreed the scope of the review – its aims and the areas it was going to cover – on 26 June 2003. In doing so, it was mindful that access to primary care is a vast subject. 'Primary care' covers all the services "on the frontline of the National Health Service (NHS)"[1] – those provided by general practitioners (GPs) and also by "nurses, health visitors, dentists, opticians, pharmacists and a range of specialist therapists"[2] 'Access' covers not only the extent to which the public can get the services they need but also the many factors that influence that: the availability of funding, the condition of premises, the needs of different groups and so on.

3.2 Given the above, the panel agreed to concentrate on general practice and the services provided by doctors, nurses, receptionists and practice managers. Responsibility for these services is shared between Barking & Dagenham Primary Care Trust (PCT) and local GP practices. Broadly speaking, the PCT is responsible for regulating the services and supporting their development and the practices are responsible for providing them. The PCT also provides a wide range of community health services and commissions the other services that are needed to meet the health needs of local people, including hospital services.

3.3 Within this, the panel agreed to focus on the following specific issues:

- Appointments
- Opening times
- The use of primary care premises
- Physical access to premises
- Training for receptionists
- Access to services for different groups (for example: children, older people, asylum seekers, people with learning disabilities)
- Resources for primary care

3.4 Its aims were:

- To identify the key issues for the community in accessing primary care;
- To identify the challenges involved in delivering primary care in Barking & Dagenham;
- To identify inequalities in access to primary care;
- To identify ways of improving access to primary care and reducing inequalities in access;
- To review evidence in relation to the impact of increased access to primary care on the use of emergency and secondary health care and to social care.

3.5 The panel has covered a lot of ground during the review but, even with the tighter focus, the topic is still large and complex and, given more time and resources, there are areas it would have liked to have covered in more detail. For example, while it hopes it has been successful in identifying the key issues facing the community as a whole, it would have liked to have looked more closely at the issues affecting different population groups and feels that health scrutiny should return to this area in the future.

[1] A guide to the NHS for members and officers of health scrutiny committees (Department of Health, November 2003)
[2] See 1

4. Membership

Panel members and independent officers

4.1 The panel members are Councillors Val Rush (Lead Member), Len Collins, Mohammed Fani, Dee Hunt and Marie West. Councillor Robert Jeyes served on the panel until his death in April 2004. Councillor Bert Collins was also a panel member until October 2003, when he had to step down because of work commitments. The panel's independent scrutiny support officer is Jane Bufton (the Head of Corporate Communications) and Steve Foster is its democratic support officer.

Lead service officers

4.2 The main health and social care representatives during the review were Caroline Ferguson (Head of Primary Care Development), Cathryn Williams (Director of Services for the Community) and Matthew Cole (Director of Public Health). The panel is extremely grateful for the co-operation and support extended by the PCT during the review and the time and hard work put in by the lead service officers - and the other representatives who assisted from the Council, the PCT and the Barking & Havering LIFT Company (LIFTCo) - particularly given the pressures they are all under in their day-to-day roles.

5. Consultation

5.1 The panel wanted to gain an understanding of the key issues relating to access to primary care from the point-of-view of the community, front-line health professionals and the Primary Care Trust. In addition to its discussions with the PCT, it carried out the following consultation during the review:

Consultation with the community

5.2 The panel asked the public two main questions:

(i) What is your experience of accessing primary care, especially general practice?
(ii) What improvements would you suggest?

5.3 The panel asked these questions through:

- The Community Forums: over 220 residents took part in workshop sessions at five of the six Forums between July and October 2003;
- The Barking & Dagenham Forum for the Elderly: presentation and discussion, November 2003 (approximately 30 residents attended);
- The Barking & Dagenham Access Group: presentation and discussion, September 2003 (approximately 10 Access Group members attended);
- The Citizen: article seeking residents' views (two responses). A similar article appeared in Member Matters (the Council's monthly bulletin for councillors) seeking councillors' views (none received).

5.4 Although this consultation was not (and was not intended to gain) a scientifically representative sample of local opinion, the panel feels that it gave it a good flavour of the key issues locally. It decided against carrying out an in-depth survey, through the Citizen's Panel for instance, as it had access to a national survey allowing it to compare the experience of Barking & Dagenham residents with those in the rest of the country.

Consultation with front-line health professionals

5.5 The panel asked three main questions:

(i) What do you see as the key issues affecting access to primary care?
(ii) What are the challenges you face?
(iii) What do you feel would help improve services in the future?

5.6 The panel asked these questions through:

- Meetings with/visits to GPs. In August 2003, having approached the Local Medical Committee for its support, the panel invited all Barking & Dagenham GPs to focus sessions at the Heathlands centre in Dagenham and the Town Hall. Unfortunately, despite further appeals from both the Council and the PCT, only four GPs and one practice manager attended. The panel was very grateful to those who took part and the sessions were useful, but it was naturally disappointed at the low turnout. It agreed that individual Members would call around and ask to meet GPs on a one-to-one basis; 5 GPs consented to this and the subsequent meetings were very positive, with Members also having the opportunity to look around the surgeries and meet patients;

- Practice Nurses forum: presentation and workshop session, December 2003 (approximately 30 nurses attended);

- Article seeking views in PCT/Social Services monthly staff newsletter (no response).

6. Key documents

6.1 This paragraph looks at the key information/documents the panel considered during the review.

Improving Health and Wellbeing through Public Health Partnership Annual Report 2002/03.

6.2 Formerly known as the Annual Report of the Director of Public Health, this report identifies the health needs of local people and looks at how the Council, local health services and their partners need to work together to address health inequalities through regeneration and modernising services. The key messages from this document are reflected below in the section on resources for primary care (part 2, section 2)

NHS performance ratings 2002/03.

6.3 In March 2003, the Commission for Health Improvement (CHI), the independent inspection body of the NHS, published star ratings providing information on how well local health services performed against key targets set by the Government during 2002/03. This was the first year in which primary care trusts were awarded a star rating. Every trust was placed into one of four categories: from three stars for trusts with the highest level of

performance to zero stars for those with the poorest performance. Barking & Dagenham PCT was awarded a zero star rating. As the CHI report made clear, this did "not necessarily mean that…the [service did] not contain some very good services or that the staff [were] not working hard for the benefit of patients. It [meant] that performance must be improved in key areas." The panel also recognised that performance in the area it was examining is the responsibility of practices as well as the PCT and that other stakeholders, including the Council, other local NHS bodies and indeed the public have a role in helping to improve performance.

6.4 The CHI's reports on individual trusts were broken down into more detail under the headings 'key targets' and 'broader indicators.' Barking & Dagenham PCT performed as follows under these headings:

Key targets:

- It achieved 6 out of 9 key targets, one of which (regarding the availability of single telephone access to out of hours services) relates to access to primary care
- It underachieved on the key target relating to Access to a GP (the percentage of patients offered an appointment to see a GP within 48 hours)
- It significantly underachieved on the two remaining targets, one of which is relevant to this review, namely: Access to a primary care professional ('PCP') (the percentage of patients offered an appointment to see such a professional within 24 hours)

Broader indicators:

- Generally, the PCT performed poorly against the access to quality services indicators (mainly because of the results of the National Patients Survey (see paragraph 6.6)) and improving health indicators and in the middle band of performance for service provision.

6.5 The PCT immediately put an action plan ('The Recovery Plan') in place to respond to the review and, as detailed in part 2 of this report, significant performance improvements have been made. This is particularly true of the key access targets: the percentage of patients offered an appointment to see a GP within 48 hours is now 100% (up from 86% in March 2003); the PCP access figure is now 100% (up from 65%). Nevertheless, as the PCT is the first to make clear, there is still a great amount to do in maintaining the areas of good performance, securing improvement in the other areas and addressing the key issues facing local services, some of which are identified in this report. The 2003/04 star ratings, based on a revised set of targets, will be issued in summer 2004.

National patient survey 2003

6.6 In 2003, the CHI carried out three national surveys, including one on primary care services, asking patients about their experiences. These were published in July 2003 and influenced how NHS Trusts fared in the national performance ratings. For the primary care survey, the survey was sent to a random sample of 850 patients. 330 Barking & Dagenham patients returned the survey (a 41% response rate). Overall, Barking & Dagenham did not perform well in relation to the country as a whole, although there were areas where it did have better than average results. In considering the results, some of which are detailed in part 2, the panel did bear in mind that the sample and response rate

were comparatively small and the progress that has been made since the survey was conducted. It also noted that, across the country, responses to the survey tended to be more negative in areas of deprivation.

Other documents/information considered by the panel

6.7 This information is listed under 'background papers' at the end of the covering report.

7. Equalities & Diversity Issues

7.1 The key equalities issue looked at during the review was physical access to primary care facilities (see part 2, section 2.3). Other issues have included:

- Health inequalities in Barking & Dagenham (see part 2, section 2.1)
- The need for flexible opening times to meet different people's needs (section 4)
- The quality of service for older people and language issues (section 5)
- The need for information in different languages and formats (section 7)
- Issues for patients living on their own (section 10)
- The importance of home visits for older people (section 11)

7.2 The panel is pleased to note that the PCT began monitoring ethnicity of patients using primary care services in April 2004.

8. Publicising and circulating the report

8.1 It is recommended that, immediately after the Assembly has approved the report and it has been sent to the PCT and the SHA for response:

1. The final report be made available:
   (i) on public deposit at the Civic Centre
   (ii) in local libraries
   (iii) on the Council's website (www.barking-dagenham.gov.uk)

2. The final report be sent to:
   - all local GP practices
   - the Minister for Health

3. The report summary be edited and produced in 'glossy' leaflet form

4. The report be publicised in The Citizen, Member Matters and through the local media

8.2 It is recommended that, once the responses of the PCT and SHA have been received,

1. The summary leaflet and responses be:

   (i) made available on public deposit, in local libraries and on the Council's website

   (ii) circulated to:

   - All Members of the Council
   - The Management Team

- The local Members of Parliament
- Local GP practices
- The Chief Executives of Barking Havering & Redbridge Hospitals NHS Trust (BHRT) and the North East London Mental Health Trust (NELMHT)
- The Chair of the Barking & Dagenham Primary Care Trust Patient & Public Involvement (PPI) Forum
- The Chair of the Barking & Dagenham Access Group
- The Deputy Chairs of the Community Forums
- The Chair of the Barking & Dagenham Forum for the Elderly

(iii) made available at the next round of Community Forum meetings

2. That the responses be publicised in the Citizen, Member Matters and the local media.

Part 2: The review

Section 1. Introduction

1.1 This part looks in detail at the main areas covered during the review, namely:

- Resources for primary care
- Funding and need – section 2.1
- Primary care professionals – section 2.2
- Premises – section 2.3
- Primary care and secondary care – section 2.4
- Primary Care Trust – section 2.5 (a short section looking at the comments and suggestions made by the public and health professionals about the PCT)
- Opening times – section 3
- Appointments and waiting times – section 4
- Quality of services – section 5
- Receptionists (focusing on training) – section 6

1.2 For each area, the report provides:

- The panel's key messages and recommendations
- Key facts, performance and other information;
- A summary of the action being taken/recently taken to secure improvement;
- Some of the views provided by health professionals and the public;
- Some of the suggested improvements put forward during the review

1.3 It also looks briefly at a number of the other issues touched on during the review, as follows:

- Public information – section 7
- The role of the public – section 8
- Prescriptions – section 9
- Referrals and results – section 10
- Home Visits and out-of-hours services* - section 11
- Locums* - section 12

1.4 In addition to the recommendations outlined in each area, the panel has the following general recommendations:

1. Formal response from relevant NHS bodies

That the report be sent to Barking & Dagenham Primary Care Trust (PCT) and the North East London Strategic Health Authority (SHA) for their formal response by 30 September 2004.

2. Publication and publicity:

That the report be widely circulated and publicised as detailed in paragraph 8 of part 1 of the report.

3. Monitoring and Review

(i) That the panel meets in October 2004 to look back at the review and consider any lessons learned, having asked those involved how they found the review and for any suggestions for improvement.

(ii) That the panel considers a progress report on the implementation of the recommendations in March 2005 (six months after the deadline set for the receipt of responses from the PCT and the SHA).

Section 2. Resources for primary care

Section 2.1 Funding and need

Introduction

2.1.1 This section of the report looks at the health needs of Barking & Dagenham residents and the funding available to meet those needs.

The panel's key messages and recommendations

2.1.2 Key messages:

There are two critical health funding issues for Barking & Dagenham, both of which must be urgently resolved if the major health inequalities facing local people are to be tackled and a healthy future for the borough secured.

1. The current under funding of the Primary Care Trust.

According to the Government's own figures, the PCT is under funded by 10.7% (or £24.4m). In other words, it has 10% less money than it needs to do its job of meeting the health needs of local people. This would be unacceptable in any area, but the impact is particularly acute in Barking & Dagenham because of the major health inequalities faced by local people (who, on average, experience 20% poorer health than the national average). Only three other English PCTs are in a worse funding position.

The Council, the PCT and the Strategic Health Authority (SHA) have taken a number of steps to address this issue, including lobbying the Government directly and through the local Members of Parliament. Following a meeting with the Leader of the Council and the Chief Executive in January 2004, the Minister of Health gave assurances that the position of Barking & Dagenham and other similarly affected PCTs will be addressed in the coming years; while it is pleasing that the Government has recognised the problem, we feel a more concrete assurance is required. More recently, the PCT was allocated an additional £700k; this is welcome, but represents less than 3% of the overall shortfall.

The shortfall must be closed without delay. If the PCT was funded to the level it should be, it would make a real difference to the lives of local people. The Joint Health & Social Care Board (a joint meeting of the Council's Executive and the PCT Board) was recently shown a long list of areas where funding has had to be held back across children's and older people's services, dental, primary and intermediate care; the list included additional funding for children's cancer and diabetes services, health checks for the over 75's and extra funding for Macmillan nursing support. If the shortfall is not closed, it will continue to be a significant barrier to service delivery and to improving the health of local people.

2. The impact of future population growth.

With the regeneration of the Thames Gateway, the borough's population is expected to grow by 40-60,000 in the next 10-15 years. This makes it imperative that the Government not only closes the existing funding shortfall but also ensures resources keep pace with the population growth. However, the formula used to

calculate health funding is based on historical figures rather than projected ones and allocations are only made on a three-year basis; this creates the risk that the growing population will outstrip the resources made available. In addition, we have noted that the Council and the health services are using different estimates of future population growth/breakdown; if services are to be planned effectively and a convincing, united case is to be presented to the Government, all local agencies need to be working to the same figures.

2.1.3 Recommendations:

1. That the Council, SHA and PCT continue to lobby the Government to address the current funding shortfall without delay and ensure that future health funding keeps pace with population growth. We would expect the PCT to lead this process. [Ongoing]

2. That the PCT submits a report to each meeting of the Joint Health & Social Care Board setting out the progress being made on these issues and any proposals for further action [Ongoing, with first report in 3rd quarter of 2004/05]

3. That this report be sent to the Minister of Health to support this process [August 2004]

4. That the Council works with the SHA, the PCT and other partners to agree a set of projected population figures to 2020 [October 2004]

Key facts, performance and other information

2.1.4 Revenue funding*

The funding shortfall:

- Barking & Dagenham PCT is under-funded by over 10%. ("At the end of the three-year period to March 2005, the Department of Health calculates that the PCT will be £24.4m (10.7%) below its revenue target"[3]). This significant shortfall in local health funding goes back a number of years.

- By comparison, at the end of the same period, Newham PCT will be under-funded by £23.2m, Redbridge by £4.4m and Havering by £16k.[4]

- PCTs are allocated revenue funds directly from the Government on the basis of the relative needs of their populations. The formula used to do this (the 'weighted capitation formula') looks at the total population served by the PCT and then adjusts this up or down to take account of its relative need for health care and geographical differences in the cost of providing this.

- In a letter to the Government in December 2003, the Chair of the SHA pointed out two key reasons for the ongoing problem:

[3] Improving Health and Wellbeing through Public Health Partnership Annual Report 2002/03
[4] Planning Health Services North East London – Thames Gateway Development: Letter from Chair of North East London Strategic Health Authority to Secretary of State for Health, December 2003

- The formula uses "historical population figures", rather than projected ones, "which represents a significant risk for PCTs" like Barking & Dagenham "with rapid growth in population;"[5]

- Revenue allocations are made on a three-year basis, which means "there is no annual opportunity to update population estimates and as a consequence reflect the impact on allocations."[6]

Where the money goes:

- The PCT's total revenue allocation for 2003/04 was £163.2m

- £30.2m was allocated to primary care as follows:
  - Personal medical services: £4.8m;
  - Primary care GP services: £3.7m;
  - Primary care developments: £1.4m;
  - Prescribing budgets: £20.2m;
  - Local Improvement Finance Trust (LIFT): £69k.

  *Some information on capital funding is provided in paragraph 2.3 (premises)

2.1.5 Need

The health needs of local people

- As shown in the Improving Health and Wellbeing Annual Report, the challenges of meeting the current and future health needs of local people are considerable. The community is carrying, in the words of the Director of Public Health, a "burden of ill health characterised by significant numbers of our population in poor health with high mortality rates" and there are significant health inequalities between the Borough and neighbouring boroughs and with the country as a whole. Here are just a few examples:

  - Male life expectancy is the 3rd lowest in London and in the lowest 10% in England and Wales. For females, it is the 5th lowest in London and in the lowest 20% in the England & Wales;

  - Barking & Dagenham has the highest rates of long term illness in London;

[5] See 4
[6] See 4

- Mortality from cancer and circulatory diseases is considerably above national levels. This table shows the relevant mortality rates per 100,000 population in this and neighbouring boroughs and also countrywide (highest rate in bold):

	Cancer (Male)	Cancer (Female)	Circulatory Disease (M)	Circulatory Disease (F)
B&D	**310**	**187**	382 (2nd highest)	233 (2nd highest)
Havering	237	165	322	191
Newham	261	172	**413**	**238**
Redbridge	216	146	303	184
LONDON	226	160	321	188
ENGLAND	232	161	337	205

- Life expectancy in some wards is the same as the national average 50 years ago.

- The borough has high levels of deprivation in social and economic as well as in health terms. It is the 24th most deprived in the country and the 7th in London: residents have the lowest incomes in London and adult educational attainment is the lowest in the country.[7] This is both an underlying reason for the poor health of local people and a barrier to improvement.

- It is expected that the borough's population will grow substantially and become increasingly diverse in the next several years, especially because of the new developments in the Thames Gateway, and this will add greatly to the size and complexity of local health needs. At the 2001 Census, the population was 164,000 (up from 146,000 in 1991). The Greater London Authority projects that it will grow to 172,000 by 2011 and 208,788 by 2016.

The need for improvements to primary care

- As this report details, local primary care provision is weak, with significant shortages in front-line staff and poor facilities among the key problems. The PCT is working hard with GPs and its other partners to secure improvement, but it has had to start from a low base and progress is, of course, hampered by the funding position.

Action taken/being taken to secure improvement

2.1.6 The local health services and the Council have been lobbying the Government to address the funding shortfall and inequalities for some years. Some of the recent steps have been as follows:

- On 12 December 2003, the Chair of the Strategic Health Authority, Professor Elaine Murphy, wrote to the Secretary of State for Health, John Reid, detailing the work being done to meet current and future health needs in North East London and pressing the Government to "ensure that resources keep pace with population needs and growth so we can provide services which meet national standards and improve the health of local people." The letter emphasised that

[7] Government Index of Deprivation (2000)

failure to address the resources issue would be “a severe threat to the maintenance of NHS services to the local population” and “threatens to create an NHS in North East London which is sub standard compared to the rest of the country.”

- On 26 January 2004, the Leader of the Council, Charles Fairbrass, and its Chief Executive, Graham Farrant, met the Minister of Health, John Hutton, to press the case for the Borough. The Minister gave assurances that the Government will address the position of Barking & Dagenham and other similarly affected areas in the coming years.

- The Council and the PCT is looking to engage a consultant from York University to carry out detailed research, in support of the ongoing lobbying efforts, on the reasons and effects of the shortfall.

The public’s views*

2.1.7 There were 5 comments in all. A sample:
- “All the money is poured in the wrong areas”
- “Budgets are a limiting factor in treatment”
- “Expensive drugs are not prescribed”

[***throughout the report, public comments are from Community Forum workshops unless stated otherwise]

Health professionals’ views

2.1.8 3 comments referred to funding, but they relate more closely to, and are reflected under, the other topic headings.

Suggested improvements

2.1.9 There were 3 suggestions, all from the public:
- “Abolish nursing agencies – cost too much – replace with a single Government nursing agency”
- “Less money in admin, more at coalface”
- “Better use of resources”

Section 2.2 Primary care professionals

Introduction

2.2.1 This section deals with the shortage of primary care professionals (PCPs) in the borough and the efforts being made to resolve this. It also looks at the workload of PCPs and some of the pressures they face, together with the introduction of a new contract for primary care medical services (the nGMS contract) from 1 April 2004.

The panel's key messages and recommendations

2.2.2 Key messages:

1. Shortage of PCPs.

To meet the national average staff/patient ratio, the borough would need around 20 additional GPs and about 5 additional practice nurses (figures are whole time equivalent (wte)). This shortage is a long-standing problem in Barking & Dagenham and the PCT has been working very hard to address it through a wide range of recruitment initiatives. For example, in the twelve months from February 2003 to February 2004, it made a net gain of nearly 8 wte GPs. Its recruitment of GPs is, however, hampered by turnover, due mainly to retirements; this problem is likely to continue: although there is now no mandatory retirement age for GPs, 8 are currently over 65 and over 20 more will reach this age within the next five years.

We acknowledge the considerable efforts made by the PCT to recruit more PCPs, along with the difficulties in doing so, and congratulate it on the significant inroads it has made so far. However, as the PCT itself makes clear, the pressure and drive must be maintained.

2. The work of PCPs.

Before we embarked on the review, we were as aware as anyone else that health care is a challenging profession. What we learnt during the review served to confirm and amplify that. We heard, for example, that GPs typically worked 11-12 hour days and that a 2 handed practice might see nearly 500 patients in a week. We hadn't realised quite how extensive the role of a practice nurse is: screening for chronic diseases, giving comprehensive individualised lifestyle advice, supporting people with mental health problems, the list goes on and on. The practice managers and support staff also have a multiplicity of responsibilities. We also learnt about the human pressures - dealing with rude and aggressive customers - and how the "usual" workload these professionals might expect to face is heightened locally by the difficulties facing primary care services. In addition, we looked at the steps being taken to reduce the pressures, for example by developing the role of other health professionals so they can take on some of the tasks traditionally carried out by GPs or practice nurses and through addressing "work/life balance" issues.

Like the members of the public we spoke to during the review, we recognise the pressures faced by local PCPs; the community owes them a debt of gratitude for the efforts they are making on all our behalf. We also support the efforts being

made by the PCT to address these pressures. Nevertheless, there are some actions we feel need to be taken to secure further improvement and these are listed below.

2.2.3 Recommendations:

1. That the PCT implements robust arrangements to monitor the set outcomes expected of GP practices under the nGMS contract and to take corrective action where practices are not meeting these outcomes [October 2004 and ongoing]

2. That all PCPs, including support staff, receive an appraisal during 2004/05 (all GP principals received an appraisal in 2003/04; the PCT is now planning to roll this out to non-principals. We feel that all staff should have the right to an annual appraisal) [March 2005]

3. That the PCT gains benefit from the vast knowledge of the primary care workforce by conducting a PCP suggestion survey and/or implementing a PCP suggestion scheme (the PCT recently conducted a staff satisfaction survey, but the new survey/scheme would seek suggestions for service improvements) [December 2004]

4. That the PCT establishes an awards scheme for recognising outstanding service by GPs, other PCPs and indeed practices (we suggest that nominations could come from three directions: the public, the PCT and from PCPs putting forward their own staff) and that these awards be presented at the Ceremonial Council [December 2004]

Key facts, performance and other information

2.2.4 Staffing levels and patient numbers[8]

- 168,000 patients are registered in Barking & Dagenham
- They are served by 81 GPs, 38.7 Practice Nurses, 32 Practice Managers and 133 reception staff (all figures are whole time equivalents [wte]).
- The borough is about 20 wte GPs and 5 wte nurses short, based on the national staff/patient ratio. The table below compares the local and national wte staff/patient ratios.

	B&D	National
GPs	1:2013	1:1528
Practice Nurses	1:4213	1:3760

- The PCT has expressed some doubt over the accuracy of the national figures. However, the borough would need another 21 wte GPs to achieve a ratio of 1 wte GP to 1600 patients and another 5.4 practice nurses to achieve a ratio of 1

[8] Figures from briefing paper for health scrutiny panel (PCT, June 2003), presentation by Director of Public Health on Improving health and wellbeing annual report (November 2003) and report to PCT Board on performance against Local Delivery Plan targets for quarter 3 2003/04 (February 2004), with subsequent updates provided by PCT officers.

wte nurse to 3700 patients. In looking at these figures, account should be taken of the efforts being made to review the skill-mix of local health professionals (see paragraph 2.2.7)

- Under the nGMS contract, there is no mandatory retirement age for GPs. As long as a GP remains 'fit to practice' and fulfils the requirements for revalidation, they can continue to practice beyond the age of 70. That said, 8 GPs are over 65 and 22 more will reach this age within the next 5 years.

- For practice nurses, the issue is only with recruitment, not retention.

2.2.5 GP contracts

- Until 1 April 2004, most GP services were provided under a general medical services (GMS) contract with each individual GP. "This was negotiated at national level and allowed little or no scope to support innovative practice, nor did it recognise service quality improvement."[9]

- On 1 April 2004, a new quality-driven GMS (nGMS) contract came into effect. Under this contract, GPs are paid a global sum for delivering centrally negotiated general primary care services; if they are able and interested, they can choose to deliver two further levels of service and receive extra funding to support these, namely additional services (preventative services such as cervical screening) and enhanced services (services that require specialist skills/ facilities/equipment such as more advanced minor surgery). Under the old contract, the PCT and GPs worked together in a fairly loosely defined arrangement. With the new contract, they have a formal commissioner/provider relationship and set outcomes are expected of each practice.

- 10 practices aim to provide a wider range of services under Personal Medical Services (contracts) designed around the specific wider needs of their practice populations.

2.2.6 A brief look at the work of primary health care professionals

GPs

- Until 31 March 2004, full-time GPs were required to carry out a minimum of 26 hours of face-to-face consultations per week, 20 in the surgery and the rest through home visits. In addition, at any one time, one in two GPs was on 24 hour call (under the nGMS contract, practices can elect to move away from their 24 hour responsibility in which case the PCT has to put alternative provision in place)

- They have many other responsibilities/demands on their time[10], including:
  - Overall management responsibility for services, surgeries and staff
  - Responsibility for staff training
  - Responsibility for practice development
  - Practice meetings

[9] Briefing paper for panel (PCT, June 2003)
[10] This section refers to GP principals who work within the General Medical Services contract (the vast majority of GPs in the borough).

- Routine paperwork: letters, repeat prescriptions, referrals
- Reports (child protection, for example)
- "Non-medical" work – filling in passport applications/forms on behalf of patients

- The PCT showed the Panel a typical day in the life of a local GP practice with two full-time GPs. Both had surgeries for a few hours in the morning, followed by a lunchtime practice meeting. In the afternoon, one GP carried out home visits (for this practice, there were 2-6 per day) while the other held another surgery. The first GP then took charge of evening surgery while the other held a clinic. They had both worked an 11-12 hour day and in the last 5 days they and their practice nurse had seen nearly 450 patients.[11]

Practice Nurses[12]

- "Practice nurses have an extensive role in prevention, health education, disease management and clinical care…the majority of their work is based in practices, though they undertake home visits with older people [and] provide telephone advice."

- Their work on preventative care includes screening for chronic diseases and potential health problems, providing a routine cervical smear service for women and immunisation of children and adults.

- Their health education work includes comprehensive individualised lifestyle advice, explanations of procedures and treatments and information about local services and agencies

- Disease management includes care for chronic diseases (such as diabetes), supporting people with common mental health problems and family planning services

- Clinical care includes wound management, some suture removal and care of minor injuries, administration of routine injections and assisting in minor surgery.

Practice Managers and support staff

- The administrative staff who support GPs and practice nurses have a multitude of duties. Here is a small sample of the activities involved in the day-to-day management of the practice[13]:

  - Arranging appointments
  - Dealing with patient enquiries
  - Registering patients
  - Updating patient records
  - Maintaining databases
  - Accommodating temporary patients and emergencies
  - Organising interpreters
  - Liaising with hospitals regarding test results/appointments

[11] Presentation to panel by Caroline Ferguson on 26.6.03
[12] See 3 (chapter on practice nursing by Karen Clinton)
[13] See 11

- Word processing
- Filing

- Also see section 6 (Receptionists)

Additional pressures

- The above is merely a list of duties; it is also important to remember the human pressures – for example, reassuring anxious patients and relatives and dealing with rude and aggressive customers.

- The "usual" workload and pressures faced by primary care professionals are exacerbated locally by the shortage of staff and locums, the shortfall in funding and the other difficulties facing primary services in the borough.

Action taken/being taken to secure improvement

2.2.7 A wide range of initiatives is in place to improve recruitment and retention and address the pressures facing staff; a few examples are listed below. A key part of the approach is reviewing the skill-mix of local health care professionals: enhancing the role of practice nurses so they can take on some of the work traditionally carried out by GPs and developing the role of other health professionals, such as community pharmacists, to relieve the pressure on both GPs and practice nurses. The PCT has informed the panel, however, that a large number of senior clinicians, either through choice or because of capacity, continue to provide treatment and care that could easily be devolved to other health care groups either through choice or because of capacity. [14]

- GPs: A GP recruitment and retention strategy was developed in June 2002 and subsequently revised in 2003 and 2004. Recruitment initiatives include:

  - recruiting qualified GPs from Spain and Germany

  - establishing a local study group for overseas qualified and refugee doctors to support them to undertake the necessary examinations required to practise medicine in the UK

  - converting GP locums into permanent posts

  - increasing the number of GP training practices thereby increasing the number of GPs in training locally who are likely to fill local GP vacancies.

  In 2003/04, the PCT's target was to recruit 8 wte GPs. 7.8 wte GPs were recruited in the period February 2003 to February 2004, including two GPs from Spain in September 2003.

- Practice nurses: In 2003/04, the PCT made around £200,000 available for investment in practice nursing, targeted at those practices with the lowest numbers of nurses.

- Other initiatives include:

[14] See 9

-Support to nurses wishing to develop additional skills allowing them to diagnose, prescribe and treat specific conditions.

-A scheme to encourage nurses who have left the profession to return to practice nursing. An initial scheme in 2001/02 secured 5 new nurses for the borough. 9 nurses have been identified for the current scheme.

- Other professional groups:

  - Health care assistants can perform a similar supporting role in surgeries as auxiliary nurses do in hospital. The PCT is looking to increase the current relatively small number of health care assistants locally and, as part of this, is offering receptionists the opportunity to train for this role (where a receptionist is promoted in this way, their receptionist's post needs to be filled by the practice).

  - Pharmacists. The PCT has introduced a 'minor ailments scheme' to enable pharmacists to carry out consultations for conditions such as coughs and colds (see paragraph 4.7 for more details)

- GP appraisal. One of the indicators in the 2002/03 NHS Performance Indicators was the percentage of GPs who had received an annual appraisal. Barking & Dagenham scored 0% (in fact, a third of GPs had received an appraisal but there were problems with gathering the relevant information). This item was included in the Recovery Plan: all local GP principals received an appraisal in 2003/04 and this is now being rolled out to non-principals.

- The introduction of the nGMS contract is also supposed to secure improvement in this area. For example:

  - As described above, GPs can opt in or out of providing certain services as their resources allow/as they wish (see paragraph 2.2.6)

  - Practice teams' workload has to be kept within safe limits, practices are allowed to adopt flexible patterns of working and protected time is provided for professional training and appraisal.

The public's views

2.2.8 There were over 30 comments on this issue:

- There was broad recognition of the pressures faced by local health professionals:
  - "GPs are under huge pressure"
  - "Nurses are overworked"

- A number of reasons were put forward for this:
  - "More doctors retire early"
  - "Doctors and nurses have too much non-patient work – administration"
  - "Doctors with the best reputations have extremely high lists"

- Several comments referred to the consequences:
  - Patients get less in-depth examinations
  - "Registers are full or have closed down" [the PCT has commented that, in fact, there are no closed lists in Barking & Dagenham]
  - "Because of overload, patients are not bothering to see their doctor for ailments not seen as a major problem"

Health professionals' views*

***[throughout the report, views expressed are from GP Focus Groups unless stated otherwise]

2.2.9 Comments included:

- "Staff shortages are a significant problem" and there is "difficulty in obtaining funding for practice nurses"[15]

- "I'm doing one-and-a-half times my hours"

- Concerns about the difficulty in meeting patients' needs:
  - "You've got to give patients time, you can't rush them, you need reflective time to plan for their needs: this creates pressure"
  - "Patients' expectations have escalated" They "are more knowledgeable about health and more willing to challenge and question than in the past; this places greater demands on GPs and their time."[16]

- Concerns about the challenges of "the new NHS":
  - "The NHS used to be reactive – now it's proactive – this has increased the workload"
  - The nGMS contract "expects a certain standard of service/accessibility but the money isn't being provided to help achieve it."[17] [the PCT comments that this statement was made before practices had details of their indicative budgets]

[15] Feedback by Lead Member on meetings with individual GPs (January 2004)
[16] See 15
[17] See 15

- "The calculation for the allocation of staff doesn't take account of the new services GPs are expected to provide" [the PCT comments that, under the nGMS contract, additional funding is provided to practices to support the provision of additional and enhanced services]

- "Another pressure is people being referred to their GP for non-medical reasons – signing grant applications" and so on.

Suggested improvements

2.2.10 There were around 45 suggestions in this category. These included straightforward pleas for more doctors, more nurses and smaller list sizes and more specific suggestions, including:

- Calls from the public and the Practice Nurses Forum to increase nurses' responsibilities and expand nurse-led services, including triage and minor treatment services (30% of the comments were on this theme)

- More training, including IT training (public/Practice Nurses)

- Recruitment and retention incentives (public)

- "Develop a liaison deal with a teaching hospital to put junior doctors into surgeries on a rolling basis." (public) [the PCT comments that practices can do this already, subject to meeting certain centrally assessed standards]

- "Survey staff for ideas" (public)

- "Availability of GP for longer at practice" (Practice Nurses Forum)

- "Salaried GPs" (Practice Nurses Forum)

- "Longer consultation time with GPs" (Practice Nurses Forum)

- "GPs to understand nurses' role!" (Practice Nurses Forum)

Section 2.3 Premises

Introduction

2.3.1 This section deals with the condition of GP premises in Barking & Dagenham.

The panel's key messages and recommendations

2.3.2 Key messages:

The borough's 44 practices are spread over 55 sites. A large number are in old, unsuitable premises: 76% are currently below the required standards, impacting adversely on the environment for patients and staff and causing access problems. This is being addressed through two main routes: the Local Improvement Finance Trust (LIFT) programme, a capital investment programme run by a public/private sector partnership, and improvement schemes put in place by the PCT and individual practices. LIFT is a very impressive programme: the first 7 schemes, involving new buildings and enhanced services at, among others, Annie Prendergast Health Centre, Ford Road Clinic and Morland Road Day Hospital, will all be underway this year and further schemes are in the pipeline. Outside LIFT, funding has been very limited: until recently, the PCT had just over £100k a year for improvement grants (against the estimated £20m cost of bringing all premises up to standard) and, under the grant regime, at least a third of the cost of each approved scheme has to be provided by the practice. There are other barriers to improvement too, not least the limited alternative accommodation in the borough. Nevertheless, outside LIFT, 4 premises have been replaced and 7 refurbished in the last few years.

We congratulate the PCT, Barking & Havering LIFTCo and the practices involved for the strides they have made in improving primary care premises but, as all parties acknowledge, there is still a considerable way to go: even when the currently programmed schemes are complete, 25% of premises will still need refurbishment or replacement to bring them up to standard.

2.3.3 Recommendations

1. We strongly encourage those practices who require improvements to (a) work with the PCT to secure capital funding and (b) make the investment required to fund any shortfall (although we do recognise the difficulties practices face in this respect - see paragraph 2.3.10) [Ongoing]

2. (i) That the PCT and LIFTCo consult the Barking & Dagenham Access Group on all developments to primary care premises. This consultation must take place at all stages of any such development: the Group should be involved in formulating the initial proposals and their advice should continue to be sought right through until the work is completed and signed off (the Group advised us that a common problem with new/modified buildings is that access work is not carried out according to what has been agreed). Although their services are outside the scope of this review, we suggest that the other local NHS bodies - Barking, Havering & Redbridge Hospitals NHS

Trust (BHRT) and the North East London Mental Health Trust (NELMHT) - also consult the Access Group in this way. [Ongoing]

(ii) That practices take up the Access Group's offer to visit surgeries and offer advice on access issues [Ongoing]

3. That LIFT Co, the PCT and practices take special heed when planning/implementing improvements of the comments/suggestions from health professionals and members of the public on this issue, particularly on access, waiting rooms, facilities for children and space for consultation [Ongoing]

Key facts, performance and other information

Number and ownership of premises

2.3.4 The borough's 44 GP practices are spread over 55 sites. 31 are owned by the GP (many of these on leasehold) and 24 are rented.

Quality of premises

2.3.5 "A large number of practice surgeries were established 30 plus years ago, mainly using converted local authority residential properties. The suitability/appropriateness of these properties to accommodate modern primary care services falls seriously short of current day requirements"" (Briefing paper for health scrutiny panel, June 2003).

2.3.6 A full audit of primary care premises in North East London was carried out in February 2001. This looked at a range of issues including floor area, physical condition, development opportunities and compliance with the Disability Discrimination Act 1995. Premises were graded into the following classifications, from 1 down to 4b:[18]

1: Meets current minimum premises standards for General Medical Services purposes and the latest amendments of the Building Regulations
2: As per 1, but not the latest amendments of Building Regulations
3a: Floor area less than standard, but has potential to meet standard and latest amendments of Building Regulations
3b: As per 3a, but not capable of further improvement to meet floor area standards/latest amendments of Building Regulations
4a: Do not possess the current minimum standards for GMS purposes/the Building Regulations, but have potential to do so.
4b: As per 4a, but cannot be adapted to do so.

[18] The classifications have been abbreviated.

2.3.7 In Barking & Dagenham, 83% of the premises were in the lowest two grades. The table below shows the number of premises in each grade per Community Forum area and Barking & Dagenham as a whole.[19]

Forum area	**1**	**2**	**3a**	**3b**	**4a**	**4b**
Eastbrook, Heath & Alibon	0	1	2	0	4	1
Abbey, Gascoigne & Thames	0	0	0	0	8	3
Wellgate	0	0	1	1	1	1
Eastbury, Mayesbrook & Longbridge	0	0	0	0	6	6
Parsloes, Becontree & Valence	0	2	1	0	5	0
River, Village & Goresbrook	0	0	1	0	9	2
TOTAL	0	3	5	1	33	13

Patients' survey and performance indicators

2.3.8 This included two questions relevant to this area:

- How clean is the GP surgery? Only 52% of Barking & Dagenham respondents said "very clean" compared to 75% nationally.
- How easy is it to move around inside the GP surgery? Locally, 63% said "very easy" (75% nationally) and 33% "fairly easy" (23%).

2.3.9 Barking & Dagenham performed significantly above average in the NHS Performance Ratings on fire, health and safety.

Practical problems

2.3.10 The poor overall standard of local primary care premises raises a number of practical problems, including:

- Adverse impact on the environment in which patients receive a service and staff have to work
- Access problems (in terms of travelling to the surgery and getting into/around the premises)
- Difficulties in maintaining patient confidentiality due to restricted space in waiting rooms, particularly in older premises

[19] Presentation to panel by Caroline Ferguson on primary care premises (September, 2003)

Action taken/being taken to secure improvement

Context

2.3.11 There are a number of barriers to success:

- Limited funding: there are three sources of funding for improvements:

  - 1: Third party funding including the Local Improvement Finance Trust (LIFT scheme). NHS LIFT is a new capital investment programme "aimed at helping to improve the health of the local population [by] providing modern services in appropriate buildings in the locations they are required."[20] There are over 40 LIFT projects currently in development in the United Kingdom, each involving the formation of a joint venture partnership between local public sector organisations and the private sector. The local LIFT programme is being managed by Barking & Havering LIFTCo, which is responsible to the five local public sector partners: Barking & Dagenham and Havering Councils, Barking & Dagenham and Havering PCTs and the North East London Mental Health Trust. There are seven schemes in Barking & Dagenham in the first phase of the programme (listed in paragraph 2.3.9).

  - 2&3: Improvement grants and GP's notional rents. Outside the LIFT programme, funding is very limited. Until recently, the PCT had a budget of about £110-120k a year for improvement grants. To put this in perspective, it would cost about £20m to bring all local premises up to the required standards, including those where there is no capacity for improvement due to restricted space and other factors. Now, the funding for improvement grants is held in a central fund for the North East London sector and each PCT has to bid for funding from this. Improvement grants can only be made up to a maximum of 66% of the cost of each approved improvement scheme; the remaining 34% has to be provided by the practice. The only other source of funding is through practices' non-cash limited rent reimbursements.

    A further limitation is that regulations prevent the PCT from investing in certain areas (for example, improvement grants can be made for expansions that support service development/improvement but practices are responsible for general repairs and maintenance).

- Other issues:

  - While a number of practices are working with the PCT on potential practice improvements, it can be difficult for them to invest, not only because they have to provide a third of the funding but also because their premises may be leased or rented (if a property is rented, the practice has to get permission from the landlord to make alterations and may have to return the premises to their original condition when their tenancy comes to an end). Another factor is the fact that many GPs are approaching "normal" retirement age.

  - The limited opportunities for alternative accommodation in the borough.

[20] Barking and Havering LIFT Strategic Services Development Plan (2002)

Improvements

2.3.12 Since the 2001 survey, 4 premises (7%) have been replaced, 7 (13%) have been substantially refurbished and 17 (31%) satisfy the requirements of the Disability Discrimination Act (DDA).

2.3.13 LIFT is addressing 13 sites. 7 of these are in the current round and should all be underway by the end of 2004:

Scheme	**Original provision/plans**
Annie Prendergast Health Centre, Chadwell Health	Original provision: GP and community services, but "in very cramped conditions."[21] Plans: New building on the same site, accommodating enhanced GP (8 GPs) and community services, including a local authority family centre.
Ford Road Clinic, Dagenham	Original provision: community services only Plans: New building in Church Elm Lane, for enhanced GP (4 GPs) and community services (original site may be used for other services)
Julia Engwell Health Centre, Dagenham	Original provision: GP and community services Plans: Looking at possibility of new building as part of Jo Richardson Community School to accommodate 6 GPs, community services and child focus centre (original building to be refurbished for health use)
Marks Gate Health Centre	Original provision: 1 GP and clinic, in small building located alongside other community services Plans: New building on site, to provide enhanced GP (5 GPs) and community services [the panel has suggested it be used for ante-natal care, of which there is a shortage locally]
Morland Road Day Hospital, South Dagenham	Original provision: older people's mental health services on large underused site. Plans: Develop site to provide enhanced older peoples services, including GP practice (4 GPs)
Porters Avenue Clinic, Dagenham	Original provision: vacant clinic alongside mental health centre and Age Concern facility. Plans: New, single complex on site for all three services, plus, it is hoped, the Community Learning Disability Service (4 GPs)

[21] See 20

Thames View Health Centre	Original provision: health centre Plans: New building on adjacent site (freeing existing site for sale/alternative use) providing accommodation for 6 GPs and a full range of community services

(The LIFT Partnership Board is proposing that the next phase of LIFT be Barking Town Centre and Barking Reach).

2.3.14 Presently, 76% are below standard (42/55). After LIFT, 53% will be below standard (29/55) and after other developments 25% will be below standard (14/55).

The public's views

2.3.15 There were nearly 30 suggestions on this issue:

- Several of these were positive:
  - "Quite happy with surgery"
  - "Access good"
  - "The Orchards – good disabled access"
  - "We think a lot of surgeries have ramps, wider doors, good lighting, access is good"
  - "Access: very good – comfortable – all faculties"

- A number of problems were identified, however:
  - "Short of facilities, facilities not large enough"
  - "Fanshawe Clinic too small"
  - Waiting rooms: "too small", "dirty", "out of date notices"
  - Access:
    -"Transport links to Minor Injuries Unit poor"
    -"New surgery built…however, bus route not available"
    -"Very steep stairs to surgery"
    -"Toilet access restricted"

- The Access Group's comments included:
  - "Access…is generally bad. A lot of practices have access problems, even some that have been recently modified. A contributory factor is sometimes…limited space."
  - "There is a lack of childcare facilities in surgeries"
  - "It is important to remember the access needs of all, not just disabled people (for example, women with pushchairs)"

Health professional's views

2.3.16 GPs' comments included:

- "It is difficult to get improvements…if your practice needs improvements and is outside LIFT, you have little or no chance of getting them."

- "Access for disabled people is not good" – "A number of premises in the Borough are in urgent need of being brought up to standard [in this respect]"[22]

- "No parking spaces at my surgery"

- "No ventilation at my surgery"

- "There is no air conditioning which [the GP] and his patients find unsatisfactory, no disabled access from the car park" [this GP occupies a new building][23]

2.3.17 The Practice Nurses Forum identified "lack of space and consultation rooms" as one of the challenges they faced.

Suggested improvements

2.3.18 There were around 20 suggestions from the public in this category, including:

- General calls for more, larger and better facilities and improved access: "move away from 'corner shop' practices to modern bigger facilities like Havering"

- Waiting rooms - general requests to improve comfort and facilities and more specific suggestions:
  - "Children's area/play facilities would be useful"
  - "Rolling message board for next patient to overcome problems of language, pronunciation or hearing problems"

- The Access Group offered to help by visiting surgeries and offering advice on access issues and also asked that they be consulted on all developments. Also on the theme of access, one of the suggestions from the Community Forum workshops was "lighter, automatic doors"

[22] See 16
[23] Feedback to panel on visit to individual GP by Panel Members (January 2004)

Section 2.4 Primary care and secondary care

Introduction

2.4.1 This section looks at the close relationship between primary and secondary care.

The panel's key messages and recommendations

2.4.2 Key messages:

One of the ways in which the Government is trying to reduce the pressure on secondary care is by looking to primary care to share more of the load. We support this approach in principle, but feel not enough attention is being paid to the practical problems involved:

- The first part of the approach is reducing inappropriate use of secondary care services - for example, by people who are attending casualty when their condition is treatable by a PCP. Where this results from a lack of responsibility on the part of the patient, this must be stopped. However, as the report shows, it sometimes results from patients being unable to gain timely access to a PCP.

- The second part is getting more work done, where appropriate, in a primary care setting. Again, we support this in theory - hospitals do need to concentrate on acute conditions and the patient may feel their local surgery is a more comfortable environment than hospital. However, faced with a range of problems including shortages of funding and staff, the local primary care service is finding it difficult enough to deliver its core service without having to take on additional responsibility.

- What concerns us most is the SHA's proposals for meeting the current and future needs of North East London. They "plan to use existing hospitals to focus on complex…care, develop further Treatment Centres to support diagnostic and planned treatment…[and] significantly expand and remodel primary and community facilities." We support this in principle, subject to the concerns expressed above. However, despite the massive projected population growth in the Thames Gateway, they "do not intend to build a new hospital." Although we have listened to the SHA's arguments, we have grave doubts as to whether the region can support this population growth without such a hospital. As it is, the local hospital trust will, by 2005/06, be 300 beds short even with the new Oldchurch Park hospital. If it really is possible not to build a new hospital, we are willing to listen, but the SHA needs to make the case more convincingly.

- One proposal covered in this section is the proposed development of a new Walk-In Centre at Barking Hospital (integrated with the current Minor Injuries Unit) which will provide enhanced primary care services. We support this proposal, for which capital funding has recently been secured, but feel it needs to be more imaginative in scope if it is to meet the needs of local people and compensate for the lack of Accident & Emergency (A&E) provision in the Borough, especially given the population growth projected for the coming years. Our preference would be for an A&E/ambulance station on a similar model as

the trauma facilities found in the United States. Our lead health representatives have advised us that the current building would not be suitable for an A&E facility and that there would in any case be concerns about clinical safety: A&E services rely on the back-up of the other departments provided at a general hospital and these are not available at the Barking site; they acknowledged that services need to be redrawn in an imaginative way but that there has to be proper regard for patient safety. We understand this but feel that these problems could be overcome: if the system works in America, it could be made to work here.

2.4.3 Recommendations:

1. That the SHA reviews its proposal not to build a new hospital in the Thames Gateway region [October 2004]

2. That the PCT reviews the scope of the proposed Walk-In Centre at Barking Hospital [October 2004]

Key facts, performance and other information

2.4.4 Throughout the review, the panel was mindful of the close relationship between primary care and secondary care ("specialist treatment usually provided by a hospital"[24], also known as "acute care")

National context

2.4.5 This relationship is one of the key health issues in the country at present. Secondary care is under significant pressure nationwide, with long waits in casualty and long waiting lists for surgery among the common problems. The Government is seeking to address this in a variety of ways, including providing additional resources for secondary care, setting challenging performance targets for hospitals and looking to primary care to share more of the work by:

- reducing inappropriate use of secondary care services (for example, by people attending casualty when their condition should be treated by a PCP – reasons for this including a lack of responsibility on the part of patient and the patient not being able to gain timely access to a PCP)

- providing enhanced primary care services (for example, by establishing 'Walk-In Centres' for treatment for minor injuries and illnesses) and, where appropriate, transferring services from a hospital to a community-based setting

[24] See 1

Local context

2.4.6 The 3 key performance targets here are: the total time spent by patients in A&E, inpatient/day case waiting times and outpatient waiting times (increased use of primary care impacts most heavily on the first target). Barking, Havering & Redbridge Hospitals (NHS) Trust (BHRT) met all the waiting list targets in 2002/03. The latest reported position is as follows:[25]

Indicator	Target	Latest position
Total time in A&E	% of patients waiting less than 4 hours (target: 90%)	82.8% (average for 2003/04 so far) There is a detailed action plan to reduce A&E waits (some of the action points and other relevant initiatives are detailed in paragraph 2.4.4).
Out-patient waiting times	No patient to wait longer than 17 weeks for first appointment (target was 21 weeks last year)	Target was achieved by year end, although the PCT had one 21 week breach during the year
In-patient and day case waiting times	No patient to wait longer than 9 months for elective admission (target was 12 months last year)	Target was achieved by year end.

2.4.7 In addition to waiting targets, further key challenges include:

- Addressing the "capacity gap [in the BHRT area] which, if expressed as a number of beds, reaches about 300 beds short in 2005/06"[26] even with the new Oldchurch Park hospital
- Meeting the current and future needs of the local population, as detailed in paragraph 2.1.5 of this report.

2.4.8 There are also strong links with social care and mental health, although the panel has not covered these in any detail.

Action taken/being taken to secure improvement

2.4.9 Under the heading of shifting the balance to primary care, relevant actions/initiatives include:

- The enhanced community provision in the LIFT programme

[25] PCT report on performance against key CHI indicators at 30.04.04 (May 2004)
[26] PCT paper on 'Developing Capacity' (presented to panel in July 2003)

- The proposed development of a new Walk-In Centre at Barking Hospital (integrated with the current Minor Injuries Unit): capital funding has been secured for this project.

- PCPs with a specialist interest: "the PCT has initially identified a number of GPs with an interest in specialities like dermatology and minor surgery who can take referrals from other GPs"[27] and treat them or advise on treatment without having to refer them onto hospital unless this is clinically necessary. The provision of enhanced services previously undertaken in secondary care is covered in the enhanced services component of the nGMS contract.

- Funding of additional services in the Primary Care Centre at Oldchurch to ensure that, where appropriate, patients can be seen by GPs, not in A&E.

2.4.10 The SHA's proposals for meeting the current and future health needs of North East London centre on the expansion of primary and community services, as its Chair outlines in this extract from her letter of December 2003 to the Secretary of State for Health:

"**We do not intend to build a new hospital.** Our vision is to provide radically different services, based on best practice nationally and internationally, with the following features:

- Less reliance on traditional hospital beds, with more operations done as day cases, more intermediate care facilities and care at home…
- Better, more comprehensive care facilities…
- Workforce development…
- A proactive and planned approach to preventing, detecting and managing chronic illness, based on working across all agencies to support people in their own communities.

We therefore plan to:
- Use existing hospitals to focus on complex, high tech unplanned care…
- Develop further Treatment Centres[28] to support diagnostic and planned treatment and give patients choice
- Significantly expand and remodel primary and community facilities, based on the basic idea of One Stop Primary Care Centres [with] GP services and practice nurses together with other 'modules' added in flexibly as needs change, such as specialist GPs…dentistry, basic diagnostic services, a children's health centre, renal services, community mental health team."

[27] See 26

[28] These will be built and run by the private sector, under contract to the NHS, and will carry out elective surgery for a range of conditions (mainly those requiring day surgery/short-term stays) thereby cutting down on waiting times and freeing up hospital beds. Planning is currently underway for a treatment centre at King George's Hospital, which will carry out about 11,000 procedures a year and free up some thirty beds [sources: see footnotes 1 and 26].

The public's views

2.4.11 There were four comments on this issue, most on the same theme:

- "When people can't get access to primary care [they] turn to other facilities, i.e. A&E."
- "Phone requests for home visits – patients are told to go to hospital"

Health professional's views

2.4.12 No specific comments (but see comments on workload and changing nature of NHS in section 2.2)

Suggested improvements

2.4.13 There were three suggestions on this issue, including "Support needed for transfer of responsibilities from acute to primary care, e.g. a roving clinic, stop closing Accident & Emergency Departments" (public)

Section 2.5 The Primary Care Trust

Introduction

2.5.1 This report is a review of primary care services, provided by GPs and the PCT, not a review of the PCT. During the review, however, the public and health professionals put forward a number of views regarding the PCT and these are reflected below.

The panel's key messages and recommendations

2.5.2 Key messages:

We received complaints from GPs that the PCT didn't keep them informed, didn't return calls, were always in meetings and didn't provide feedback. The PCT, while acknowledging there is always room for improvement, felt that GPs did not appreciate that officers' jobs took them away from their desks. We feel the PCT must address this communication issue, real or perceived, in consultation with practices.

2.5.3 Recommendations:

That the PCT discusses with GPs the issue of communications and puts any necessary improvements in place [November 2004]

The public's views

2.5.4 There were three comments, including:

- PCT – a big quango – what does it do?
- Need Chief Executive with bottle to take on GPs

Health professionals' views

2.5.5 There were three comments on the following theme, including:

- "Communications poor – PCT doesn't keep me informed and doesn't return calls"
- "We don't have access to the PCT – they are always in meetings and there is no feedback"

The PCT, while acknowledging that there is always room for improvement, advised the panel that it felt that a large part of this is that GPs do not appreciate that officers' jobs take them away from their desks; the Primary Care Development team, for example, is diligent at returning calls but officers spend a large part of their time out in the community working with practices.

Suggested improvements

2.5.6 There were three suggestions from the public and GPs, including these from the GP Focus Group:

- PCT needs to improve its attitude towards/communications with GPs
- PCT needs to provide necessary equipment more speedily and efficiently

Section 3. Opening times

Introduction

3.1 This section deals with opening and consultation times.

The panel's key messages and recommendations

3.2 Key messages:

- Under the nGMS contract, which came in on 1 April 2004, practices have to make services available between 8.00am and 6.30pm from Monday to Friday. In the past, a typical practice might have opened from 8.30-12.30, 1.30-4.30 and 5.30-8.30; Thursday was a half day and there was a Saturday morning emergency surgery. We understand a key reason for the change is to address the work-life balance of PCPs, an aim with which we are sympathetic.

- At the same time, however, local people are calling for flexible opening times that meet their needs. In the national patients' survey, 27% of patients were put off by the opening hours (20% UK) and 44% wanted weekend opening (30% UK). The feedback from the consultation carried out for this review included a number of calls for evening and Saturday surgeries.

- If a PCT concludes that services are required outside the fixed hours, it has to tender for their provision. We feel our PCT must make the necessary arrangements to meet local people's needs.

3.3 Recommendations:

1. That the PCT tenders for the provision of evening and weekend GP services that adequately meet the needs of local people [October 2004]

2. That the PCT monitors the operation of the new contractual hours [Ongoing]

3. That the PCT informs the public of the new arrangements [October 2004]

Key facts, performance and other information

3.4 Until April 2004, opening times were decided by individual practices. GPs had an obligation under the old GMS contract to "open at times acceptable to the public" and a certain amount of their consultation time had to be carried out in their surgeries. They had to open no less than 5 days a week but there were no specific times set.

3.5 In the typical day in the life of a local GP surgery (see paragraph 2.2.4), surgery opening times were 8.30-12.30 (both GPs), 1.30-4.30 (1 GP) and 5.30-8.30 (the other GP). Thursday was a half-day and there was a Saturday emergency surgery (1 GP for 1.5 hours).

3.6 Under the nGMS contract, practices are required to make services available between 8.00am and 6.30pm from Monday-Friday. If a PCT concludes that services are needed outside these hours it would have to go out to tender for their provision.

Performance indicators

3.7 There are no specific performance targets on opening times, but they impact on and are relevant to the access targets referred to in Section 4 below (Appointments).

3.8 Patients' survey

- Locally, 27% of patients (20% UK) were 'put off' by the opening hours
- 44% (30% UK) would like weekend opening
- 26% (29% UK) would like evening opening

Action taken/being taken to secure improvement

3.9 Part of the PCT's approach, in line with NHS policy, has been to extend the range of other primary care services so that, where appropriate, patients can receive treatment without having to go to see their GP. Some of these have already been mentioned above (such as the Walk-In Centre referred to in Section 2.4) and others are detailed in Section 4.

The public's views

3.10 There were 18 comments:

- 5 of these were positive/fairly positive, including
  - "Opening times are good"
  - "We have no problems with…opening times"
  - "Are good but could be better"
- The remainder were more negative:
  - General comments included: "Hours not long enough" and "Inflexible"
  - Several were on the theme that there were "No or less evening or weekend surgeries"
  - Some complained this made life difficult for working people:
    -"[I asked] was an evening appointment possible. 'Oh yes [the receptionist] said, we're open until 5.30 one day a week' And she really seemed to think that 5.30 is late evening." (letter from Dagenham resident)
    -"I work in Central London…so I can never make…the first or last appointments…the surgery does not open on a Saturday either. Every time I need to see the doctor I need to take a half day…or I just wait until any minor problems become more serious." (e-mail from Barking resident).

Health professional's views

3.11 There were 5 comments on this theme from GPs:

- Two on this theme: "Opening the whole day is not the solution. If we were open 24 hours a day, patients would come all day. For emergencies, someone is available 24 hours a day; for routine appointments, morning and evening surgeries are quite sufficient."

- "We work late hours at our surgery"

- "We tried Saturday opening for emergencies, but patients persisted in coming for non-emergency reasons"

3.12 The Practice Nurses Forum identified "restricted opening hours of the surgery" as one of the key issues affecting access to primary care

Suggested improvements

3.13 There were 12 suggestions from the public and 1 from GPs:

- The public suggestions were mostly calls for extended opening hours, including in the evenings and at weekends. Some of these included specific proposals (for example, 9-12am and 2-7pm), based on "flexible working to suit the community." One of the tables at the Wellgate Forum remarked "they vary between doctor – there should be uniformity/core opening hours across the borough."

- There were two suggestions for "specific timespans" in surgeries for specific conditions ("baby only surgeries" and "minor things [like] coughs and colds").

Section 4. Appointments and waiting times

Introduction

4.1 This section looks at appointments and the time patients spend in the waiting room.

The panel's key messages and recommendations

4.2 Key messages:

Appointments are measured by two national performance indicators: the percentage of patients able to be offered an appointment to see (i) a GP within 48 hours and (ii) a PCP within 24 hours. In the last year, there has been a huge, sustained improvement in local performance against these indicators, the first figure rising from 86% to 100% and the second from 65% to 100%. This is the result of extremely hard work by the PCT and individual practices and we congratulate them on their achievement.

Nevertheless, we do have some concerns:

- Our view is that the emphasis should be on patients seeing their usual GP if at all possible. We feel it is hard to overestimate the benefits of continuity: the relationship that builds up between doctor and patient, the GP's detailed knowledge of patients' case histories and so on. However, we rather get the impression that this is not the current thinking in the NHS, not least because the wording of this key indicator is "access to **a** GP" and not "the patient's usual GP."

- One of the issues raised by the public was that, with a number of different appointments systems in operation, the ease of obtaining an appointment varies considerably. The PCT is currently rolling out a best practice toolkit to local practices; we hope this resolves this issue but urge the PCT to monitor progress carefully.

- Due to the way they are worded, the indicators do not count any patient who refuses the offer of a 24/48 hour appointment and chooses to wait. We suggest it might be useful for the PCT to look into this.

In the national patients' survey, 74% of local patients (84%UK) waited less than 30 minutes after their appointment time. The public feedback to our consultation included some positive comments but also complaints that appointments were not kept to time.

4.3 Recommendations

1. That the PCT adopts a policy that patients see their usual GP wherever possible and, with practices, takes action to promote this [November 2004 and ongoing]

2. That the PCT monitors the implementation of the best practice toolkit (the 'Advanced Access Programme') [Ongoing]

3. That the PCT collects figures on the number of patients who refuse a 24/48 hour appointment [December 2004]

4. That the PCT discusses with GPs the latter's concerns regarding the Access Satellite Clinic at Abbey Medical Centre and the Minor Ailments Scheme (see paragraph 4.5 of the main report). [October 2004]

Key facts, performance and other information

Performance indicators

4.4 In the 2002/03 NHS Performance Ratings, local performance against the access targets was as follows

- Access to a GP [% of patients able to be offered an appointment to see a GP within 48 hours]: 86% (target: 87.5% or better)

- Access to a Primary Care Professional [% of patients able to be offered an appointment to see such a professional within 24 hours]: 65% (target: as above)

Note 1: The panel noted that the target refers to access to "**a GP"** rather than "**the patient's usual GP"** and also that, under the nGMS contract, a patient registers with the practice, not an individual GP.

Note 2: The figures are measured by taking a snapshot of performance on one day a month. However, the PCT advises it conducts its own surveys at the mid-point of each month to check performance and works with individual practices to help them maintain 24/48 hour access.

4.5 Since then, there has been a huge improvement (it should be noted that the target is now 100% for both indicators):

- Access to a GP: 100% at March 2004

  (Average from April 2003: 88%)

- Access to a PCP: 100% at March 2004

  (Average from April 2003: 81%)

4.6 Patients' survey

- Locally, 86% visited their surgery or had a home visit in 2002/03 (86% UK) Of these:

  - 24% (29%UK) were seen within 2 days; 15% (10% UK were seen without an appointment)*
  - 66% (58% UK) saw their usual GP
  - 74% (84% UK) waited less than 30 minutes after their appointment time; more didn't have an appointment time

*****Nationally, the drive is towards appointments but, locally, some practices do have open surgeries.

Action taken/being taken to secure improvement

4.7 A large proportion of the improvements to local primary care services are aimed wholly or partly at improving access to a GP or PCP. They include:

- The efforts of GPs and their staff, supported by the PCT, "to ensure that they can provide patients with a routine appointment within the target waiting times…("the nGMS contract places a further emphasis on the waiting time targets and it is envisaged that this will further help…meet the targets)."[29]

- The roll-out of an 'Advanced Access Programme' across the borough in which practices use a best practice toolkit to help them ensure effective and timely access for their patients

- The efforts to enhance the role of practice nurses and other health care professionals to reduce the pressure on GPs (see section 2.2)

- The recruitment and retention initiatives (see section 2.2)

- The LIFT and premises development programmes (see section 2.3)

- Efforts to develop services outside GP practices:

  - The Walk-In Centre at Barking Hospital referred to in section 2.4

  - An 'access satellite clinic' is now in place at Abbey Medical Centre providing patients with an alternative if they wish to see a PCP within the target waiting time. There are nurse-led satellite clinics at Julia Engwell, Annie Prendergast and Ford Road clinics.

    The GPs the Lead Member spoke to argued that the satellite clinic has a limited impact on improving access: to refer patients there, they said they have to diagnose what's wrong with them first and their usual expectation is: "If I diagnose, I treat." The PCT advised that, while there are strict criteria for the conditions that can be treated there, patients can go direct to the clinic and see a GP there if they wish. The Director of Public Health advised that there had been an issue in terms of what types of condition to refer to the clinics.

  - A new minor surgery service became fully operational at Orchards Health Centre in February 2004.

  - The development of a pilot minor ailments scheme under which pharmacists carry out consultations for such conditions, for example where patients can't get access to a practice-based PCP as quickly as they might wish. All local pharmacists and 7 practices are participating in the pilot scheme.

[29] Report to PCT Board on performance against key CHI Indicators (February 2004)

The following minor ailments are covered by the scheme: colds, fever, athletes foot, vaginal thrush, head lice, constipation, diarrhoea, eczema and sore throats. The pharmacists adhere to strict protocols for each of these conditions.

Patient participation in the scheme is voluntary: those who wish to consult a GP must not be discouraged from doing so and if a patient returns to the pharmacist more than a set number of times with the same condition they are automatically referred to a GP as a safeguard.

Patients who are normally exempt from prescription charges do not need to pay for any medicines supplied. Patients who pay prescription charges can either purchase medicines from the pharmacy or pay the current prescription charge (whichever is cheaper). If a prescription charge is paid, the amount is deducted from the professional service payment made to the pharmacist.

The pilot commenced in February. In the first four weeks, 95 patients were referred to 5 pharmacies for a total of 101 ailments. The most frequent type of ailments were colds (21%), high temperature (20%), sore throat (18%) and head lice (17%).

Issues raised during the pilot included inappropriate referral by a receptionist in one practice, the need to streamline paperwork and ensure patient feedback. A patient questionnaire has been developed and is being included in the evaluation of the pilot. The scheme is being rolled out to other practices in May 2004.

The GPs the Lead Member spoke to expressed concern about this initiative. They felt it detracts from the accuracy and continuity of patient records and that, if they received the funding the pharmacists got for providing this service, they could provide an extra nurse in their surgeries. The Director of Public Health added that he and his GP colleagues had concerns about the ailments included in the scheme, which was longer than that in other boroughs, as they had wanted to focus on conditions such as coughs, colds and hay fever.

The public's views

4.8 There were 54 comments (the highest figure for any topic area):

4.9 Appointments (the discussion heading was "appointments and waiting times", so some of the following may also have been referring to the latter)

- Positive/Neutral (roughly 1/3rd):
  - "Excellent service, no long waits"
  - "We have no problems with appointments"[30]
  - "Where no appointment system seen straight away"
  - "Rang at 9am, got appointment for 10, can see nurse within 10 minutes"
  - "Better than used to be. If you want a specific doctor, the wait is around 2-3 weeks. In an emergency, you can always get someone."

[30] Letter from 2 Dagenham residents (both members of the Forum for the Elderly)

- Negative (roughly 2/3rds):
  - There were over 20 complaints about the length of time it took to get an appointment/problems in getting appointments (where quoted, "too long" was between 4 days and 3 weeks")
  - A couple of comments were on this theme: "Different doctors, different systems. Some have no problem getting appointment so why the difference?"

4.10 Waiting times

- Of the 15 or so comments that referred specifically to this issue, over half complained that appointments were not kept to time; where stated, delays were between 20 minutes and 2 hours

- There were 2 positive comments:
  - "Waiting time when in surgery is OK"
  - "6-12 months ago would wait up to an hour. Situation has improved lately as an appointment system has been introduced."

4.11 When Councillors Mrs Hunt and Mrs West visited one local surgery, they were given permission to speak to the patients present (without the doctor in attendance) who were "all highly complimentary of the doctors and how quick their appointments were."

Health professional's views

4.12 Comments by GPs and the Practice Nurses Forum were on the following themes:

- the conflict between access targets and the need to give patients' quality time (referred to in Section 2.2 and in more detail in Section 5 on Quality of Services)

- the pressure caused by GPs' non-medical roles and the problems caused by patients not turning up for appointments (covered in more detail in Section 7 on the Role of the Public).

4.13 The GPs the Lead Member spoke to indicated that the access targets are open to interpretation. "If a patient asks for "an appointment" on a Monday, they might not be booked in until the Friday. If they ask "to see a GP" they would have to be booked in within 48 hours."[31]

4.14 Health professionals' views on the actions being put in place to secure improvement in this area are set out in paragraph 4.7

[31] See 16

Suggested improvements

4.15 There were nearly 20 suggestions, including:

- General calls to cut the waiting time for appointment/in the waiting room and for greater efficiency with the whole process (public)
- "Waiting times - be realistic – don't say 10am, if it's going to be 11am" (public)
- Fining patients who miss scheduled appointments (the public) – comments from the GP Focus Group were "fines…are a good idea" but "given that many patients are unemployed, it is perhaps unrealistic"
- "Restrict social appointments by introducing nominal charge" (the public)
- Introducing different systems:
  - Abandoning appointments in favour of a 1st come, 1st served system (the public)
  - Allowing appointments via e-mail (the public)
  - More use of triage systems (GP Focus Group)
- Stopping people going to the GP for no reason/trivial reasons (public; see Section 7)
- The need to manage GPs non-medical roles (passport applications and so on) and educate patients about their responsibility, for example in turning up to appointments (GP Focus Group; see Section 8 on the Role of the Public)

Section 5. Quality of services

Introduction

5.1 This section deals with the quality of local primary care services.

The panel's key messages and recommendations

5.2 Key messages:

- In the national patients survey, Barking & Dagenham performed poorly on service quality issues: for example, only 61% of local patients had confidence/trust in the person they saw, compared with 76% nationally. In terms of the public comments we received on this issue, roughly 60% were negative. It was difficult, however, to get an accurate picture because the primary care performance targets focus on quantity more than quality; we were pleased to note, therefore, that more quality-based targets are likely to be introduced in the future.

- The introduction of the nGMS contract should lead to improvements in service quality. It includes a 'Quality and Outcomes' framework setting out a broad range of quality based performance indicators and all local practices have signed up to this.

- A further positive development is that a number of local practices have set up patients' participation groups (PPGs). Another step which should improve service quality is that practices are now required to carry out an annual patient questionnaire and are encouraged to feedback the results to PPGs and/or the PCT.

- Something that is immediately apparent from the public feedback is that there are wide variations in service quality locally: on the positive side, we heard about practices which provided an excellent service, taking time with patients, listening to them and responding to their needs. On the negative side, there were complaints about indifference, rudeness, a lack of feedback and inefficiency. In continuing with its improvement agenda, the PCT needs to work with local practices to create and maintain a seamless, unified service across the borough so that patients can expect the same high standard of care and service wherever they go.

5.3 Recommendations:

1. (i) That all local practices establish a patients' participation group to help them identify necessary service improvements (we accept that it may be difficult for every practice, particularly the smaller ones, to set up their own group and that, in these cases, it may be appropriate for two or three practices to "share" one group so they can spread the work between them?). [March 2005]

   (ii) That the PCT supports this process by formulating standard terms of reference for the groups and ensuring adequate reporting lines are in place

between the groups and the PCT, Patients' Forums, Health Scrutiny and so on [December 2004]

2. That practices feedback the results of their patient questionnaires to their PPGs and the PCT as a matter of course [Ongoing]

Key facts, performance and other information

Performance targets

5.4 Most of the primary care performance targets are expressed in terms of quantity rather than quality. While good performance against such targets would be expected to lead to improvements in service quality, the CHI has recognised this is a weakness and is looking to introduce more quality-based targets in the future.

5.5 The overall performance ratings of NHS Trusts are based on these targets and on clinical governance reviews carried out by the CHI. They have a significant influence on issues such as securing investment for local services and the amount of flexibility given to Trusts in deciding how services are provided. NHS Trusts therefore have to maintain a close focus on meeting these targets, with the pressure particularly acute for those that did not perform well in the 2002/03 star ratings; at the same time, they have to ensure that they meet their obligation to seek to constantly improve service quality.

5.6 The PCT's main tool for managing performance is the 'Local Delivery Plan', which is the responsibility of the PCT Board. The Plan includes the key targets referred to in this report (for example: 48 hour Access to a GP) and lists the latest improvements made against these targets (for example: Provision of Satellite Clinic).

5.7 The nGMS contract has a strong focus on quality. It includes a Quality and Outcomes framework setting out a broad range of quality-based performance indicators. For example, these cover how well the practice cares for patients with different conditions, including coronary heart disease, cancer and asthma, and how well the practice is organised, looking, among other areas, at patient records and staff training. Practices receive payment for achievement against the quality criteria. All local practices have signed up to the framework.

Patients' survey

5.8 This covered a number of service quality issues, including:

- 69% of local patients (83% UK) said they were definitely listened to
- 55% (69% UK) said the reasons for their treatment were explained
- 61% (76% UK) had confidence/trust in the person they saw
- 80% (93% UK) were treated with respect and dignity

5.9 Under the nGMS contract, practices are now required to undertake an annual patient questionnaire on the lines of the national survey, choosing one of 2 nationally produced models, and are encouraged to feed back the results to PPGs

and/or the PCT. Some practices already run PPGs to help them identify what improvements are needed; the PCT can provide support to these groups and is working with practices to develop new ones.

Action taken/being taken to secure improvement

5.10 All the improvements listed in the report are intended, directly or indirectly, to improve service quality.

The public's views

5.11 There were 52 comments, 14 positive, 31 negative and 7 neutral, including:

- On the positive side:
  - "GP is very good and takes time with patients"
  - "Excellent service"
  - "Good listener"
  - "Responds to need"
  - "Cannot be faulted"
  - "All GPs seem to know their job, a few are very good at explaining things to their patients"

- Neutral:
  - "Experience varied from excellent to disgraceful"
  - "Varies from surgery to surgery (and doctor to doctor)"

- On the negative side:
  - "Attitude of GPs to all, seem to be in a hurry"
  - "Not enough time to explain: get the feeling you're being shunted out"
  - "5 minutes with doctor not enough"
  - "Never get to see the same doctor (no relationship)"
  - "No feedback/follow-up"
  - "Indifference in the service"
  - "Elderly patients not well catered for"
  - "No choice, i.e. female doctor"
  - "Language problems: some senior citizens have difficulty being understood by GPs whose first language is not English"
  - "OAPs feel they cannot hold a conversation (fear factor)"

Health professional's views

5.12 The issue of ensuring adequate time for consultations was raised by both GPs and the Practice Nurses Forum (see section 2.2). The latter also identified "quality issues" as one of the main challenges they face. One of the new quality markers for practices is average consultation times of 10 minutes.

Suggested improvements

5.13 There were 35 suggestions, all from the public, including:

- Quality:
  - "GPs' communications skills need to be improved"
  - "Surgeries should be on a rating system, 1-2-3 star"
  - "More feedback", "satisfaction surveys"
  - "Continuity of doctor on case"
  - "Better co-operation between doctors"
  - "Easier access to doctor by phone"
  - "Solve linguistic/accent problem"
  - "Better, slicker systems"
  - "Better, updated IT"
  - "Use modern communications. The postal service for instance"

- Extent:
  - Preventative services including "well-man and well-woman clinics for under and over 50s every five years", "routine check-up for people at retirement age" and "regular blood tests"
  - "More clinics such as Fanshawe"
  - "More services offered by GP practices", "specialised services"
  - "More facilities – blood tests, medicine, dispensing minor drugs"
  - "Provide natural remedies – within the law"

Section 6. Receptionists (focusing on training)

Introduction

6.1 This section looks at the issue of receptionists, focusing on training.

The panel's key messages and recommendations

6.2 Key messages:

- Practices are responsible for staff training and development, with the PCT providing a supporting role. In the national patients' survey, 21% of local patients (16% nationally) rated receptionists' courtesy from "fair" to "poor." The comments from the residents we spoke to ranged from "receptionists are wonderful" to "receptionists are stand off-ish and gas to each other." On the common complaint that "you can't get by the receptionist", the GPs commented that "it's not their fault - we are simply too busy to take more appointments." GPs and the public alike commented on the rudeness receptionists sometimes have to put up with from patients. A number of comments referred to the difficulties stemming from the volume of telephone enquiries. Suggestions included customer care training/guidelines for receptionists.

- We recognise that, as one resident put it, "receptionists have a lot to go through and a difficult job." We feel that they would benefit from further support in terms of training and guidance; something must also be done about the telephone situation.

6.3 Recommendations:

1. That all practices ensure they have proper arrangements in place for the recruitment and induction of receptionists (including a job description, person specification, formal interviews, references and induction programmes) [December 2004]

2. That all practices send their receptionists on a recognised customer care training course, unless they have recently attended one, and ensure their training is kept updated [March 2005]

3. That the PCT produces customer care guidelines for distribution to all practices (or, if there is something readily available, distributes this immediately) [December 2004]

4. That the PCT and practices review the comments made about telephone enquiries and take appropriate action [November 2004]

Key facts, performance and other information

6.4 In April 2004, there were 294 reception staff in Barking & Dagenham (133 wte)

6.5 As mentioned in section 2.2, practices are responsible for their staff training. Under the nGMS contract, this has to be provided to a specified standard. The PCT's role is to give support by providing some courses and working with practices in setting up and implementing Practice Development Plans.

6.6 In the Patients' Survey:

- 21% of local respondents (16% UK) rated the courtesy of receptionists from "fair" to "poor."
- 25% were unhappy that others could hear them at reception (18% UK)

Action taken/being taken to secure improvement

6.7 The ongoing work is described in paragraph 6.5. There was a practice staff training course on communications in December 2003 (nearly 40 staff attended).

The public's views

6.8 There were 11 comments:

- "Receptionists are wonderful"
- Receptionists are "rude", "stand off-ish, gas to each other", "often impolite", "charmless"
- "Receptionists have a lot to go through and a difficult job – difficult customers who are often downright rude to them"
- "Difficult to get past receptionist" (one of five similar comments)

Health professional's views

6.9 There were 10 comments from GPs:

- Receptionists:
  - "The days of the 'dragon' have gone. Most receptionists are good, although the picture may not be rosy everywhere."
  - "A common complaint is that 'you can't get by the receptionist.' It's not their fault – the doctors are simply too busy to take more appointments/patients."
  - "Receptionists get a lot of rudeness from patients"
  - "In some practices there is not a lot of communication between receptionists and GPs"
  - On the issue of receptionists keeping patient confidentiality – "the restricted space and/or open-plan set up of some practices does not help."
- The telephone:

- “If they’re not answering the phone, it’s because they’re already on it”
- “Some surgeries have ISDN [Integrated Services Digital Network telephones] – this gives them more lines, but not more staff to answer them!”

- Training for receptionists:
  - “Practices often end up having to pay up front for this as the necessary monies take time to come in from the PCT”
  - “There is a lot of training: updates, practice meetings”,
  - “The majority of practices have induction (communications, confidentiality and how the service works)”

Suggested improvements

6.10 There were 8 suggestions from the public and GPs:

- “Customer care training”
- “Guidelines to receptionists”
- “Do need to be more courteous.”
- “Better confidentiality”
- “Do something about overload on telephone system – have a receptionist dedicated to the telephone/arrange staff accordingly”

Section 7. Public information

Introduction.

7.1 This section summarises the views of health professionals and the public on the issue of information for the public on primary care services.

7.2 Responsibility for providing this information is shared by the PCT and practices. The PCT produces a wide range of published information, both in leaflet form and on its website and there is a Health Information Shop at its headquarters in Barking Town Centre.

7.3 Practices have a statutory responsibility to provide information on the services they provide. Many of them have produced practice information leaflets and others have set up websites. The PCT's role is to ensure practices meet their responsibilities and it can provide associated guidance and support.

The panel's key messages and recommendations

7.4 Key messages:

There were only a few comments and suggestions on this topic. These included calls for better publicity, including information on opening times and so on, and a suggestion that an article be included in The Citizen each month focusing on a particular health issue or service area.

7.5 Recommendations:

1. That the PCT and practices include regular articles on their services in The Citizen (although their services are outside the scope of this review, we suggest BHRT and NELMHT do the same). [Ongoing]

2. (i) That GP practices and other primary care facilities provide clear information to the public on the following

   (a) opening and consultation times (in addition to the places recommended under (ii), these should be clearly displayed outside the building)

   (b) any charges levied for services (in addition to the places recommended under (ii) these should be clearly displayed at reception)

   (c) the quality standards that they are aspiring to achieve under the Quality and Outcomes Framework

   (d) other key information on their services, including arrangements in place for appointments, repeat prescriptions and so on

   (ii) That this information be made available to the public through a variety of methods, including practice leaflets, notice boards and websites, and in appropriate languages and formats (e.g. Braille, audio tape, large print and so on)

(iii) That GP practices ensure they are fulfilling their obligations under the Freedom of Information Act and

(iv) That the PCT monitors progress with (i), (ii) and (iii) and provides guidance and support as necessary, particularly in terms of the provision of information in appropriate languages and formats

The public's views

7.6 There were two comments from the public:

- "Appearance of waiting areas; out of date notices"
- "Lack of information on services available"

Health professional's views

7.7 The Practice Nurses Forum referred to "patient awareness of services provided" as a key issue affecting access to primary care and as one of the challenges the service faces.

Suggested improvements

7.8 There were four suggestions from the public, including:

- "Better publicity/more leaflets for local health services – more information on the leaflets (e.g. key info – opening times)"
- "One page in the Citizen giving health information – focus each month on a particular area"
- A newsletter
- "Self help material leaflets, books, diet sheets etc should be available. Prevention is better than cure"

Section 8. The role of the public

Introduction

8.1 One of the themes that emerged during the review is that the public have an important role in helping to improve access to primary care by making appropriate use of services. This section looks at some of the comments and suggestions on this theme and also on that of the “non-medical” roles of GPs (filling in passport applications and so on).

The panel’s key messages and recommendations

8.2 Key messages:

1. The role of the public. We all have a role to play in helping to ensure local primary care services run smoothly by acting responsibly and making appropriate use of them. The health professionals we spoke to emphasised this repeatedly - complaining about problems caused by patients not turning up for appointments, insisting on seeing the doctor when they could be treated equally well by the practice nurse and so on. The public also recognised the problem, one resident talking about "people who go to see a doctor and just need an aspirin."

   We have made a number of recommendations on this issue to the PCT, but would like to take this opportunity to make a direct plea to the public to heed the above message and the following advice:

   - If you cannot make your appointment, please let your practice know. This is not just a matter of courtesy. If you simply fail to turn up, at best someone else in the waiting room will take your place but, at worst, you may be denying someone else the care they need.

   - Please do not visit your primary care practice unless it is necessary. You should of course consult your GP if you are in any doubt, but if, for instance, you have a minor condition such as a cough or a cold, there are a range of other services available to you (for instance, your local chemist or NHS Direct).

   - When you visit your practice, please let the appropriate professional deal with your case. Unless it is absolutely necessary, do not insist on seeing a GP if, for instance, you can be treated by the practice nurse or the receptionist can arrange for your prescription, otherwise you are just adding to their burden unnecessarily.

2. The "non-medical" work of GPs. By this, we mean activities like signing passport applications and filling in non-medical forms on behalf of patients; one of the GPs we spoke to also commented about the time taken up from having to contact Council services for his patients. The first issue with this is the additional burden it places on GPs. Some GPs charge for this work; we would like to see greater transparency in relation to these charges.

8.3 Recommendations:

1. The role of the public:

(i) That the PCT, working with practices and their public participation groups, devises and implements an ongoing public information campaign to encourage appropriate use of primary care services [November 2004 and ongoing]

(ii) That the Council supports the above by offering space in The Citizen and slots at Community Forums. [Ongoing]

2. GPs' "non-medical" work:

(i) That the Head of Customer First and the PCT investigate what they can do to alleviate the burden of GP's non-medical role. We feel the Council should be able to deal with the Council-related queries currently being referred to GPs, that the PCT may be able to deal with more issues centrally (for example, through the Health Information Shop and Patient Advice & Liaison Service (PALS)) and that the Voluntary Sector also has an important role to play. [November 2004]

(ii) That the PCT recommends the Local Medical Committee to encourage local practices to formulate and then sign up to a standard, local list of charges for "non-medical" work. The agreement should also cover associated administrative arrangements (for example, the issue of receipts for such work). The PCT would then publish the list of charges and the details of the practices who had signed up to it. [October 2004]

The public's views

8.4 There were six comments including:

- "People missing scheduled appointments"
- "Abuse of system by patients e.g. people who go to see a doctor and just need an aspirin"

Health professional's views

8.5 There were around 15 comments from GPs, including:

- "Patient's attitudes need to be improved"
- "People don't turn up for appointments"
- "In my surgery, non-attendances run at 30-40 per week"
- "Patients need to be educated, especially in terms of unnecessary consultations ("I had a cough in the night, but it's gone etc)"
- "People should see the practice nurse where appropriate, but some want to see their doctor whatever their condition"

- "Patients often aren't prepared to see another doctor at the practice if their GP is unavailable"

The GPs visited by panel members commented on the pressures of their non-medical roles, one of them speaking about the time taken up from having to contact Council services on behalf of his patients.

Suggested improvements

8.6 There were around 10 suggestions from the public and GPs, including:

- Patient role:
  - Fines for patients who do not keep appointments (public and GP Focus Group) – some GPs questioned whether fines are realistic "given…that many patients are unemployed."
  - "Stop people going to GP for no reason/trivial reasons – put more notices in surgeries to this effect" (public)
  - Need to educate patients to take more responsibility for their health/ helping the system to run smoothly (GPs/Practice Nurses Forum)
- Non-medical role:
  - "Restrict social appointments by introducing nominal charge (public)"
  - An adviser from the Council should make regular visits to surgeries to pick up on patients' concerns regarding Council services (GP)

Section 9. Prescriptions

Introduction

9.1 This brief section summarises the comments made by the public and health professionals on the issue of prescriptions.

The panel's key messages and recommendations

9.2 Key messages:

There were only a few comments on this issue from the public, mostly negative - with complaints about long waits for repeat prescriptions and associated bureaucracy. The GPs complained that patients sometimes don't help, for instance by insisting that their GP fills out their prescription when this could quite easily be arranged by the receptionist. Under the Quality & Outcomes Framework, the target turnaround for prescriptions is 48 hours.

9.3 Recommendations:

1. That practices carry out an annual check of all long-term prescriptions to ensure their continued effectiveness [Ongoing]

2. That the PCT looks at the possibility of introducing a credit-card style system for prescriptions as used in a well-known high street chemist [December 2004]

The public's views

9.4 There were 10 comments, including:

- "Why so long wait for repeat prescriptions?" (1 of 3 comments on this theme, with waits from 2-4 days)
- "Flexible prescription system"
- "Prescribed cheap drugs" (1 of 2 comments on this theme)
- "While this is not the case in every surgery, there are so many rules and regulations around prescriptions etc and a lack of humanity" (Access Group)

Health professional's views

9.5 There were two comments from GPs:

- "Where there are streamlined prescription systems, some patients upset it"
- "Prescriptions could be done by the receptionist. However, the GP ends up having to do it at the patient's insistence"

Suggested improvements

9.6 There were five suggestions from the public, including:

- Partnerships between GP practices and pharmacies
- “Faster”, “separate system for repeat prescriptions”
- An annual check of all long-term prescriptions to ensure their continued effectiveness

Section 10. Referrals, tests and results

Introduction

10.1 This brief section looks at the issues of referrals, tests and results, focusing mainly on the comments of health professionals and the public.

10.2 In the Patients' Survey, 22% of local respondents were given choice about where to be referred (25% UK)

The panel's key messages and recommendations

10.3 Key messages:

The feedback from the public and health professionals is that, too often, these processes take too long and are hampered by 'red tape.' Practical problems were raised too; for instance, if you are living alone and are feeling too unwell to leave your home for a few days, how are you supposed to get your sample to hospital?

10.4 Recommendations:

1. That the PCT generally reviews and addresses the concerns/suggestions put forward on this matter in conjunction with BHRT and other relevant NHS bodies [December 2004]

2. That the PCT specifically:

   (i) pursues the suggestion raised by the Practice Nurses Forum that nurses be empowered to make referrals where appropriate (we have been advised that this is already possible in some cases) [November 2004 and ongoing]

   (ii) investigates and reports back to GPs (and the panel) on their complaint that they are being asked to double-check the need for referrals with hospitals even when they know these are necessary [November 2004]

   (iii) finds a solution to the problems faced by patients living at home on their own, one of which is referred to under "key messages" above (one possible solution might be home testing) [November 2004]

The public's views

10.5 There were 12 comments, including:

- "Delays for treatment: 1 year for physiotherapy appointments"
- "Delay in results getting back to GPs: delayed treatment results; testing can take very long"
- "5 months for a scan"
- "Results of test were available in 2 weeks – took two months to get appointment"

- "Communication between hospitals and GPs (papers misplaced)"

Health professional's views

10.6 There were 4 comments from GPs:

- "It takes too long to process patients through secondary care and there are too many stops on the way"
- "Referrals for acute conditions are OK. The problem is with other conditions, e.g. for arthritis pain – the letter to the hospital, the long wait for a response, the waiting list."
- "Sometimes not allowed to make referrals directly as funds not available and have to check need for referral with hospital, even though you know it's necessary."
- "Some patients want to see a specialist or want a referral letter without letting their GP try to treat them first – this causes delay, delay, delay!"

Suggested improvements

10.7 There were 4 suggestions:

- "Quicker blood test result – London hospitals turn round results in 1 hour, locally it's at least 5 hours" (public)
- "GPs should be able to refer patients directly to physiotherapy" (public)
- "The process needs to be shortened/made smoother" (GP Focus Group)
- "Nurses able to refer" (Practice Nurses Forum)

Section 11. Home visits and out-of-hours services

Introduction

11.1 This brief section summarises the views of the public and health professionals on home visits and out-of-hours services. The panel feels that it would be beneficial for health scrutiny to look at these areas in more detail at a later date.

11.2 Under the nGMS contract, the PCT is able to take over out of hours services from those GPs who no longer want to provide 24 hour care.

The panel's key messages and recommendations

11.3 Key messages:

Barking & Dagenham scored poorly on these issues in the national patients survey: only 7% of local residents who contacted their surgery out of hours got a home visit, as against 14% nationally, and 59% (46% UK) were unsatisfied with the out of hours assistance given. The public's feedback to the panel was also largely negative, with a number of complaints about difficulty in obtaining and being refused home visits. Home visits are not, however, always necessary: many issues can be managed appropriately over the telephone.

11.4 Recommendations:

That all practices reflect on how far the comments made by the public apply to them and make any necessary improvements and that the PCT supports them with this as necessary [October 2004 and ongoing]

Patient's Survey

11.5 Roughly 1 in 5 respondents tried to contact their GP surgery out of hours (the same as nationally). Of these:

- 19% of local respondents (19% UK) didn't get through to anyone
- 7% got a home visit (14% UK)
- 20% got told to attend the surgery when it opened (14% UK)
- 59% (46% UK) were unsatisfied with 'out of hours' assistance given

The public's views

11.6 There were 15 comments, two positive and the others negative:

- "Good, quick home appointments"
- "Some doctors very willing to come out, especially for the elderly"

- "Problem with getting home visits – critical for elderly people", refusal to do home visit by doctors", "locums refuse outright to come out" (9 comments in all on this theme)

- "Lack of attention when home visits call out"

- "Phone requests for home visit – patients are told to go to hospital"

Health professional's views

11.7 None

Suggested improvements

11.8 There were three suggestions from the public, two proposing that their practices have a rota with one doctor on home visits at any one time.

Section 12. Locums

Introduction

12.1 This brief section summarises the views of the public and health professionals on locums. The panel feels that it would be beneficial for health scrutiny to return to this area in more detail at a later date.

The panel's key messages and recommendations

12.2 Key messages:

There are two key issues here. First, we have been advised that too many locums are being used at any one time: like any "agency" cover they cost more than a permanent GP and their use can adversely affect the continuity of patient care; it is hoped that this will become less of an issue as the shortfall in GPs is reduced through the recruitment and retention strategy. Secondly, we have been told that locums do not provide the same level of service as GPs: for instance, they will not, for the most part, undertake home visits; this is an unacceptable situation - if you buy in cover you need it to include the whole service - and means that local residents are being denied the service they need.

12.3 Recommendations:

That the PCT and practices work together to ensure that locums cover the whole service provided by the GP they are being brought in to cover [November 2004]

The public's views

12.4 There were four comments, including:

- "No weekend/evening cover for surgeries"
- "Frequent changes of doctor (too many locums)"
- "Problem when 1 GP is on holiday; no locum steps in"

Health professional's views

12.5 There were two comments from the GP Focus Groups:

- "Too many locums"
- "Locums won't do housecalls"

Suggested improvements

12.6 None.

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THE EXECUTIVE

3 AUGUST 2004

REPORT FROM THE DIRECTOR OF REGENERATION AND ENVIRONMENT

REGENERATION BEST VALUE REVIEW IMPROVEMENT PLAN: QUARTERLY PROGRESS REPORT	FOR DISCUSSION

This report is for the Executive as it deals with issues of a strategic nature.

Summary

This is the first progress report on the implementation of the Regeneration Best Value Review Improvement Plan. The key conclusions are:

- Good progress in improving project delivery and policy focus, including the restructuring of regeneration activities, the establishment of the Regeneration Board and greater policy congruence with the Community Strategy. Further work is needed to agree and disseminate the Regeneration "Vision;
- Progress in promotional, lobbying and influencing work and work underway to raise the Council's game around the Barking Town Centre programme and to meet the challenge of the UDC's establishment;
- Good progress with the regeneration of Dagenham Dock. We have developed an Action Plan to coordinate and monitor the implementation of the Economic Development Strategy;
- Steps to embed a culture of design excellence in the borough and the securing of Sustainable Communities Fund resources to improve the public realm in Barking Town Centre;

Implementation delays have been caused by restructuring or recruitment difficulties in Regeneration, Planning and Lifelong Learning. There is some risk that these may continue to delay or constrain implementation.

Recommendation

The Executive is asked to discuss these findings and to agree the report.

Reasons

Implementation of the Improvement Plan is critical to the Community Priority of Regenerating the Local Economy.

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1. Background

1.1 Last year's cross-cutting Best Value Review (BVR) of regeneration resulted in a comprehensive Improvement Plan covering all Council Directorates. The Executive agreed the Improvement Plan on 17th February 2004 and asked for quarterly reports on its implementation. The attached matrix (Appendix 1) reports on progress towards each of the Implementation Plan's twenty targets.

1.2 Implementation of the Improvement Plan is being monitored by Regeneration Implementation Division, overseen by the Regeneration Board. The Board has corporate ownership of the Review and of the Balanced Scorecard for Regeneration, for which the delivery of the Improvement Plan is an underlying objective. The quarterly reports to the Board form the basis of the reports to the Executive and other Council bodies, including the BVR Member Challenge Panel, Scrutiny Management Board and Corporate Monitoring Group.

1.3 The Improvement Plan is divided into six sections. Significant achievements and delays are summarised below for each section.

2. Achieving Step Change

2.1 We have made good progress with the restructuring of regeneration activities, the establishment of the Regeneration Board and policy congruence with the Community Strategy. We are taking forward work to improve project management systems and to agree social infrastructure needs with partners. We need to do more to enable Members to engage with external partners, get closer to primary stakeholders in business and the community, and step up our influencing and lobbying work. Completing and agreeing the "Vision" for Regeneration is the most urgent priority.

3. Education

3.1 We have undertaken or commissioned surveys of employment land use and patterns of recruitment in the borough and secured NRF funding for a package of support for business and skills development in Barking Town Centre. However, progress towards other milestones has been delayed by restructuring in the Lifelong Learning Division and by delays in external bodies releasing funding.

4. Jobs and economy

4.1 We have made significant progress in the development of Dagenham Dock as a focus for environmental technologies and have strengthened our support for social enterprises. A number of activities have helped the Council get closer to business stakeholders. We have developed an Action Plan and reporting matrix for the implementation of the Economic Development Strategy (EDS). We are making progress against most objectives in the EDS, but some further project planning may need to be done by the new Group Manager for Economic Development on arrival. Recruitment delays for this and other posts in Economic Development have added to implementation delays, particularly around actions to improve our ability to access European and other external funding streams.

5. Transport

5.1 A Strategic Transport Group and Champion have been appointed. The Council has undertaken lobbying work around the DLR extension and East London Transit and we have taken forward the Renwick Road proposal. Recruitment difficulties are likely to delay achievement of some milestones, including the development of a Transport Strategy.

6. Housing

6.1 The housing needs survey and Housing Futures Appraisal are underway. The Charlecote Road project, the first to incorporate our policy on space for learning has won a number of design awards. The main priority here is to step up our marketing work to private sector housing developers in Barking Town Centre over the summer and autumn of 2004.

7. Distinct Environment

7.1 A Design Champion and a Project Manager for the Parks and Green Spaces Strategy are in post. An Action Plan for the Parks and Green Spaces Strategy has been adopted and the Regeneration Board agreed a Design Framework for the borough in March 2004. £2 million from the Sustainable Communities Fund was secured in January 2004 for the implementation of the Public Realm Strategy.

8. Financial Implications

8.1 This is a progress report on the implementation of the agreed Improvement Plan. There are no financial risk or implications for the Council. Finance Department is content with the report.

9. Consultation

9.1 The report was compiled from contributions by officers in: Regeneration and Environment; Education, Arts and Libraries; Corporate Strategy; Social Services; and Housing and Health. It was discussed by the Regeneration Board (TMT and the Lead Member for Regeneration) on 29th June.

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SECTION 1 – ACHIEVING STEP CHANGE IN REGENERATION				
Target		**Action**		**Update**
1	Improving Project Delivery	1.1	Restructure the internal regeneration function to give a single division responsible for regeneration implementation	Achieved. Following consultation with staff and Unions, the Executive agreed the restructuring of regeneration activities in October 2003. The new structure, which created unified Divisions for Regeneration Implementation and Strategic Planning and Transport, came into effect in November 2003. The new posts were advertised in March 2004.
		1.2	The establishment of the Regeneration Board to commission, monitor and evaluate all regeneration projects	Achieved. The Regeneration Board held its inaugural meeting on 25th November 2003. Under its terms of reference it is responsible for all strategic policy issues relating to regeneration and for monitoring the implementation of regeneration programmes. Assisted by the Urbancanda consultancy, the Board reviewed its modus operandi in April 2004.
		1.3	The re-organisation to include a strengthened capacity for project management in line with the Council's improved approach to asset management, including CPMO project management standards	Underway. A dedicated team has been created within Regeneration Implementation Division to work on this issue. The Division computerised its project monitoring information in the first quarter of 2004. The Division is currently working with consultants BPP and SQW to agree new project management and monitoring arrangements, consistent with the Council's CPMO systems. These will be rolled out first in Barking Town Centre, but will apply to all regeneration projects in due course. The Divisional Training Plan makes project management training its key priority.
		1.4	Ensure improved planning performance and lobby for better legislation	Underway. The Division has completed the review of staffing structures to ensure the delivery of change in planning, secured increased delegation in Development Control, introduced two-weekly Development Control Board meetings and is in touch with GoL to review UDP processes to reflect emerging LDF frameworks. Work is ongoing to amend the UDP review process to reflect emerging LDF frameworks and to review administrative processes in DC to enable prompt delivery of decisions to meet the new PIs. The Division also has work in progress to gain ISO 9000 accreditation in DC to support service delivery and to reinforce management and monitoring systems to provide early warning of potential slippage in performance. The Division has yet to submit to the Executive to enable CPO powers to be used in support of regeneration activities and also intends to increase levels of survey work to support statutory plans and policies.

2	Creating a tighter focus on priorities	2.1	The community strategy will be redrafted – incorporating the Regeneration Strategy and Neighbourhood Renewal Strategy	Achieved. The new Community Strategy, "Building Communities Transforming Lives" was launched in April 2004 and incorporated the regeneration and Neighbourhood Renewal Strategies. It is supported by a comprehensive handbook and a performance management framework (PMF). The PMF includes and is consistent with the BVR Implementation Plan and the Balanced Scorecard for Regeneration Implementation.
3	Creating a Shared Story or Vision for Regeneration	3.1	To create ownership within the Council on a shared vision for Regeneration in Barking and Dagenham	Underway, but completion has been delayed. Two workshops for staff, facilitated by Urbancanda, were used to help develop a comprehensive vision for regeneration in Barking and Dagenham. The draft Vision was discussed by the Regeneration Board in April 2004 and further work was requested. An amended draft has been put to the July Regeneration Board.
4	Making the Most of Funding Opportunities	4.1	Establish a more effective approach to funding opportunities that meet our strategic needs	Delayed. A European Funding Officer was appointed in May 2004, but has yet to take up post. Work has not yet been undertaken to develop a Funding Action Plan.
		4.2	Enhance capacity for funding from the private sector, in particular from S106 of the Town and Country Planning Act 1990	Delayed. "Prospectus mapping" of spatial and land use needs is underway and should now be completed by July 2004. Officers are having separate discussions with English Partnerships regarding alternative ways of achieving "Section 106 type" requirements spread out over the lifetime of the development project.
5	Increasing External Profile and Influence	5.1	Enable Members to engage with external partners more frequently	Underway, but some milestones delayed. A timetable for Members' Briefing has been agreed for 2004-05. The first event - a pre-Assembly briefing on Barking Town Centre – was held on 23rd June 2004. New arrangements have been put in place to provide co-ordinated briefing for the Lead Member for Regeneration.
		5.2	Understand emerging relevant Government policy initiatives and raise issues with Local MPs	Achieved. Officers have submitted to the Regeneration Board/Executive on relevant Government policy initiatives including the ODPM/HMT business incentive scheme and the Government's proposals for the London Thames Gateway UDC. There has been regular liaison with MPs and the GLA Member over transport issues in particular.
		5.3	Require a broader range of senior officers to engage more pro-actively with external partners and others around the Regeneration Agenda	Limited progress. More work is needed to co-ordinate activity by senior officers on the lines set out in the Implementation Plan. This should be facilitated by the inclusion on the Regeneration Board agenda of a standing item for discussion of "key messages".
		5.4	Create an influencing plan at the start of all major projects and monitor through the Regeneration Board	Limited progress. Major project plans contain consultation programmes and stakeholder analyses, but projects do not as yet have influencing plans for external partners or the media. This will be done on a programme basis for Barking Town Centre through the BTC Partnership and for all projects through the Influencing Plan Steering Group

6.	Getting closer to primary stakeholders	6.1	Improve consultation and participation for local residents	Underway. Consultation with local people on a project basis is good and we have just initiated consultation around the Interim Planning Guidance (and other planning briefs) and Equal Opportunities Impact Assessment for Barking Town Centre. We want to supplement this with more strategic contacts and are developig a programme for stakeholder meetings, including regular reporting to Community Forums. As part of the LDF process, we will be preparing a Statement of Community Involvement that will help coordinate the Council's consultation on planning and regeneration issues. Community consultation and capacity building is also a key issue in our discussions with the incoming UDC.
		6.2	Establish a bi-annual Business Forum	Limited progress towards a "Forum" of this kind, although our contacts with business on an issue and area basis are improving. Meetings with employers in the Dagenham Dock area are now being supplemented with meetings covering Thames Road. Estate associations are gradually being established. The LBBD Business Partnership (dealing with regulation) is now an established fact. We believe it may be more useful to build credibility with local businesses by developing area forums than seek to establish a single Business Forum for the borough, at least in the short term.
		6.3	Develop and implement a Regeneration Communications Strategy	Underway. The Regeneration Board agreed an Influencing Strategy for regeneration activities in April 2004. A Marketing/Communications post was advertised in March but the standard of applications was too low to appoint. Corporate Communications and Regeneration are discussing alternative staffing arrangements to ensure implementation of the strategy.
		6.4	Organise a community regeneration convention	Underway. We have significantly strengthened our relationship with community umbrella organisations during this period, including with EMPA and CVS. We are about to start preliminary discussions with partners on a Community Regeneration Convention.
7.	Improving information and knowledge	7.1	Ensure effective access to funding, influence and information through supporting professional development and developing a best practice programme	Underway. The Division has held internal discussions on professional development and the conclusions incorporated into a Divisional Training Plan. The Division's team meetings consider conference invitations on a regular basis. It remains to pull these elements together into the annual programme as defined in the Implementation Plan.
		7.2	Enhance the use of e-government capacity, with an explicit objective of creating a virtual development and investment one stop shop	Milestones out of report period.
8.	Balancing Social and Physical Regeneration	8.1	Further develop the strategic partnerships in place with the Primary Care Trust (PCT) and the Strategic Health Authority in relation to reducing ill health and increasing life expectancy within the borough via economic inclusion measures	Underway. A Regeneration Manager has been recruited in Social Services and is part of the Director of Regeneration and Environment's strategic programme management meeting. This group also includes the PCT. A social regeneration programme has been drafted and submitted to the Regeneration Board.

		8.2		Ensure that social and community facilities are included in major regeneration projects as a prerequisite for them commencing	Underway. Although the milestones are out of this report period, the issue has risen to the top of the regeneration agenda. Work is underway with partners to agree the statistical basis for the facilities needed, including convening a population "summit" with partners if necessary.
SECTION 2 – EDUCATION					
9.	Improve the levels of qualifications of residents	9.1		Analyse patterns of recruitment and consult on participation, provision, retention and achievement. Continually benchmark data against national best practice. Identify and fill gaps in existing provision.	Pilot audit activity underway. Priority assigned by the Education sub-group of the LSP on 17 December to the use of NRF to fund an extended project using external consultancy. Sub-group awaiting confirmation of date from the NRF project appraisal panel for funding to provide for consultancy support. Neighbourhood Renewal Fund monies have only recently been confirmed to fund consultancy work on this proposal. A range of information from the Index of Multiple Deprivation 2004 has recently become available that will also be utilised to inform this work. When the work is completed it will be disseminated through a range of networks, including the Better Education and Learning for All LSP Sub-Group (which approved the NRF funding) and the Voluntary Sector Training Providers Network. It will also be used to support external funding applications.
		9.2		Identify opportunities with residents and employers to link employees informal/recreational learning into routes leading to accredited qualifications	Underway. We are awaiting a staff appointment to the lifelong learning division in order to commence the outreach work NRF funding, recently confirmed, will see the production of a directory listing courses and qualifications in the borough. The Jobnet project (job brokerage) will have a dedicated base in the borough from June 21 2004, co-located with Barking College and the University of East London advice shop in Vicarage Fields, Barking. This will be used to promote local provision. NRF funding will support a range of community-based events in Abbey and Gascoigne wards (the two wards with the highest unemployment), with funding available to overcome the barriers to learning and employment that cannot be met from other funders. This will be delivered in partnership with Jobcentre Plus, who have dedicated funds targeted at these wards, and the East Thames Information, Advice & Guidance network. Links to the hardest to reach groups/communities will be taken forward through the borough's Voluntary Sector Training Providers Network and Welfare to Work for Disabled People Steering Group. Barking and Dagenham Training Services are approved providers for the LSC's Profit from Learning initiative in the care sector. This supports employees to secure Level 2 qualifications.

		9.3		Increase access to and marketing of learning opportunities throughout the borough	Delayed. We have secured endorsement by the Education sub-group of the LSP for NRF money to fund the design, evaluation and circulation of publicity materials. We are awaiting confirmation of dates from the NRF project appraisal panel to confirm funding for consultancy support. NRF funding has only recently been confirmed to design and produce targeted publicity materials. These will be marketed through partners in the Better Education and Learning for All LSP sub-group, Training Providers Network, Welfare to Work for Disabled People Steering Group, and work in Abbey/Gascoigne with local partners.
		9.4		Ensure employers link employees' informal/recreational learning into routes leading to accredited qualifications and encourage advanced learning opportunities in further and higher education	Delayed. We are awaiting staffing appointment to lifelong learning division in order to commence outreach work principally with small and medium business enterprises
		9.5		Ensure the barriers such as finance, childcare and access to HE are minimised	Delayed. A revision of staffing structure within the lifelong learning division is pending, which will address progression issues to higher education for adult learners.
		9.6		To improve training and guidance services	Delayed. Achievement of this target is dependent on completion of the analyses in 9.1
		9.7		Identifying and filling gaps in learning provision for adults	Delayed. Achievement of this target is dependent on completion of analyses in 9.1. NRF funding has only recently confirmed to fund a consultancy to collate information relating to learning provision. Information on basic skills provision has recently been received through the Adult Basic Skills Initiative from LSC London East. Collaborative funding bids are to be co-ordinated within the voluntary sector by the Training Providers Network. Joint work/bids will also be taken forward through the Better Education and Learning for All LSP Sub-Group, where partners are scheduled to receive regular updates on funding (especially European Social Fund co-financers) from Regeneration officers.
10.	Increase the average income in B&D households	10.1		Widen the scope and work of the Education Business Partnership	Delayed, pending the revision of the staffing structure within lifelong learning.
		10.2		Map the key features of the local workforce and businesses, and in consultation with key business support agencies	Underway. The URS survey of employment land use in Barking and Dagenham has been produced and shared with partners. We are discussing with partners how this relates to workforce development needs.
11.	Reduce the digital divide to ensure local people have access to ICT resources	11.1		To ensure training is available when ICT access projects are provided in existing and new accommodation	Delayed, as achievement of this target is dependent on completion of analyses in 9.1. The Gascoigne project for community champions is underway, with machines installed and training underway.

		11.2		Implement the home and community learning strand of the TestBed programme to access 5000+ homes in the borough and link to 'Wiring up the Gascoigne' project	Underway. The Adult Basic Skills Initiative is acting as an independent broker to liaise between Test Bed schools and providers. Borough software has been installed at Ripple Junior. At Manor Infants - ESOL and literacy developments. We are working with Barking College content workshop to make ABSI literacy and numeracy materials interactive and available to all Test Bed schools.
SECTION 3 – JOBS AND ECONOMY					
12.	To implement the Economic Development Strategy	12.1		Develop and agree action plan with milestones and targets	Underway. A reporting matrix has been developed and we undertook a first monitoring exercise on implementation of the EDS alongside the BVR report. Most actions within the EDS are underrway, but there are some exceptions that will require attention and possibly further project planning by the new Group Manager for Economic Development, once he/she is appointed.
		12.2		To improve relationships with business and investors to attract and retain businesses that offer employment opportunities	Underway. An Action Plan has yet to be agreed, but work is underway in a number of fora: - the LBBD Business Partnership has been established to deal with regulation issues; - the Protocol between LBBD and Gateway to London is currently being reviewed; - we intend to open tenders for the Small Business Service in Autumn this year - a Procurement event was held in April 2004; and monies secured for larger events combined with diagnostic service for companies (with BL4L); selling to the council data base on stream within 6 months (Nov 04) - Business directory established
		12.3		Increase the amount of business floor space	Underway, but some milestones delayed. The Creekmouth study has been delayed to July 04, due to the absence of a DLR decision, but project plans have been completed.
		12.4		Open up opportunities within construction industries at all levels for local people	Underway. With partners we are preparing a bid for ESF funding in the Autumn of 2004. We are seeking to persuade the LDA to support the use of the Fords EDAP facility in South Dagenham for construction training. If so, both Barking and Havering Colleges are keen to participate. The Economic Development Team will be providing input into the Council's use of s106 agreements to deliver the Economic Development Strategy. Use of these in relation to construction will be dependent on establishing the training side through local facilities.

		12.5		Developing new sectors e.g. environment technology, construction, etc.	Good progress with the regeneration of Dagenham Dock as a focus for London's environmental technology businesses. A Project Manager for the ETRCL has been appointed and a Project Plan is in place. ODPM funding will be confirmed by September 2004. We are working now to establish partnership working arrangements. Work is expected to start on site in October 2004.
		12.6		Develop six social enterprises	Good progress. A social enterprise champion has been appointed and capacity building project plan agreed.
		12.7		Get closer to business stakeholders	Underway. A manufacturers' action day and one business breakfast has been held. A new business association has been formed in River Road and the potential for a Thames Road Forum is under exploration. The Council has published a Business Support Directory and a BME business take-up survey is being carried out. The Dagenham Dock Occupiers' Forum has failed to elect an independent Chair. We have yet to establish a programme of visits by Members to estate associations or a training programme for the Chamber of Commerce.
SECTION 4 – TRANSPORT					
13.	Improving existing transport infrastructure in the borough and region	13.1		Establish a Strategic Transport Group	Achieved. We have agreed the structure and job descriptions for a Strategic Transport Group and appointed a Group Leader.
		13.2		Develop and agree a Transport Strategy	Delayed. The new Head of Strategic Transport will act as a Champion within the Council. Delays in recruitment are likely to delay the production of a Strategy until March 2005, but the Council has lobbied proactively on both the East London Transit and the DLR extension.
14.	Ensure commitment to Major Public Transport Infrastructure relating to regeneration area	14.1		Secure improvements to Barking Station by 2006	Underway. The first milestone – identification of areas for improvement – has been met.
		14.2		Ensure that major regeneration areas have good public transport links	Milestones out of report period.
		14.3		Encourage/lobby the completion of the first phase of the East London Transit by November 2006	Underway. Working with MPs and the LA Member, the Council has lobbied strongly for an early introduction of the East London Transit and to strengthen the quality of its design. Presentations were organised for officers in March 2004 and for the Assembly in May 2004.
		14.4		Lobby and accelerate the decision for the DLR extension to Dagenham Dock by 2009	Milestones out of report period.
		14.5		Undertake a feasibility study and Business Plan for new station at Renwick Road to serve Barking Reach	Underway. We have agreed with partners the brief for a feasibility study. This is about to undergo CPMO appraisal and will then be advertised. An OJEC notice will be issued in July/August.

SECTION 5 – HOUSING					
15.	Ensure that all housing regeneration areas and larger sites have a genuine mix of housing types and tenures	15.1		Confirm with partners the tenure and type of dwellings that the Council will be seeking from Barking Reach/South Dagenham/Barking Town Centre and land disposal areas	Underway. A joint EP/LBBD study of affordable housing provision across the whole of LBBD has been commissioned, with results due in July/August. There is ongoing dialogue with the GLA about levels of affordable housing in these areas. This will be informed by the above study and the production of a housing regeneration strategy for BTC
		15.2		Incorporate affordable housing approach in forthcoming Local Development Framework	Underway.
		15.3		Undertake a housing needs survey	Underway. Fordham Research was appointed to conduct this survey in March 2004. Fieldwork began in June with focus groups organised for June and July. We expect the final report in August 2004, with the presentation of results and publication in September.
		15.4		Monitor through the housing corporation PI compliance with the UDP/LDF and new developments compliance with the development briefs	
16.	Ensure that sustainable communities are created	16.1		Define sustainable communities for LBBD in context of Egan review on the key criteria that make up sustainable communities	Underway. A report is being prepared for the Regeneration Board in Summer 2004.
		16.2		Develop and implement programme of Home Improvement Zones targeting vulnerable home owners, offering assistance to ensure decent homes in the private sector	Underway. The Youth Offending Team is now working in the first Zone, with £5000 put towards alley gating, ground works and tree planting. 100% of homes have been offered advice, 102 dwellings accessed surveyed and detailed advice given. 102 dwellings have been referred to the warm zone.
		16.3		Identify transport and social infrastructure and ensure it is linked to development phasing	Underway, with delays to some milestones. The work is being progressed within the context of the Thames Gateway Development and Investment Framework. There is good dialogue with external agencies and the lobbying required will flow from this.
		16.4		Undertake 'Housing Futures Appraisal' for all existing Council owned estates	Underway. The areas of synergy with the regeneration programme have been identified as the Gascoigne, Harts Lane and Thames View Estates and project plans are being drawn up within the regeneration programme. PPCR associates have been appointed as ITA; NBA appointed for stock condition survey. The Stock Option consultant Beha Williams Norman was appointed in January 2004. A Housing Futures forum was held with stakeholders. Housing and Regeneration officers are holding internal meetings to define links and project plans.

17.	Ensure LBBD facilitates/encourages new housing development	17.1		Establish LBBD as key location for house builders in the Thames Gateway	Underway. We are continuing to promote opportunities to housebuilders, with the brief for the Tanner Street Triangle about to be issued. The Charlecote Road development has won four housing design awards. We intend to start work on a promotional strategy over the summer. The Government has decided that the UDC will take over planning powers. However, the UDC is likely to want to use local authority planning staff to carry out its planning functions and Housing and Planning will liaise to devise protocols that will protect the borough's interests in this respect.
18.	All new affordable homes to accommodate space for learning for provide ICT connections	18.1		Develop appropriate policies on space for learning in new affordable dwellings	Underway. We have explained our policy to our partner RSLs and the policy is set out in the Barking Town Centre Interim Planning Guidance. The Balanced Scorecard for Housing Strategy sets a target of 50 homes in 2004/5. The Charlecote Road project, the first to reflect this policy, has been completed and won 2 major design awards
		18.2		Develop appropriate policies on ICT connections for new affordable dwellings	Underway. The Housing Strategy Balanced Scorecard sets a target for all affordable homes to be broadband enabled.
SECTION 6 – DISTINCT ENVIRONMENT					
19.	Embed a design culture in the Borough	19.1		Appoint Design Champion through recruitment programme	Achieved. An internal candidate took up post in January 2004.
		19.2		Develop a Design Programme that sets a framework for championing a design culture within the Borough	Achieved. The Regeneration Board agreed a Design Framework for the borough in March 2004, with implementation activities due to begin in the third quarter of the year. A Design Steering Group will develop the programme for 2005-06.
		19.3		Adoption of a Public Realm Strategy that sets out a long-term development framework.	Underway. £2m in ODPM sustainable Communities Fund money was secured in January 2004. Consultants 'Burns + Nice' have been appointed to devise an overall approach to the public realm within the town centre. They are developing the 'Barking Code' (a pallet of quality materials to be used to enhance the public realm within Barking Town Centre) and concept designs for four pilot projects. This Code is about to be signed off by the Urban Design Panel and will be reported to the Executive in the summer for final agreement. A project manager, who is to be appointed this year, will oversee the next stages of implementation and construction.
20.	Improve the quality and diversity of the Borough's Parks and Green Spaces	20.1		Identification of a Borough-wide development framework that supports a sustainable programme of iconic developments	Underway. The framework will form part of the Urban Design Framework Plan and Public Realm Strategies for the borough (see above).
		20.2		Appointment of a Project Manager for the delivery of the Parks and Green Spaces Strategy	Achieved. The Project Manager took up post end May 2004.
		20.3		Implement Parks and Green Spaces Strategy	Underway. Project briefs for Phase 1 of the Strategy has been prepared and an Action Plan adopted. A Steering Group will be established now that the Project Manager has taken up post.

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THE EXECUTIVE

3 AUGUST 2004

REPORT OF THE DIRECTOR OF HOUSING AND HEALTH

BEVAN AVENUE BUILDING – BUILDING NAME	FOR DECISION

This report sets out a request for a name to be provided for the new shared office accommodation being built for Primary Care Trust and Council staff at Bevan Avenue. The authority for naming new buildings is reserved to the Executive.

Summary

The Bevan Avenue office building is currently under construction. The provisional completion date is November 2004. It is hoped that the building will be occupied prior to Christmas 2004. Although the building will be owned by the Housing and Health Department it will be occupied jointly by council staff and the local Primary Care Trust. A name is required for the building acceptable to both parties.

Recommendations

The Executive is asked to:

1. Consider naming the new building at Bevan Avenue;

2. One of three names have been suggested following detailed consultation with both the Primary Care Trust and the Eastbury, Mayesbrook and Longbridge (ELM) Community Housing Partnership (CHP); and

3. Either endorse one of the suggestions made or any other suitable name for the Bevan Avenue building.

Reason

A name is required for the new office building at Bevan Avenue in order to obtain the correct postal address.

Contact Officer:		
Anthony Alexander	Community Housing Manager	Tel: 020 8227 3538 Fax: 020 8227 2841 Minicom: 020 8227 2685 E-mail aalexander@lbbd.gov.uk

1. Background

1.1 The Bevan Avenue office building is one of a series of buildings replacing land formerly occupied by sheltered housing schemes at the Ravensfield and Bevan Avenue sites.

1.2. The building is due for completion and occupation by the Primary Care Trust and the ELM CHP office team in November 2004.

1.3 A request has been made from the developer for the building to be named in order that a postcode application could be submitted.

2. Authorised Naming Procedure - New Council Buildings

2.1 Advice was received from the Democratic Support Division that the matter should be referred for the attention of the Executive. There is no established procedure at present for naming buildings.

2.2. Advice on suitable names has been sought from both the Borough Archivist and Building Control. This has resulted in several names being put forward for consideration. The Building Control section have indicated there is no objection to any of the names forwarded.

2.3. The Primary Care Trust along with the ELM Community Housing Partnership have been consulted. The following name(s) have been endorsed by either or both parties.

a. **Dan Felton House** – the preference of the ELM CHP Board

b. **Bevan House** – in the tradition of names of social reformers in the Keir Hardie estate area. This name is endorsed by the Primary Care Trust.

c. **ELM House** – The adopted name of the local community housing partnership.

The Executive may, of course, wish to choose a name different from those above.

2.4 A suitable name that the Executive are prepared to endorse is required by August 2004 so that the builders may apply to have the postal address for this new office established.

Background Papers used in the preparation of this report.

- ELM Community Housing Partnership Meeting Minutes – 9th December 2003.

THE EXECUTIVE

3 AUGUST 2004

REPORT OF THE DIRECTOR OF HOUSING AND HEALTH

REVIEW OF VOID PERFORMANCE 2004/5 AND PLANS FOR 2005/6 ONWARDS	**FOR INFORMATION**

This report includes recommendations on issues which are the Executive's responsibility.

Summary

This report reviews the void performance, in relation to the Public Sector Agreement target, and sets out an action plan for achieving it. The target turnaround time for minor voids is:

i) 30 days by March 2005
ii) 25 days by March 2006 and beyond.

Achieving the PSA target will place the Council into the top quartile and will require a step change in performance - for 2003/4 we achieved 42 days. This report looks at the current gaps in performance and outlines the steps that have and are being taken to achieve the target.

Reason

Improving void performance is of crucial importance to the Council and affects all wards. Achieving the PSA target will mean; more homes available to let quicker and an increase in rental income.

Contact:		
Jim Ripley	Head of Landlord Services	Tel: 020 8227 2827 Fax: 020 8227 2846 Minicom: 020 8227 5755 E-mail: jim.ripley@lbbd.gov.uk

1. Background

1.1 The number and percentage of empty homes, and the speed with which they are re-let, are crucial measures of housing management performance. Every empty home means one less home to offer someone in housing need and loss of the rental income. Empty homes also can attract vandalism, anti-social behaviour and create a bad impression to neighbours and passers-by.

1.2 The Council has signed a Public Sector Agreement (PSA) with the Government. Target 10 relates to the turnaround times of minor voids. The following is a summary of our void performance:

	2000/01	2001/02	2002/03	2003/04	May 04	PSA Target end March 06	Week 14	Week 15
Average re-let times (minor voids) – days	61	60	42	47	47	25	24	37
% of vacant properties (minor voids	1.61%	1.30%	1.16%	1.32%	0.99%	n/a	n/a	n/a
Rent loss % from voids	2.49%	2.37%	2.81%	2.77%	n/a	n/a		

Appendix 1 shows our performance in relation to other councils and the Council's standard graph for BV68 for 2003/4.

Following the introduction of a series of measures, our performance showed a great improvement between 2001 and 2003. Performance has since 'plateaued' at around 45 days and in response we have developed a strategy to achieve the quantum leap necessary to meet the challenging PSA target.

1.3 Our target for this year (average relet times minor voids) is 30 days by March 2005 and for the following year the PSA target is 25 days by March 2006.

This report builds on our experience to date, sourcing on performance in the last 12 months and proposes actions to achieve both the above targets. It also lays the foundations for further improvements.

When comparing to other London Boroughs (Housemark London Boroughs Benchmarking club) (Appendix 1.) we are 14 out of 16 for 2003/04. Top quartile is 31.65, median 33.88, bottom 40.36. Our 2006 target of 25 days and this years' target of 30 days would put us in the top quartile. We have joined the newly formed London Voids Benchmarking Forum (a Housemark sub-group) to enable us to process benchmark and learn from best practice elsewhere.

As this is no longer a BVPI there is no comparative national data. The Audit Commission have this week issued a consultation paper on the proposed changes to the BVPIs for 2005/06. They propose re-introducing the former BVPI 68 on average relet times.

2. Progress to date

2.1 We have established a partnership with Thames Accord and the good working relationship we have with them will help us to deliver the improvements required.

2.2 Voids have continued to be of the highest priority in Landlord Services. The last year saw some major changes with the start of the partnership with Thames Accord in May 2003. This resulted in changes to the organisation with some staff relocating in the CHPs and the decentralisation of void control functions. There were two vacancies to these positions which were filled in June 2004.

2.3 For the last year the Head of Landlord Services has held weekly void monitoring meetings with Thames Accord and Estate Management staff. New working procedures have been drawn up and staff has been trained in their new roles. Crucially, we have been working towards giving the CHPs control over the void process.

2.4 Many initiatives have been introduced. For example we introduced 'instant lets' in January 2004. CHP staff inspect voids and identify those that require safety checks/minimal works prior to occupation. These properties are typically re-let within 1 or 2 weeks. New tenants are advised on sign up of any works to be carried out once they have moved in. Currently around 5 instant lets are processed every week.

3. Reasons for Lack of Progress

3.1 We have analysed the progress of each void in April to identify where hold ups occur. Thames Accord was taking an average of 36 days to turn round minor voids whilst an average further 10 days was taken with estate management and lettings. The main reasons for this are:

1. Our biggest problem is that there have been far greater numbers of voids than expected. In 2003/4 Thames Accord processed 370 decent home voids and 1000 minor voids as opposed to contracted targets of 250 and 950 respectively. For the first 9 weeks of 2004/5 the projected year end figures are 500 MRA voids and 1500 minors as opposed to the contracted target of 250 MRAs and 950 other voids.

The main reason for the high number of voids is the backlog of voids resulting from the delays to the MRA programme. Members have been made aware in previous reports of the failure of the contractual arrangements with Cubbitts Interiors Ltd which has had the additional effect of keeping properties void for longer than we would normally expect. Between March 2003 and January 2004 Thames Accord took over this backlog of some 130 properties and had to reallocate resources to deal with the heavy extra work load.

3. The other significant factor has been the ending of the trickle transfer system whereby the highest cost void properties were held for transfer to Stort Housing Association. This had an appreciable impact on both the funds needed for voids and the overall average turnaround time.

4. The voids process has continued to be sequential whilst part of the new procedure is still being implemented. For example, we have tried to allocate properties and sign up new tenants, whilst works are taking place, but the vast majority of offers have only taken place once the properties have had works completed.

4. Improving Performance 2006 and beyond

4.1 We recognise that the task of achieving a step change in performance is a major challenge which requires detailed business analysis, good forecasting and risk assessment. There have been a number of obstacles to achieving this during 2004, including the restructure of Landlord Services, the transfer of the repairs service to Thames Accord and the uncertainties caused by the trickle transfer and MRA voids programme. We, therefore, propose to work on a further void improvement business plan which we intend to present to the Executive in January 2005 for meeting the 2006 target.

The business plan will:

- Review performance to date, highlighting recent trends and improvements;
- Review the success of accompanied viewings, looking at the need to update the tenants' decorations allowance if appropriate
- Review the performance of Thames Accord in their first year in the contract and partnership aspirations. Look at the need to incentivise quicker repairs turnaround times with Thames Accord and their subcontractors.
- Review the achievability and long term viability of the voids, decent home programme
- Take into account the effects of More Choice in Lettings.
- Take into account the possible affects of the emerging position on Housing Futures
- Analyse in greater details the numbers of voids expected in future years.
- Report on whether better enforcement of tenancy conditions could result in less repairs being needed to voids
- Highlight any changes by the government to BVKPIs
- Produce an updated action plan with an associated risk assessment.

In order to facilitate this report and to monitor and implement the action plan, we will appoint a Void Project Co-ordinator for a period of 1 year. This post is funded from within existing Landlord Service budgets and will be located within the Business Services Team. The post will be filled by September 2004.

4.2 The 2004/5 target

In the mean time the following actions are planned to meet the 2004/5 target:

- We have analysed our performance, in partnership with Thames Accord, and identified areas where performance can be improved. A detailed process map has been developed which will enable the component parts of the process to be monitored and targets set for them.

- The effects of improved procedures and processes will take time to work through and be reflected in better performance.

- The impact of 'external' factors such as trends in housing needs and applications/allocations policies – particularly the likely impacts of MCIL.

- In order to achieve this year's target of 30 days and then the PSA target of 25 days there needs to be a step change in performance. This will be achieved through the actions shown on the enclosed Void Performance Action Plan – Appendix 2.

- Delivery of the action plan as well as overall void performance management is undertaken through weekly void monitoring meetings chaired by the Head of Landlord Services.

- A target has been set to reduce the total number of void properties with Thames Accord from 348 to 220 by October. Given the current rate of around 36 new void properties per week this requires an average completion rate of some 46 properties per week until October. This target will be closely monitored at the weekly meetings and additional action taken, if required, to ensure it is met. Thames Accord is producing an action plan setting out how they will achieve this.

- A number of actions have already been put in place to ensure this higher production rate is met. These include:

  - Thames Accord increased from 2 to 4 the number of staff administering their void process.
  - Thames Accord established a dedicated voids surveying team of 5.
  - Thames Accord nominated named officers with responsibility for liaising directly with CHP staff. There will also be joint training for all relevant staff.

  Thames Accord is producing weekly lists of properties that are expected to be ready within 7 days. These are then allocated straight away and wherever possible tenants are signed up before the properties are ready.

4.3 The following actions will also be taken over the coming weeks to ensure the October target is met

- Thames Accord have introduced a mobile key-cutting service. This allows CHPs to retain copies of keys enabling viewings to take place whilst works are in progress.
- All properties wherever possible will be allocated, viewed and signed up for, as soon as they become vacant, while works are being carried out. Thames Accord has carried out an appropriate risk assessment.
- Accompanied viewings have been introduced at the discretion of Community Housing Managers so staff can 'sell' more difficult to let properties to applicants and result offers quicker.

4.4 The current and proposed void processes are illustrated in Appendix 3.

4.5 The new Voids procedure is now working well and early results are encouraging. We have now achieved weekly monitoring of void turnaround times. The results in the last two weeks are week 14; 24 days and week 15; 37 days. These figures include 2 properties that were turned around in zero days; showing that instant relets are working their way through the system. In addition, Thames Accord has continued to improve its performance. The overall number of voids with Thames Accord are reducing on target. Since the beginning of the year the total has come down from 371 to 312. Thames Accord returned to us 47 properties in week 15 as opposed to 26 in week 1. They are also turning round voids that require minor repairs quicker. Year to date figure is 31 and by week 15 this has improved to 25 days against a performance target of 28 days

5. Summary

5.1 Voids performance is if of crucial importance and we have a long way to go to achieve the PSA target.

5.2 We are confident that implementing the action plan appended will deliver the improvements necessary to achieve the target.

5.3 The weekly void monitoring meeting will keep a close watch on progress and enable the impact of the various initiatives to be assessed. Keeping the process under continuous review in this way will ensure that we can respond quickly and effectively if any changes or additional measures are necessary.

5.4 Members will continue to receive regular progress reports as part of the quarterly monitoring programme.

5.5 A further report on the Business Plan for meeting the 2006 standard will be ready by January 2005.

Background Information used in the preparation of this Report:

Good Practice In Void Management – Housemark January 2004

London Borough and ALMOs Forum
Quarterly PI Tracking 2003/4 - Year End

APPENDIX 1	3		4	
	BV68		BV69	
	Average relet times for dwellings let in year		Percentage of rent lost through vacant dwellings	
	Days	Rank	%	Rank
Number in sample	16		16	
Upper quartile	31.65		1.22	
Median	33.88		1.55	
Lower quartile	40.36		2.05	
Corporation of London	17.00	1	0.74	2
Kensington & Chelsea TMO/Royal Borough	24.84	2	0.41	1
LB of Barking & Dagenham	46.62	14	2.77	15
LB of Bexley				
Brent Homes/LB of Brent	34.00	9	1.60	9
LB of Camden	28.20	3	1.50	8
LB of Ealing				
LB of Enfield				
LB of Greenwich	33.00	6	1.87	12
LB of Hackney				
LB of Haringey	33.76	8	1.47	6
LB of Harrow	45.92	13	1.14	4
LB of Havering	36.00	10		
Hillingdon Homes/LB of Hillingdon	33.40	7	1.25	5
Hounslow Homes/LB of Hounslow	65.79	16	1.47	6
LB of Islington				
LB of Lambeth	37.55	11	1.60	9
LB of Lewisham	38.50	12	2.57	13
LB of Merton	47.60	15	0.76	3
LB of Newham	28.75	4	2.69	14
LB of Redbridge				
LB of Southwark			4.07	16
LB of Sutton				
LB of Tower Hamlets				
Ascham Homes/LB of Waltham Forest				
City West Homes/City Council	32.62	5	1.74	11

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APPENDIX 2

Void Performance Action Plan

RESOURCES	Action	Outcome	Timescale	Lead
1.	TA to increase the number of sub contractors to address high number of voids	• Reduction in number of voids held with TA	September 2004	TA
2.	TA have increased from 2 to 4 the number of staff administering the void process	• Tighter control of void processing	May 2004	TA
3.	Review the impact of Housing Futures and the delivery of Decent Homes on Voids	• Improved delivery of Decent Homes and Better VFM	April- June 2005	HoLS
MONITORING				
1.	Weekly void monitoring meetings chaired by Head of Landlord Services	• Ensure actions being met and performance increases	Ongoing	***HoLS***
2.	TA to produce a weekly list of properties that are expected to be ready within 7 days	• Allows for pre allocation	Ongoing	TA
3.	Void monitoring reports to be produced weekly not monthly	• Increased awareness of performance	July 2004	CA
TRAINING				
1.	Institute of Housing to provide training to estate staff with regards to the scope of works to achieve letting standard	• Estate staff clear about the level / standard of works that will be done in a void	11 July 2004 29 July 2004 3 Aug 2004	***Institute of Housing***
PROCEDURES				
1.	Write and launch void manual	• Consistent guide to void management	***Sept 2004***	***CHM***

				A.Alexander
2.	TA review and streamline procedures	• Improvement in performance • Reduce number of voids with TA from 348 to 220	• ***June 2004*** • 1 Oct 2004	***TA*** TA
3.	TA to introduce a mobile key cutting service	• Allows keys to be retained by local housing office to enable viewing whilst works in progress	• ***June 2004***	***TA***
LETTINGS				
1.	Introduce pre allocation procedure	• **Property viewed and accepted prior to works completed**	***Aug 2004***	CHMs / Project Leader Homelessness and Rehousing
2.	Where appropriate introduction of accompanied viewings	• Increase in acceptance level of more difficult to let properties • Faster offer results	***May 2004***	***CHMs***

IMPROVING VOID PERFORMANCE **Appendix 3**

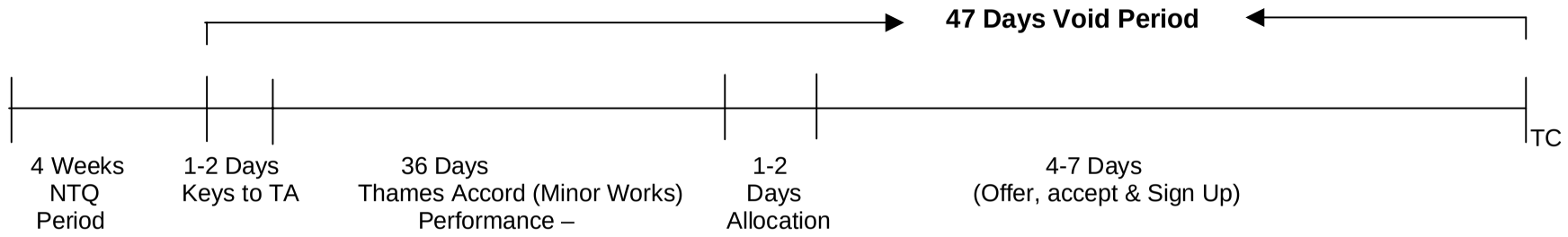
New void procedures have been devised which aim to improve efficiency and turn around performance with a target of 25 days to be achieved by March 2006.

Underpinning these procedures is an empowerment of the Community Housing Project structures to take control of the processes and manage them within their resources. Community Housing Managers (CHM) will be the responsible manager of void turn around performance.

Timely and positive communication between the Void Officer and CHP colleagues, Thames Accord and Allocations are pre-requisites for achieving the void turnaround targets.

Current – Based upon April 2004 Analysis

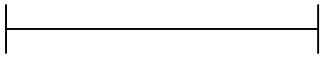
The following flow diagram illustrates the sequential nature of the void turnaround process prior to April 2004.



Changes in Process to Improve Performance:

4 Week Notice Period

Tenants are required to give 4 weeks notice prior to terminating their tenancy. Any reduced notice is agreed by the CHM.



4 Week NTQ Period

The Void Officer (VO) and Thames Accord (TA) Asbestos Surveyor will make every effort to arrange a visit to the property and see the tenant(s) within 5 working days of notice being given.

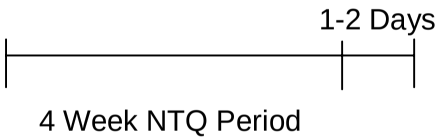
Purpose:

- Identify asbestos
- Identify improvements
- Identify repairs which are tenants' responsibility along with the Borough's Policy on recharging.
- Complete Property Characteristics form
- Determine need for De-fest, security and clearance requirements once property vacated, arranging as necessary.
- Identify disabled adaptations
- Identify gas related work
- Form an opinion on whether or not Tenants decoration Allowance will apply
- Outline responsibilities regarding termination of gas, electric and telephone contracts, housing benefit, rent arrears, replacing damaged fixtures and leaving the property including garden clean and tidy.
- Confirm tenant's new address.
- Identify any other work
- Decision reached on whether void will be instant, minor or major repair re-let.
- VO alerts Allocations and TA Voids section of imminent void and likely status.

If let is to be an Instant Re-let, Allocations will advise CHM of allocation details so arrangements can be made for viewing, subject to existing tenant consent, and agreeing a tenancy commencement date. This can be achieved prior to the existing tenant handing the keys in at termination.

1-2 Days - Keys & Inspection

This phase relates to the property keys being returned to the CHP office on the date of termination.



Within 1-2 days, VO with TA Asbestos Surveyor will visit the vacated property if no inspection possible during NTQ period. The purpose is as listed above.

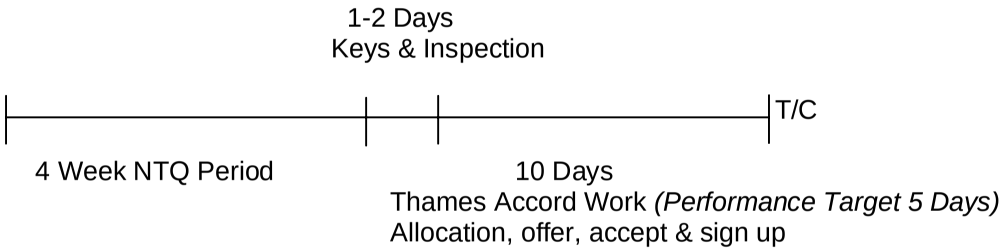
Where a visit occurred during NTQ period, within 1-2 days, VO will have revisited to update report and confirm to TA Voids Section instant or minor repair re-let.

VO advises Allocations of vacated property and requests decision on whether or not adaptations remain. VO advises TA voids section if adaptations are to be removed.

Keys to TA, copies cut by TA at time of collection if necessary.

Instant Re-letting

This illustrates the route used for properties that require gas and electric checks and change of locks, prior to re-letting. Other minor work is carried out once the property is occupied.

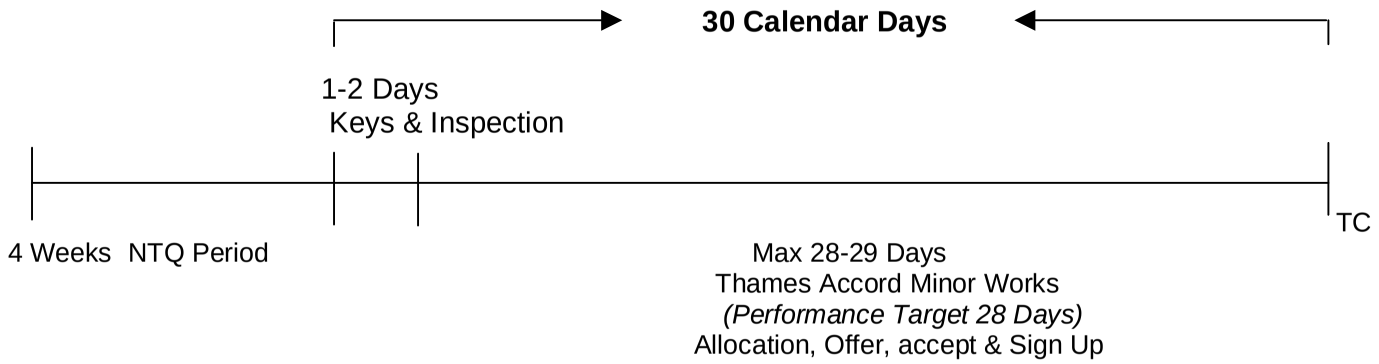


Upon receipt of keys, TA within one working day, advise Allocations the date property will be available to let.

Within one day, Allocations provide allocation details to CHM, who arranges within two days a visit (accompanied at discretion of CHM) and sign up as soon as practicable agreeing a tenancy commencement date. Maximum 10 days void.

Minor Repairs Re-letting

This is the new process for 2004/05. The flow diagram summarises the timescales targeted to achieve prompt re-letting.

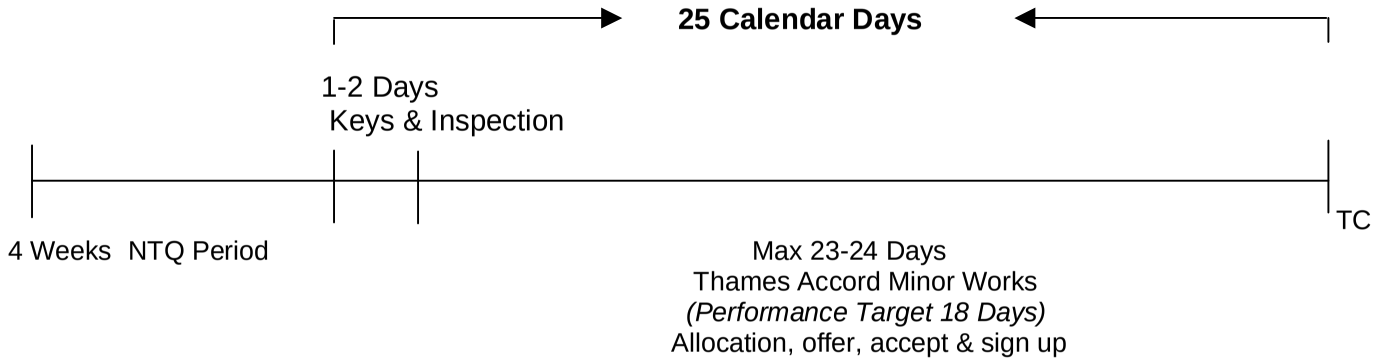


TA carries out minor works, gas and electric checks.

Seven days prior to property being available to let, TA advises Allocations who within one day advises CHM details of the applicant to be offered the property. Within two days, CHM arranges a visit (accompanied at the discretion of CHM) and sign up with agreement on tenancy commencement date.

March 2006 Target

This flow diagram illustrates how the PSA target of 25 calendar days can be achieved by March 2006.



Key

NTQ Notice to Quit
TC Tenancy Commences
CHP Community Housing Partnership
CHM Community Housing Manager
VO Voids Officer
TA Thames Accord

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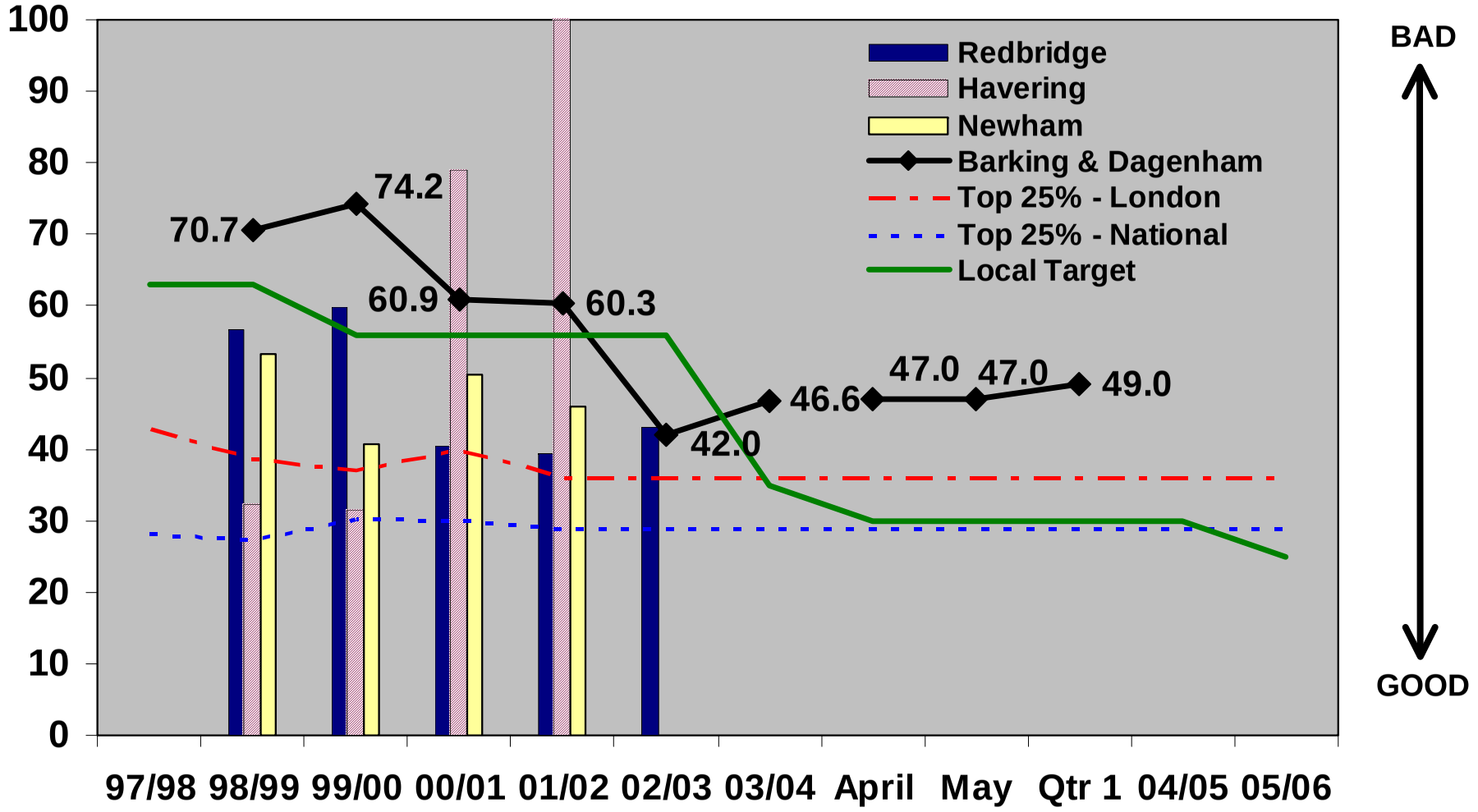
CPA / PSA

HOUSING & HEALTH - Housing Needs & Advice

Local PI [BV68] and PSA Target 10 - Average time taken to relet dwellings available for letting or awaiting minor repairs (calendar days) [cumulative]



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of the Local Government Act 1972.

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of the Local Government Act 1972.

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