CHALLENGES FACING PRIMARY MEDICAL CARE IN LEICESTER CITY

Introduction

National Context

1. *"Everyone Counts: Planning for Patients 2014/15 to 2018/19" (December 2013)* sets the overall medium term planning framework for the NHS and describes what the NHS must deliver to patients nationally. The NHS 'Call to Action' asks all NHS providers and commissioners to respond to the significant challenges facing the NHS in delivering health and care policy into the future, including:

    - An ageing society
    - The rise of long-term conditions
    - Rising public and patient expectations
    - Increasing costs of providing care
    - Limited productivity
    - Pressure of constrained public resources that the NHS (and social care) face
    - Variation in quality of care across the health system.

LLR Context

2. The financial picture that is seen nationally is reflected in the local health economy, perhaps with even clearer focus. There is an accepted need to deliver greater local efficiencies and a recognised potential to achieve that by the development of integrated out-of-hospital services, increased in-hospital efficiencies and a stronger focus on disease prevention. The case for change at an LLR level is summarised in the diagram below:-

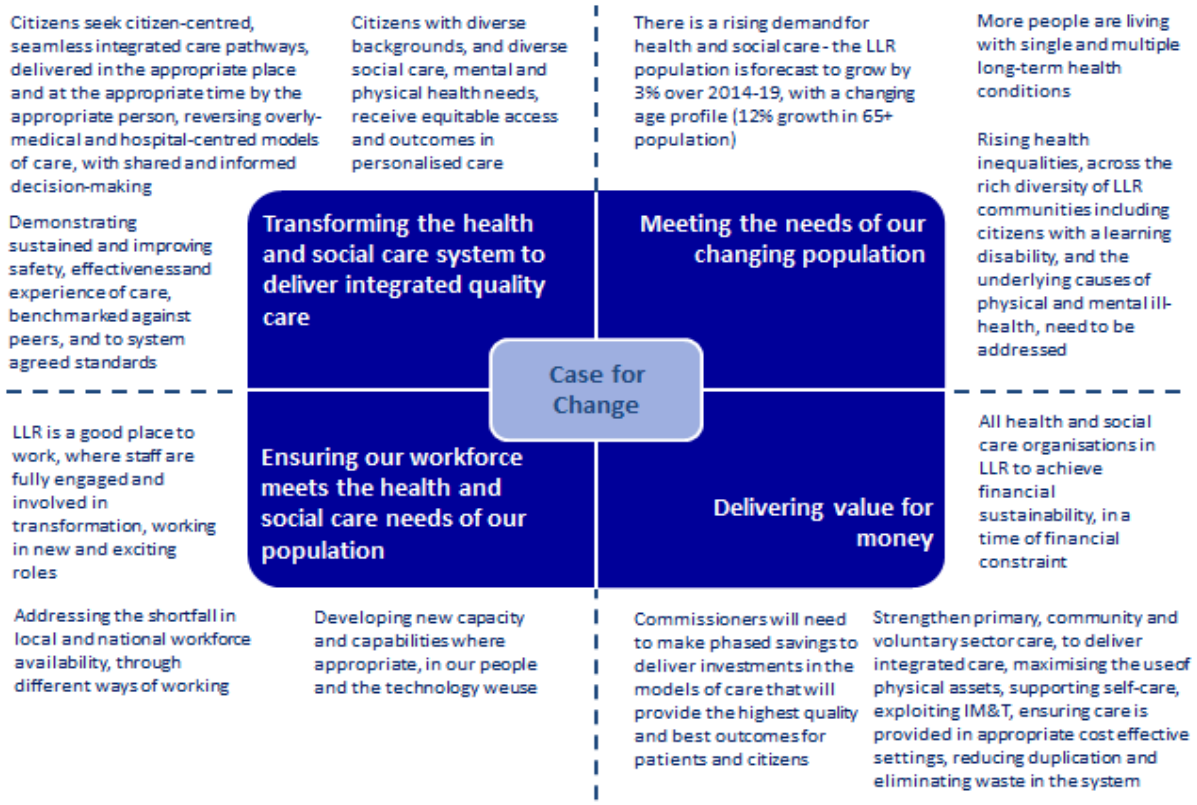

Figure 1. The case for change in Leicester, Leicestershire and Rutland

Leicester City Context

3. The national direction of travel, as outlined in "Everyone Counts" fits the vision of Leicester City's Health and Wellbeing Board and their strategy "Closing the Gap".

4. Our vision for a healthier population goes much further than just ensuring people get the right care from individual services. We want to create a holistic service delivery mechanism so that every Leicester citizen benefits from a positive experience and better quality of care. We will do this through focussing on three priority areas, delivering one integrated model of care:

    i) Prevention, early detection and improvement of health-related quality of life
    ii) Reducing the time spent in hospital avoidably
    iii) Enabling independence following hospital care

5. A strong, fit-for-purpose primary medical care service is a pre-requisite if we are to address the national requirements and to achieve our local ambitions in closing the health inequality gap for the people of Leicester City.

PROFILE OF PRIMARY MEDICAL CARE IN LEICESTER CITY – 2014

6. Leicester City's *resident* population is estimated at 331,606 whilst the *registered* population is approximately 378,000 i.e. the City is a "net importer" of patients from the County. Those 378,000 patients are cared for by a total of 62 GP practices (as at September 2014.)

7. At the present time (September 2014), ten GP practices in Leicester are single-handed; the remaining 52 practices have multiple GP partners or are ocntracts held by alternative providers (for example corporate bodies).

8. In terms of population, 13% of patients are treated by single-handed GPs in Leicester compared to approximately 9% nationally. Analysis shows that as a result, the average practice list size in Leicester is below that seen nationally.

Average list size (Leicester City CCG)	5,920
National average list size	6,487

Table 1. Average GP practice list sizes

Looking at the deprivation levels and health need assessments by ward, there are four distinct areas or Health Need Neighbourhoods which we propose maka a logical footprint for planning and service delivery. Although their names have not been finalised, for the current time we can refer to them as North, South, Central and North East.

Health Need Neighbourhood	Ave Pop'n per practice June 14	75+ Pop'n	% 75+ Pop'n	Total GPs (WTE)	*Ave List Size per WTE GP*
1 North	5973	4954	5.6%	44.6	*2058*
2 South	6056	3130	4.5%	44.3	*1888*
3 Central	6093	6113	4.5%	74.7	*1875*
4 North & East	6205	5709	8.0%	44.6	*1876*
TOTAL	**6077**	**19906**	**5.4%**	**208.2**	***1922***

Table 2 Profile of the four City Health Need Neighbourhoods

9. The CCG currently has 14 training practices. This is important as training practices can play an important role in supporting new GPs and encouraging them to stay in the area once they are qualified.

10. With regard to contract type, there are:-

    - General medical services (GMS) – 35 Practices
    - Personal medical services (PMS) – 16 Practices
    - Alternative provider medical services (APMS) – 11 Practices.

11. Until fairly recently, practices were almost exclusively run on a GP partner basis, with occasional use of locums to cover study, sickness or holiday absence. More recently, there has been a significant growth in locum and salaried GPs, with fewer being attracted to the partnership model. The latest information indicates that Leicester now has a GP workforce made up of almost equal thirds of partners, salaried GP and locums. The graph and table below highlights the number of GP partners that are likely to retire in the next 5 to 10 years – 60 out of a total of 121 partners are 50 or over, which is almost 50%. The current structure of practice-based primary care provision is likely to undergo severe instability if new partners cannot be attracted into the system to take their place. Effective recruitment and retention is key to maintaining the City's local primary medical care services.

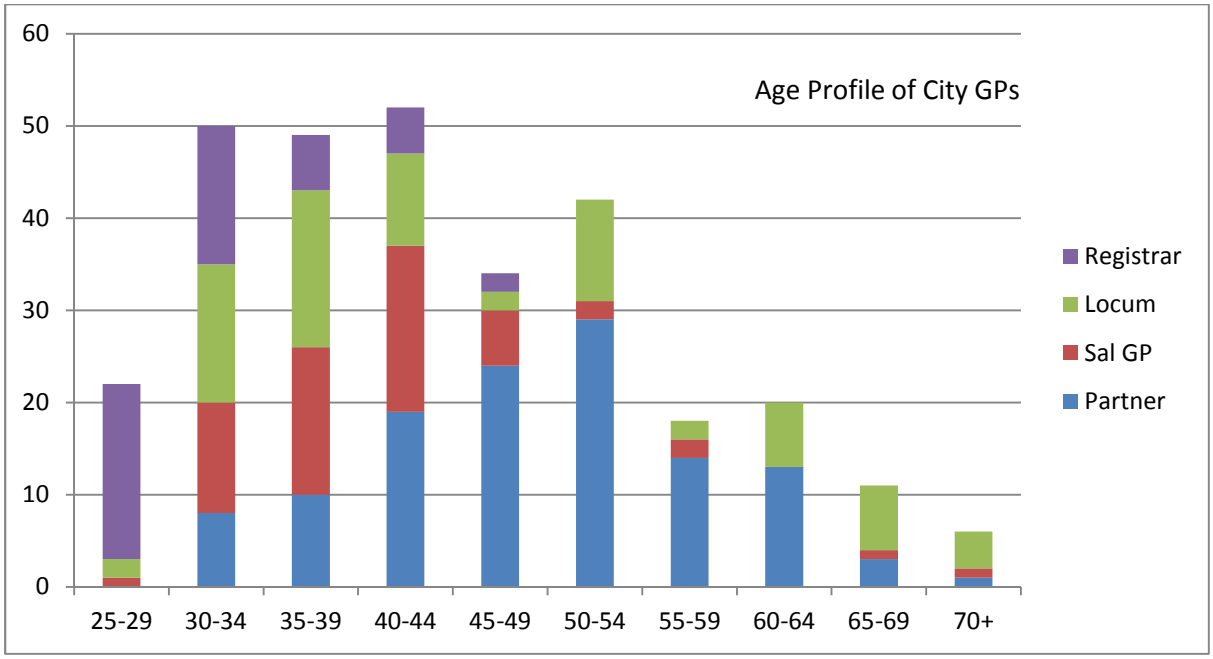

Figure 2 Age Profile and GP type, by age band

Age	Partner	Sal GP	Locum	Registrar	No
25-29	0	1	2	19	22
30-34	8	12	15	15	50
35-39	10	16	17	6	49
40-44	19	18	10	5	52
45-49	24	6	2	2	34
50-54	29	2	11	0	42
55-59	14	2	2	0	18
60-64	13		7	0	20
65-69	3	1	7	0	11
70+	1	1	4	0	6
TOTAL	**121**	**59**	**77**	**47**	**304**

Table 3 GP age profile by type

CHALLENGES FACING PRIMARY CARE IN LEICESTER CITY

12. Since the "Call to Action" in November 2013, the CCG has embarked on a series of engagement activities with the public, patients, member practices and wider stakeholders to understand what the challenges and issues are perceived to be and to gather information on what an improved primary care system might look like. With regard to patients, we have worked with representatives from practices' Patient Participation groups, gathered information from listening events with the public, from community and faith leaders, membership feedback, from HealthWatch, national patient surveys and from comments and complaints.

13. To gain feedback from member practices, we have held discussions at Locality meetings, at Protected Learning Time (PLT) events, undertaken electronic surveys, taken feedback at professional forums (e.g. Practice Manager and Practice Nurse forums), at individual practice meetings and at Board Development sessions. The main themes that emerged are shown below:-

Patients	**Practices**
Improve access	Excessive workload
Variable quality across practices	Insufficient resources
More personalised care	Severe recruitment and retention issues
Longer appointments	Premises constraints
Clearer communication	Population diversity
More patient information	Health burden and inequalities
	Patient expectations

Table 4. Patient and GP Practice feedback on issues facing primary care

To a large extent, the challenges facing practices are causing the issues raised by patients.

What patients said

14. **Access** is poor. Patients told us that in many practices it is just too hard to make an appointment. They wanted fast access to appointments that are easy to make, particularly for children, those with long terms conditions and older people. Telephone systems should be able to cope with the volume of calls and there should be the choice of on-line booking. Those in most need should be given priority.

15. The **quality** of general practice should be improved. Patients noted that practices varied in the quality of service that they offered their patients and this variation was justifiably felt to be unacceptable.

16. **Personalised care** is not always available. Patients want to be treated by a GP who knows them, where this is appropriate (e.g. where patients have Long Term Conditions (LTCs)). If the complaint is straightforward e.g. a minor illness, many patients who expressed a view were not concerned about seeing their normal GP.

17. There is insufficient appointment **time.** Patients said they wanted their GP to have time to listen to them. The length of the appointment should be linked to the nature of the condition e.g. automatically have longer appointments for patients with more complex conditions, particularly mental health issues and those with multi-morbidities. Several mentioned their unhappiness at only being able to discuss a single condition at each appointment.

18. **Communication** and **Information** is sometimes poor. Several patients and carers requested clear, easily understood information in an appropriate format and language that helps them to take responsibility for their condition and to use NHS services wisely. This was felt to be particularly important for those who might be

new to the City and who came from a country where primary care was not provided. Training in communication skills for the whole primary healthcare team was suggested by several patients. There were several patients who did not understand what they had been told but felt unable to take up any more time in asking questions. They wanted to feel unrushed and be able to discuss their issues properly.

What practices said

19. The past two years have seen a rapidly growing **workload** with too little capacity to deal with it, leading to many clinicians feeling stressed and unable to take on any more work. There was an overwhelming message from the majority of practices that "something needs to change" – either less work or more resource, but certainly that the current model is not sustainable and has reached crisis point. With the planned transformation of services to an increased out-of hospital model of care, practices feel that demand needs to reduce or capacity increase, which requires more resource coming into primary care.
20. A lack of **resources**. The extra workload needs to bring resource with it to enable teams to be expanded and provide the extra capacity that is required. The funding of new services needs to recognise the real cost of delivery and offer a sense of financial stability to encourage practices to sign up to them and employ with confidence the extra staff required to support delivery.

21. Acute difficulties with **recruitment** and **retention**, particularly relating to the GP workforce. This is an immediate and urgent priority bearing in mind the age profile of the City GPs and the number likely to retire over the coming five to ten years. Younger doctors are showing a growing reluctance to become partners, with more of them enjoying a portfolio of different roles, one of which is as salaried or locum GPs. Numbers going through GP training are falling and for those that do complete training, they are anecdotally reported as not being attracted to working in the City. *Addressing recruitment and retention is the highest priority in the immediate term.*

22. **Premises** issues. Several practices have reported a lack of space to accommodate new services, a lack of funding available for refurbishment / expansion and general improvement. Some practices have also encountered issues in LIFT buildings, where they claim that the service costs are very high and there is often a lack of flexibility in discussions with the property company relating to extended opening hours or issues with accommodation.

23. These challenges come on top of those that are due to the complexities of the city population i.e. population **diversity**; levels of **deprivation**; variation in health **outcomes**, health **inequalities**; **disease** burden as well as growing public **expectations** of the service.

PLANNED SOLUTIONS

The CCG and AT are working together on a five year strategic plan to address primary care in the City, which will tackle the issues set out above. The strategic plan will be underpinned by an implementation plan covering the following main themes / areas:-

Key Theme	Detail
1. Service development plan	Review current service provision in light of local health need
2. Demand and capacity modelling	Undertake modelling based upon analysis of future activity, new models of care and more prevention work. Compare with capacity modelling (workforce, skills, and premises) and identify gap.
3. Develop workforce plan	Develop workforce plan based upon capacity and demand model and local service review. Identify numbers and any skill requirements. Explore the use of other primary care contractors in pathway and service reviews, for example Community Pharmacists and Optometrists and ensure these forecast numbers are included in the workforce plan.
4. Recruitment	Develop immediate and longer term recruitment strategy to attract GPs and nurses to work in Leicester City. A short term resolution funded non-recurrently is being implemented in collaboration with the Area Team. This is a GP recruitment incentive scheme which will fund a practice to enable it to offer an additional cash incentive to their employment offer. The AT is currently working on criteria that will underpin the scheme. It is proposed that approval of incentive payments will be via the HWB. A link has also been established with Health Education East Midlands (HEEM) to improve Leicester City profile as a place to work
5. Retention	Develop retention strategy which in particular supports trainee doctors, nurses and allied health professionals, encouraging them to stay in Leicester following qualification.
6. Health Inequalities	Explore quantification of health inequalities benefits and relevant associated health outcomes measures
7. Quality Contract	Develop and test quality contract based upon measurable achievement of health outcomes sensitive to local health need

Key Theme	Detail
8. Premises	Update premises survey to enable accurate capacity planning
9. Public engagement exercise	Undertake further public engagement exercise, particularly with regard to exploring the definition of appropriate access and new primary care models and feedback on the overall strategic plan.
10. Communications plan	On-going plan, but in particular to focus upon • Accessing services • Increasing self-care • Improving information availability for the public
11. IM&T	Maximising the use and efficiencies offered by IM&T e.g. through access to patient records, on-line booking etc.

Table 5. Implementation plan themes

There will be a comprehensive consultation exercise on the strategic plan over the coming months.