Scrutiny

Leicester City Council

Scrutiny Review

Primary Care Workforce

A Review Report of the Health and Wellbeing Scrutiny Commission

March 2016

Leicester
City Council

Contents

Please note these abbreviations have been used in this report:
CCG – Clinical Commissioning Group (Leicester City)
HWSC – Health & Wellbeing Scrutiny Commission
HWB – Health & Wellbeing Board
GP – General Practitioner (family doctor)
CQC – Care Quality Commission
UHL – University Hospitals of Leicester NHS Trust
LPT – Leicestershire Partnership NHS Trust
NHE – National Health Executive
DH – Department of Health

Health and Wellbeing Scrutiny Commission

Commission Members:

Councillor Lucy Chaplin (Chair)
Councillor Luis Fonseca (Vice-chair)
Councillor Dawn Alfonso
Councillor Harshard Bhavsar
Councillor Dr Shofiqul Chowdhury
Councillor Deborah Sangster
Councillor Kulwinder Singh Johal

Chair's Foreword

The Health and Wellbeing Scrutiny Commission started this review in November 2015. We knew that people in Leicester faced problems in trying to see their GP. Over the course of the review it was alarming that five GP surgeries announced closure, or potential closure. The CCG faced an unprecedented problem that highlighted the true crisis in local primary care. As well as this review, questions were asked at full council, and patients raised their concerns at public meetings with the CCG. The commission stretched the scope of the review to capture views from the public, particularly around the surgeries that faced closure.

Cllr Rory Palmer, Deputy Mayor and Chair of the HWB also raised his concerns earlier this year, these are clearly stated in his letter (appendix B). He has also announced plans for a local primary care summit to bring together all stakeholders (date tbc).

In preparation for that summit, the HW Scrutiny Commission prioritised this review. The recommendations are based on the findings we have to date. However it should be noted that work to look at practice nursing and different ways of organising surgeries is something the commission could take further in future.

Without improved funding, better communications and transparency of accountability, the crisis in primary care workforce will continue. These issues need addressing locally and nationally.

I would like to thank all those who gave their time for this review, particularly the GPs and staff at Downing Drive Surgery. I would like to thank members of the public who spoke about their experiences and concerns at public meetings or came to meetings of the commission.

Thanks also to the scrutiny support staff who worked on this review.

Councillor Lucy Chaplin

Chair, Health and Wellbeing Scrutiny Commission

1 Executive Summary

1.1 Background to the Review and Key Findings

1.1.1. The aim of this review was to try and highlight some of the issues that exist around primary care and what the impact is on patients and the public as well as the General Practitioners (GPs) and Practice Nurses. The scrutiny committee announced this review in October 2015.

1.1.2. Throughout the review the commission heard of pockets of work happening across the city but this seems to be disjointed currently and therefore the commission welcomes the Clinical Commission Group (CCG) setting up a Primary Care Workforce Planning Group and the Health (set up in late 2015) the Deputy City Mayor announcing in February 2016 that he will host a summit to bring all this work together. A date for the summit is to be announced

1.1.3. The closure of a number of GP surgeries during the period of this review further highlighted the impact on patients of the workforce planning crisis. The issue of single doctor surgeries closing is one that needs addressing.

1.1.4. Improved communications with patients, and better monitoring of the overall situation by the CCG, and the HWB themes throughout this report.

1.1.5. Making sure student nurses and doctors have full information about careers at an early stage, as well as better information about the benefits of living and working in Leicester are important.

1.2 Recommendations

The Executive and the Health and Wellbeing Board are asked to consider the following recommendations:

1.1.6. There needs to be a concerted effort to promote the prospects of the city, not only in the city but other cities and maybe even internationally.

1.1.7. That the CCG in partnership with the Health and Wellbeing Board summit look at ways to address issues of low morale locally.

1.1.8. That the Health and Wellbeing Board summit considers the evaluation of this summit event.

1.1.9. Ensure that the local enhanced payments scheme to recruit new GPs is fully evaluated by the CCG and monitored by the Health and Wellbeing Board

The CCG are asked to consider the following recommendations:

1.1.10. There needs to be better engagement and consultation with patients by GPs/Partners and the CCG with patients when surgeries are due to close.

1.1.11. That the nursing courses should look at how doctors organise their trainee placements in primary care to help remove the barrier to GP placements for nurses in training.

1.1.12. That the CCG explores ways to improve training opportunities for practice nurses.

1.1.13. That as part of the CCGs annual audit meeting with practices, there is a specific question to ask about financial risks for a practice, and to offer advice and support to GPs.

1.1.14. That the CCG engages with local Federations and members of the public to look at ways of addressing concerns about transparency and public interests.

1.1.15. That the CCG improves and provides timely consultation and communications with patients about their primary health care, particularly when the surgery may close.

1.1.16. That university courses / GPs / CCG make full careers information available early in medical training.

1.1.17. That communications about these innovative ways to organise primary care should have a higher profile across the city. The scrutiny commission should invite these practices to make presentations at a future scrutiny meeting.

1.1.18. That the CCG in partnership with the Health & Wellbeing Board summit look at ways to address issues of low morale locally.

1.1.19. That the local enhanced payments scheme to recruit new GPs is fully evaluated by the CCG and then presented back to the Health and Wellbeing Board.

Public Health England/Department of Health/NHS England are asked to consider the following recommendations:

1.1.20. Nationally, the issue of notice periods needs to be looked at and extended to ensure that there is enough time to ensure patients are adequately catered for.

1.1.21. Nationally greater investment needs to be made into primary care, to help protect this vital first port of call for patients trying to access healthcare, and to help improve preventative measures as part of the Better Care Plans.

The CQC are asked to consider the following recommendation:

1.1.22. That CQC reconsider their inspection regime and the impact that it has on patients, particularly on a single GP surgery.

2 Report

1.3 Background

1.1.23. With reports stating that a third of GPs in the UK plan to retire in the next five years the commission felt it was important to consider what the impact will be at a local level and how it can be addressed. It has also been reported that there is a shortage of practice nurses. Nationally there is a seven per cent vacancy rate for GPs (NHE press release appendix C)

1.1.24. Members of the public are struggling to get GP appointments, which is putting pressure on acute and emergency health care.

1.1.25. The commission was told that the city's universities have exceptional facilities and courses for medical students and good nursing colleges, yet we have an issue in retaining these students in the city. The commission was keen to understand why this is the case and what the plans are to find solutions to this.

1.1.26. Given the importance of having a strong primary care workforce to deliver Better Care Together, sustaining the workforce is vital. In the review the commission aimed to shine a spotlight on the issues so those involved at a strategic level in the local health economy could consider solutions to try and tackle the issues faced around our primary care workforce.

1.1.27. The modern NHS is not one organisation. It is a maze of different national and local bodies, which makes for difficult navigation (see kings fund video) The complexity of responsibility for workforce planning is illustrated in Cllr Palmer's letter (appendix B page 12-13). This complexity means that accountability is unclear, and therefore workforce planning is always in danger of falling into a gap, only to emerge when crisis looms.

1.1.28. The commission became aware that Dr Peter Miller, CEO of Leicestershire Partnership NHS Trust, also has a role as chair of the Local Education and Training Council (Appendix B, page 13). Commission members expressed concerns that holding dual roles at that high level could be demanding. The commission welcomes that Cllr Palmer is taking up issues regionally and nationally. **RECOMMENDATION**: **that the Health & Wellbeing Board take regular monitoring reports about workforce planning issues as part of its strategic work for local healthcare.**

1.4 Closure of GP Practices

1.1.29. Since the review began five surgeries in the same area of the city have faced closure or at least potential closure. Whilst the review was not looking at this directly, the issues of the GP closures have certainly highlighted the impact on patients of workforce planning for local primary care.

1.1.30. The commission heard that the Maples Surgery closed on Evington Road. Then Springfield Road Branch Surgery was closed (the main surgery in Wigston remained open). This was followed by news that the Queens Road Medical Centre is closing at the end of /march 2016. Subsequently a further two surgeries at Bowling Green Street and Asquith Surgery also faced closure but the CCG has been able to step in to keep these two open while alternative management options are found.

1.1.31. In some cases when one surgery closed; patients were being given options to register at a surgery which shortly also faced closure. The commission heard the frustrations from members of the public with regards to this and the lack of communication they felt over these closures.
RECOMMENDATION: There needs to be better engagement and consultation with patients by GPs/Partners and the CCG with patients when surgeries are due to close.

1.1.32. The commission heard that the issue with notices that GPs have to give in that it is only three months for single handed practices and six months for multiples. The CCG reported that following a proposal from Cllr Palmer and the HWB (supported by Cllr Chaplin, chair of this commission) they have requested a voluntary six month agreement with single GP practices. The response has been mixed, but some have been supportive.
RECOMMENDATION: Nationally, the issue of notice periods needs to be looked at and extended to ensure that there is enough time to ensure that CCG can plan services and that patients are adequately communicated with.

1.1.33. The commission was told that some GP practices are not financially sustainable, partly due to the sixe of patient lists, but other factors such as different contracts and ownership of premises are also factors. The CCGs state that GPs are independent businesses so they have very little control of how they are run and on their financial position. The commission expressed concerns that they are funded with public money so that there should be more accountability. This was also echoed at the public meeting

on 25th February re Queens Road Medical Centre by patients. The commission is pleased that from April, GPs will be required to disclose their 'take home' pay but more needs to be done to have transparency across the board. **RECOMMENDATION**: **that as part of the CCGs annual audit meeting with practices, there is a specific question to ask about financial risks for a practice, and to offer advice and support to GPs.**

1.1.34. RECOMMENDATION: nationally greater investment needs to be made into primary care, to help protect this vital first port of call for patients trying to access healthcare, and to help improve preventative measures as part of the Better Care plans

1.5 Care Quality Commission (CQC) Inspections

1.1.35. The Chair met with GPs and trainee GP at the Downing Drive surgery to discuss their feelings about the state of primary care. The GP partners in particular mentioned the pressure of a CQC inspection on the surgery stating that 6.5 hours were spent with one doctor looking at individual patient records, taking that doctor away from actually seeing patients

1.1.36. Via the interviews at Downing Drive surgery, it became apparent that the new CQC regime of inspections puts a lot of pressure on GPs. Whilst the commission understands the need to ensure a rigorous process of inspection to ensure patient safety it should not impact on the surgery treating patients or pressure doctors to the point where perhaps older and experienced doctors would rather retire than deal with a CQC inspection.

1.1.37. The CQC says that 80 per cent of GP inspections are compliant, and due to funding changes to the CQC it is looking at ways of working more efficiently and effectively across it's entire inspection regime.

1.1.38. Ofsted inspections changed when the pressure put on teaching staff and headteachers on school was realised. **RECOMMENDATION: the commission recommends that CQC look again at their inspection regime and the impact that it has on patients, particularly on a single GP surgery.**

1.6 Federations

1.1.39. GP surgeries can come together to form a Federation. By doing so they can share resources, have joined up plans to provide care and training for staff. However, it was not clear to the commission exactly what the role of these Federations was. The commission feels there needs to be an openness and clarity of what they are and the impact on service provisions in the future of having more federations. **RECOMMENDATION: that the CCG engages with local Federations and members of the public to look at ways of addressing concerns about transparency and public interests.**

1.1.40. There was also a lot of discussion at the public meeting re Queens Road Medical Centre about the perceived conflict of interest for Federation GPs sitting on CCG Boards. The CCG felt that this was not a concern as the GPs that sit on boards are there following a vote of all practitioners in that area and that these boards should be led by clinicians that have experience in the area rather than management boards with no practical experience.

1.7 Locum GPs

1.1.41. A locum GP temporarily fulfils the duties of GPs at various different practices. They can be used when another GP is absent or when a practice is short-staffed. The commission was told that currently locums can earn as much as a partner GP, but would not have any of the management and financial responsibilities to the practice. This has been recognised nationally as an issue in workforce planning. It is noted that the Government is looking at ways to 'incentivise' being a Partner GP rather than a salaried GP or locum.

1.1.42. GPs at Downing Drive explained that one of the benefits of being a locum is that doctors can gain learning and experience by working in numerous practices before becoming a partner.

1.1.43. The CCG says (some anecdotal evidence agrees) that generally patients prefer seeing a regular doctor who understands their medical history and one that they have seen over time. However at the public meeting re Queens Road Medical Centre, patients clearly stated that they would rather be looked after by Locum GPs than have their surgery close. Geography is important for patients. Patients from that surgery asked why they hadn't been consulted at an earlier stage about the options for delivering their primary care. **RECOMMENDATION: that the CCG improves and provides timely consultation and communications with patients about their primary health care, particularly when the surgery may close.**

1.8 Training and Retention of Students

1.1.44. Evidence the commission heard said that medical students felt it was helpful to have information available with regards to their career path early on, before they become a partner or took a specialist path. In particular information about what was involved in becoming a partner GP and how long or short contracts could be, how involved or not a GP would be in decision-making in a practice. **RECOMMENDATION: that university courses/ GPs/and CCG make full careers information available early in medical training.**

1.1.45. The commission was told that if specialist doctors wanted to become GPs later in their career that they may not have the latest general experience required for tests to become a GP. Opinion was that it was easier to set out on the path as a GP early on.

1.1.46. In evidence from Professor Harris (appendix A) it is noted that a higher proportion of students choose to be GPs than in other comparable medical schools, however they do not choose to stay in Leicester. He also mentions low morale in the local GP community. If students on placement are not having a positive experience they are not likely to stay. Professor Harris also mentioned a scheme called 'Medics into action" to help make the working environment attractive to help recruitment and retention. **RECOMMENDATION: that the CCG in partnership with the HWB summit look at ways to address issues of low morale locally.**

1.1.47. The trainee GP giving evidence to the commission was from outside Leicester and had done basic training elsewhere, and only knew of Leicester through family connections. They were also attracted to the city for the low house prices and the attractions of the city more generally. The commission however recognises this range of knowledge is not available to everybody.

1.1.48. Professor Kevin Harris personally highlights (Appendix A) some issues that are involved in retaining students in the city and most notably issues around the city underselling itself as a prospective city in comparison to other areas in the country. Cllr Palmer has also addressed this in his letter to the commission (Appendix B) and mentioned some work that is happening to try and address this.

1.1.49. The CCG stated that they have set up a Workforce Planning Group across the three CCG's that service the city, county and Rutland. The commission welcomes this and also welcomes a summit that will be set up by the Deputy City Mayor via the Health and Wellbeing Board to try and bring together all the work that is happening to address the issues around primary care and make a plan to move forward.

1.1.50. **RECOMMENDATION: the commission feels there needs to be a concerted effort to promote the prospects of the city, not only in the city but across the UK and internationally.**

1.1.51. The commission heard that there is a Local Education Training Committee that is chaired by the Chief Executive of the LPT. This is made up of representatives from primary and secondary care as well as from the universities and social care. They have a specific workstream to look at workforce planning and connecting it to Better Care Together and other workstreams. Dr Peter Miller who chairs this committee stated they have looked closely at training and retaining students, but student feedback has found that the are not happy with the courses and as other evidence suggests, student retention rates are low.

1.1.52. Dr Miller stated that recruiting more GPs is not the only answer currently as there are low numbers of GPs nationally so therefore other methods for dealing with issues in primary care must also be considered.

1.1.53. The commission did hear that there are some surgeries that are using innovative ways of using other health practitioners such as employing paramedics or nurses as part of their staffing to release the pressure on GPs. Concerns were expressed about patient expectations for primary care appointments. **RECOMMENDATION**: **that communications about these innovative ways to organise primary care should have a higher profile across the city. The scrutiny commission should invite these practices to make presentations at a future scrutiny meeting.**

1.1.54. Health Education East Midlands is holding a careers event on 17 March 2016 to promote careers in health and care professions. **RECOMMENDATION**: **that the HWB summit considers the evaluation of this event.**

1.1.55. In his evidence Cllr Rory Palmer mentions that in 2014 the HWB endorsed measures put in place by the CCG to improve recruitment of GPs, including a local enhanced payments scheme to recruit new GPs to Leicester. NHSE gave £250,000 for these 'golden hellos', but to date the scheme has 'not been as successful as we would have wanted'. The scheme is still open via the CCG. **RECOMMENDATION**: **that the local enhanced payments scheme to recruit new GPs is fully evaluated by the CCG and then presented back to the Health & Wellbeing Board.**

1.9 Practice Nurses

1.1.56. A practice nurse stated that there are no placements available for trainee nurses at GP surgeries and welcomed that the CCG and De Montfort University have started looking into this. Without these placements student nurses will not be aware of the full range of career options.

1.1.57. Two other issues mentioned were on who pays the liability insurance for student nurse placements in primary care and availability of continuing training for practice nurses. We were told that training is patchy because some surgeries do not have the resource to release nurses for training which leads to nurses moving to practices where they are better valued and have opportunities (leaving some practices without a nurse). **RECOMMENDATION: that the nursing courses should look at how doctors organise their trainee placements in primary care to help remove the barrier to GP placements for nurses in training.**

RECOMMENDATION: that the CCG explores ways to improve training opportunities for practice nurses

1.1.58. There was more hope that these issues would be address as the CCG have set up a practice nurses forum and it is hoped that these networking opportunities will better support nurses. The commission would have liked further information on this from the CCG but this was not possible within the timescales for this report. **RECOMMENDATION: that the health and wellbeing scrutiny commission has an progress report on the CCG work in respect to practice nursing**

3 Financial, Legal and Other Implications

1.10 Financial Implications

There are no direct financial implications arising from this report

Martin Judson, Head of Finance, Leicester City Council

1.11 Legal Implications

There are no direct legal implications arising from this report.

Kamal Adatia, City Barrister & Head of Standards Monitoring Officer, Leicester City Council

1.12 Equality Implications

Our Public Sector Equality Duty focuses on the decisions we make as a local authority and aims to ensure that they are part of a fair and robust process that considers the impact of those decisions on service users and likely service users across relevant protected characteristics.

In relation to the Primary Care Workforce Review Report by the Commission, the Public Sector Equality Duty applies equally to relevant partners, and they need to ensure they consider the impact of their decisions on service users and likely services users as well.

The report highlights the closure/part closure of a number of surgeries across the city, and the impact this would have on patients, for example older people being able to access GP services locally. Within this report recent national research carried out by the National Health Executive highlights there is likely to be disproportionate impact on younger people, full time workers and people from ethnic minorities getting appointments with their preferred doctors.

Sukhi Biring, Equalities Officer, Leicester City Council

4 Summary of Appendices

Appendix A – Evidence, in a personal capacity, from Professor Kevin Harris, University of Leicester.
Appendix B – Letter from Cllr Palmer
Appendix C – National Health Executive Article
Appendix D – Executive Response to Scrutiny

5 Officer to Contact

Kalvaran Sandhu, Scrutiny Support Manager
Tel: 0116 454 6344

APPENDIX A

Evidence from Professor Kevin Harris (views and observations)

1. How do you feel the primary workforce development in the city is progressing?

I remain to be convinced that there is a sustainable workforce model for primary care in general in the UK. This matter is widely discussed in the medical press but no credible solution has been provided and even if there were one the nature of training the workforce is that it will take many years to deliver. This is particularly a problem for Leicester City with a number of factors coming together (notably retirements from GP, rising demand and sometimes unrealistic expectation, low morale in the workforce, high levels of NHS red tape diverting dedicated workforce from front line patient care etc). All this is occurring in a tight financial environment where we are spending much less on healthcare as a %GDP than comparable western countries.

My impression in the city is that things have reached crisis point with some areas having no effective primary care which translates into a rising demand on acute hospital services (I believe the rise in attendances at A+E from LE1 & 2 has been c10% in a year). This is what patients frequently report and is both expensive and often not in the patients best interest.

As such there is an urgent need to have a co-ordinated workforce strategy and for it to be properly resourced and implemented recognising this will take some time to deliver. This has to involve all agencies and be set in a context of making Leicester an attractive place to work. I have lived here for over 30 years and love the city but I feel it continuously undersells itself in comparison to larger metropolitan areas including others in the East Midlands.

2. How can the city retain medical students? What part can you play in this?

The University of Leicester Medical Courses (like all others) are oversubscribed and recruitment to Leicester to is not an issue.
It is inevitable because of the nature of the way doctors in training are selected for posts that a number will move away from areas where they have trained and this may be a good thing in order to allow doctors in training to get broader experience for their medical training and achieve their lifestyle goals. Many will chose to move to London for example. This has always been the case and would not necessarily be of concerns if a similar proportion chose to return to or to come to Leicester once they had completed their training to take up senior positions in primary care. This does not happen however. The reality is that those who have completed their training have a choice to work anywhere in the country (the demand for GPs outstrips the supply) and too few choose Leicester for a number of reasons including possibly the difficulties in primary care within the city described above.

The medical workforce is particularly mobile by its nature – but these factors also play but to a lesser extent with allied health professionals who may be more tied to an area because of family commitments etc.

We know a higher number of Leicester graduates do choose to move away and not come back than at other comparable medical schools.
The University and the local NHS Trusts are working together to try and make the working environment in Leicester more attractive recognising this is likely to have an impact on retention and in due course feed through to recruitment from other areas – this programme is known as “medics into action” and is based on a “Listening into Action” model which has been widely used within UHL. We recognise this will take a time to result in a more positive view of Leicester as a place to work and the efforts currently are focused on secondary care which is where most students spend their time training. However, this year the Medical School is introducing a new curriculum which will rely much more heavily on primary care for student placements – we are anticipating this will encourage more students to choose to work in primary care once they have completed their training and hopefully do that in due course in Leicester. This of course is contingent on them having a positive experience in their placements and we are actively working with primary care colleague to ensure this.

3. Is there anything you feel that can be done to support health services and universities to ensure a strong workforce?

Both the University of Leicester and DMU are working together to look at the provision of training for non-medical workforce and for the development of new roles. For example we will launch a course in 2017 for Physicians Associates who will be able to undertake a number of tasks currently done by doctors in both primary care and secondary care. There appears to be a great demand for such individuals by the NHS. Their training requires placement in a clinical setting for which there is no national funding (unlike for doctors and nurses). Secondary care have offered to provide this training for free recognising that this is likely to ensure the workforce once trained will want to stay in their institution (assuming of course they had a positive experience). A similar agreement to train these individuals within primary care for free could have a similar impact.

The University of Leicester is actively looking at ways of supporting a widening participation agenda within the medical school with foundation years and possibly funded scholarships (we are looking for funds to support this). The rationale for this is that such students who may not traditionally have thought of going to medical school will prove to be excellent doctors and possibly have a higher motivation to stay in the area in which they trained. This initiative will be positive in terms of widening participation but of course it is possible that once trained such individuals will use their newly acquire transferable skill to move away to another area of the country.

Leicester in general needs to market itself to a much greater extent – it is a great vibrant city to live in with great arts, transport links, surrounding country side, 3 Universities etc etc. And yet its image outside of Leicester is poor or non-existent. All too often I go to meetings where people don't know anything about Leicester and at best view it as a little town just south of Nottingham.

We are working actively with Health Education East Midlands to promote the area in general and the training opportunities in particular to junior doctors in training.

4. Do you survey graduates on how they are progressing in their career?

We do exit interviews on our students – many (but not all) have enjoyed their time here but now want to look for other opportunities elsewhere. We are addressing the issues that are raised but we have to raise the profile of Leicester as a place of opportunity so we can reciprocally attract people to us from other areas by encouraging them to see the opportunities we have to offer.

It must be of concern that the recent problems with the junior doctor contract and their low morale will further reduce our ability to retain trained doctors not just within Leicester but within the profession or the UK.

We also know that a higher proportion of Leicester graduates choose primary care as their career than at other medical schools – unfortunately many choose not to practice in Leicester.

APPENDIX B

Please ask for: Councillor Rory Palmer
Tel: 0116 4540002
Our ref: 2016/MARCH/LC/RP/MH
Date: 10 March 2016

Via email: lucy.chaplin@leicester.gov.uk

Dear Councillor Chaplin,

Thank you for your e-mail of 8 March 2016 setting out two questions ahead of the Health Scrutiny Commission this evening. I thought it might be helpful to set out initial responses in writing.

I will answer each of your questions in turn.

1. **What activities does the council/LLEP do or have planned to promote Leicester as a place to work around the UK?**

The City Council and public sector partners actively work to promote Leicester as a place to work and live. Demonstrating the advantages and benefits of Leicester as a place to live and work are fundamental aspects of recruitment exercises and feature regularly in specific recruitment campaigns. For example, we have sought to portray a positive picture of life in Leicester as part of the materials and narrative to support recruitment exercises for council officers including for relatively recent new appointments such as the Director of Public Health and Director of Adult Social Care.

There has been a specific programme of work in recent months to address the recruitment challenge in children's social work. This has involved a bespoke programme of work linking with universities on a learning and development scheme to promote entry into social work opportunities and to support career progression.

A new Living and Working in Leicester guide is currently in design stage and will be approved for production in the coming weeks. This will include personal testimonies and case studies from social workers in Leicester and will provide practical information and advice on housing, cost of living, transport, culture, leisure and quality of life in Leicester.

Beyond these HR related activities work is progressing on Leicester's broader place marketing. This includes the launching of the investinleicester.co.uk website to support inward investment work and a tender is currently advertised for a new tourism destination management system and website for visitleicester.info. This will bolster efforts to actively promote Leicester to national and international audiences and will help drive forward our determination to portray Leicester as a positive place to visit, live and work. All of this contributes to a combined and significant effort to strengthen Leicester's profile and brand, which in turn I believe will support work to attract people to work in Leicester across a variety of professions and sectors.

2. **What activities has the health and wellbeing board undertaken in the last 5 years to look at workforce planning in the health economy?**

Health & Wellbeing Boards were formally constituted from 1 April 2013. The Leicester Health & Wellbeing Board had been meeting in shadow form before that point. However, I was not the chair at that point and do not know what discussions took place on workforce planning issues. At that stage of the board's development I know that much of the discussion was taken up with putting in place the board's formal arrangements and producing the initial Joint Health & Wellbeing Strategy.

From April 2013 the Health & Wellbeing Board has been mindful of the challenges facing the NHS locally and nationally in areas of workforce planning, recruitment and retention. It is important to recognize the national context of workforce challenges in the NHS. It is predicted that by 2021 there could be national shortfalls of between 40,000 and 100,000 nurses and 16,000 GPs. In 2012 GPs reported lower job satisfaction than at any point in the last decade and it is highly likely this has only got worse. More and more UK trained health professionals are choosing to work abroad. As I write this letter junior doctors are on strike.

These pressures do not necessarily directly reflect the additional challenges of the general direction of travel in the NHS of moving care away from hospitals and into primary care. There has to be a credible and robust workforce plan nationally, regionally and locally to support this direction of travel.

Workforce planning for the health economy is clearly a crucially important area of work, however it is not something which Health & Wellbeing Boards have direct responsibility or budget control for. Insofar as I am aware it is not a formal requirement for Health Education England to seek Health & Wellbeing Board endorsement of their workforce plans, however this is something I intend to seek via Leicester's Health & Wellbeing Board.

Workforce planning across the health economy is the responsibility of Health Education England. Health Education England is an executive non-departmental public body of the Department of Health and is organised into Local Education and Training Boards (LETBs) at a regional level.

In the East Midlands Health Education England's work is organised across five key areas:

Workforce planning:

Based on the national workforce plan and in response to local intelligence from employers a local workforce plan is developed to ensure that the NHS has the right number of staff with the right skills, values and behaviours, in the right areas to provide safe, effective care for patients.

Commissioning pre-registration education and training:

Health Education England commissions education and training programmes for 129 different types of healthcare staff including nursing, allied health professions, biomedical scientists, and midwives. Locally the number of places commissioned is designed to meet the future workforce requirements.

An upcoming example of Health Education East Midland's work locally is the Careers in Health and Caring Professions event at Leicester Racecourse next week aimed at school and college students and designed to showcase career opportunities across the full range of healthcare professions.

Postgraduate medical and dental training:

The LETB through the postgraduate deanery provides postgraduate medical education and training, covering hospital medicine and general practice, including recruitment, foundation, core and specialty training, medical education centres and courses, study leave, appraisals and medical leadership.

The LETB also provides postgraduate dental education and training, focussing on dental education and workforce development, foundation, core and specialty training, study leave and appraisals

Attracting and developing the current workforce:

The LETB also has a responsibility to undertake work to attract people with the right skills to the local area and for ensuring that staff currently employed have the right skills and competencies. This includes looking at skill mix, different ways of working, developing new roles, and funding appropriate education and training.

The Local Education and Training Board at a regional level is then organised at a county level via a Local Education and Training Council. At a Leicester, Leicestershire & Rutland level the Local Education and Training Council is chaired by Dr. Peter Miller, Chief Executive of LPT.

I understand that the LETC is currently developing its workforce plan for 2016/17.
There is also a specific workforce planning strategy aligned to Better Care Together. This strategy maps the likely workforce requirements of the local healthcare system linking this to the emerging Better Care Together plans and patient pathways.

The Health & Wellbeing Board has considered workforce implications throughout significant programmes of work the board oversees and which report to the board such as the Better Care Fund. Discussions have also taken place with provider organisations including LPT and UHL at the Health & Wellbeing Board about the workforce challenges facing them. Staff recruitment and retention was also a feature of discussions around the challenges facing urgent care/ A&E.

As you are aware the Health & Wellbeing Board has also considered the GP recruitment and retention issue. In October 2014 the Health & Wellbeing Board requested and considered a paper from Leicester City CCG setting out the range of challenges facing primary care in the city. The board endorsed a number of measures aimed at beginning to address these challenges. This included the agreement to administer a local enhanced payments scheme to recruit new GPs to practices in Leicester. £250,000 of additional funding was secured from NHS England to support this in the form of 'golden hellos'.

As you will know from reports to the CCG's Co-Commissioning Committee and reports in other places this scheme has not been as successful as we would have wanted, underlining how complex the primary care recruitment and retention challenge is. It is worth noting in the current context that this scheme is still open and practices can make applications via the CCG. Work to address the GP recruitment and retention challenge has been the subject of continued discussion over many months and I have sought to ensure we have raised this at a national level as well.

For example, workforce challenges were included in a formal submission made to the House of Commons Health Select Committee Inquiry on primary care. The City Council is also actively supporting the development of a Living and Working in Leicester guide targeted specifically at GPs. The City Council has made available our place marketing materials and narrative to support to this (based on the children's social workers campaign mentioned above). I hope that funding can be agreed in the very near future to progress the production of this guide and that is made available online and disseminated to medical schools.

UHL has secured funding from Health Education East Midlands to develop a recruitment microsite aimed at hospital staff and this will link with other public sector recruitment sites in the area.

Workforce planning is something the Health & Wellbeing Board sees as fundamentally important to securing a sustainable and effective healthcare system which delivers excellent care and outcomes for patients in Leicester.

Health Education England's LETB in the East Midlands will be invited to present their 2016/17 workforce strategy at a future meeting of the Health & Wellbeing Board and the board will be asked to seek assurance that the proposed strategy is consistent with local needs in Leicester and is consistent with local priorities. I will also be seeking additional resources from Health Education England to support efforts in Leicester to address recruitment challenges in the health economy.

I also believe that whilst we need a strong and appropriate approach at a Leicester city level to health and care workforce planning this cannot and should not be decoupled from the national and regional challenges in this area. All parts of the country are struggling to recruit and retain doctors, nurses and other health professionals and we need coherent and co-ordinated regional and national approaches.

I have requested that the regional workforce plan is also considered at the East Midlands Health & Wellbeing Boards Chairs network. This will ensure the plan is considered and assurance sought from Health & Wellbeing Boards at the regional level, given the footprint of the plan.
Given the significance of funding and resources in delivering an effective workforce strategy I intend to raise this issue at the Local Government Association's Health & Wellbeing Board Chairs summit which takes place later this month.

In the coming weeks the Health & Wellbeing Board will be hosting the Leicester Primary Care Summit to bring together all those with an interest in securing an ambitious and sustainable plan for primary care in the city. Addressing workforce issues will be a key part of that process including not just recruitment per se but also understanding the day-to-day pressures facing GPs and healthcare staff.

The Health & Wellbeing Board will also be overseeing the development of further specific initiatives around GP recruitment and retention and will be seeking to broaden this to other areas of the health workforce as well. We will be seeking to do this in a way that aligns with the Better Care Together workforce plan, the regional plan and the specific plans of individual commissioners and providers, including LPT and UHL. I hope that the report your commission is producing will be able to contribute to this work.

It is clear to me that the underlying issues of the current recruitment and retention challenge in primary care and across the wider health economy are complex and wide-ranging. There are things that can and are happening in the short term but this will also require a sustained longer-term effort that will need to be properly resourced. The Health & Wellbeing Board will be seeking to ensure that is the approach adopted locally and regionally.

As soon as a date is confirmed for Health Education England to attend the Health & Wellbeing Board to present their 2016/17 workforce strategy for LLR/ the East Midlands I will let you know so you and members of the commission can attend.

I hope you find this letter helpful. I will make copies of this response available to other members of the Health Scrutiny Commission.

Yours
sincerely

COUNCILLOR RORY PALMER
DEPUTY CITY MAYOR & CHAIR OF HEALTH AND WELLBEING BOARD

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APPENDIX C

NATIONAL HEALTH EXECUTIVE

09.03.16

DH and NHS given until end of year to set out strategy for tackling GP crisis

The government must set out plans to tackle the GP crisis by the end of the year, the Public Accounts Committee (PAC) has said in a new report which found that the staffing gap is creating increasing difficulties for patients accessing care.

In its new report, the PAC reiterated that more GPs are leaving the profession and not enough are being recruited, and that access to GP appointments is uneven, with patients who are young, from a minority ethnic group or living in a less affluent area less likely to be able to make an appointment.

It said the Department of Health and the NHS must set out plans to reduce the number of GPs leaving the profession, how they aim to attract more GPs to return to practice, and establish the best incentives for attracting new recruits to general practice.

The influential group of MPs want the organisations to report back on their progress meeting these targets and fulfilling their goal of 5,000 more GPs by 2020 in December 2016.

Meg Hillier MP, chair of the PAC, said: “There is a looming crisis in general practice. For too long staffing levels have failed to keep pace with the growth in demand and too little has been done to close the gap.

“Experienced GPs are quitting while training places go unfilled; there are alarming variations in the experience of different groups of patients, and in some cases even basic information is hard to find - piling additional pressure on other parts of the health service.

“These are serious problems requiring serious solutions.”

Lack of GPs

As we have known for some time, GP staffing levels are not keeping pace with the demand on services, with the number of consultations growing by an average of 3.5% a year in 2004-15, compared to just 2% growth in GP levels.

A recent BBC FOI request found that there is **a 7% vacancy rate** for doctors.

The report found that in 2014-15 12% of patients reported a poor experience making an appointment, compared to 8% in 2011-12.

The proportion of patients saying it was not easy to get through to their GP practice on the phone increased from 19% to 27%. Also, increasing proportions of GPs of every age group are leaving the profession, with the amount in the 55 to 64 age group doubling.

Factors causing this include frustration at administrative burdens, difficulties communicating with other parts of the health service, and attractive pensions for older GPs.

A National Audit Office report found GP morale is at its lowest since 2001.

According to a recent Health Foundation report, **nearly a third of GPs** are planning to retire or switch careers in the next five years.

A **British Medical Association survey also found** that 10.4% of GP practices are financially unsustainable, 37.3% had doctors who are planning to retire and 8.6% had doctors who are planning to leave UK general practice.

Recruitment is also a problem, with 12% of GP training places unfilled in the past year and Health Education England recently admitting that **it may miss its recruitment target** this year.

Dr Maureen Baker, chair of the Royal College of General Practitioners, which gave evidence to the PAC, said: “We are pleased that the Public Accounts Committee have listened to the College and recognised the enormous resource and workforce pressures currently facing our profession.

“GPs and our teams are making an estimated 370 million patient consultations a year – 60 million more than five years ago – to meet the increasing demand of our growing and ageing population, yet the number of family doctors over this period has remained relatively stagnant.

“This toxic mix of increased demand and plummeting resources is leading many established GPs to leave the profession, and not enough medical students are choosing a career in general practice to take their place.”

Unequal access to appointments

Most deprived areas tend to have the fewest GPs and nurses per 100,000 people, making it harder for patients to get an appointment, and this is likely to get worse because a higher proportion of older GPs work in urban and deprived areas are likely to retire in the next few years.

Younger people, full-time workers and people from ethnic minorities are most likely to have difficulties getting an appointment with their preferred doctor. For example, 19% of Asian patients were unable to get an appointment, compared to 11% of white patients.

The report recommended that by the December 2016 deadline, NHS England must develop a strategy for identifying and sharing best practice on access to general practice, including on how to improve access for patients from minority ethnic groups, review the effectiveness of its incentives to attract staff to understaffed areas.

NHS England recently confirmed that it is offering a £20,000 bursary to **send 100 GPs to unpopular regions.**

The PAC also said that the NHS should set out the minimum level of information that all general practices should provide to the public to help them access services easily, monitor practices' compliance annually and, with the Department of Health, publish a plan for improving the information they have on demand, activity and capacity in general practice.

An NHS England spokesperson said: "We will soon announce more plans aimed at supporting GPs, tackling workload and ensuring high quality primary care remains at the forefront of NHS services", adding that the NHS had recruited 5000 full time equivalent GPs in the past ten years and was already improving recruitment through a £10m investment and measures such as the 'There's nothing general about general practice' campaign and a £31m fund to employ clinical pharmacists to take the burden off GPs.

A Department of Health spokesperson: "We are taking wide-ranging action to improve GP access as part of our commitment to a safer, seven day a week NHS" and that **the promised 1% pay rise** for NHS staff would attract more GPs.

Appendix D

Response to Scrutiny

The Council's Executive and Health Partners will respond to the next scrutiny meeting after a review report has been presented with the table below updated as part of that response.

Introduction

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Scrutiny Recommendation	Executive Decision	Progress/Action	Timescales