NHS

Workforce for the Future

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Workforce for the future - Section 1: Introduction

Introduction

This report sets out the context for and the findings of research into gaps that exist in the clinical workforce within the central Lancashire area.

The research was funded from the Cumbria and Lancashire Workforce Education Group's (CLWEG) Forerunner Fund sponsored by Health Education North West (HENW), as part of a wider project to develop portfolio careers that span across primary, secondary and acute care, to address workforce gaps and to create the workforce for the future.

The project is a partnership between NHS Chorley and South Ribble Clinical Commissioning Group, NHS Greater Preston Clinical Commissioning Group ('the CCGs') and the two main healthcare providers within central Lancashire (Lancashire Teaching Hospitals Foundation Trust and Lancashire Care Foundation Trust) - together referred to throughout this report as the 'local health economy'.

Project governance has been provided by a Project Team comprising senior managers from each of these organisations, together with senior representatives from HENW.

Phase 1 of the project was to undertake research into gaps in the clinical workforce, using quantitative and qualitative research techniques. This was done to provide an evidence base to support perceptions that primary care was under pressure and putting delivery of the shared vision for healthcare in central Lancashire at risk.

Phase 1 is now complete and this report sets out the findings of the research undertaken under this phase of the project.

The research findings will be shared at an event being held in May 2015. This event will also provide the vehicle for key strategic leaders from the local health economy to define the priorities and next steps for delivery during 2015-16 (Phase 2).

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Workforce for the future - Section 2: Executive summary

As a health economy we want to meet the needs of our patient population in a safe, effective and productive manner. This can only be achieved with a competent, confident and collaborative workforce

The local workforce strategy needs to address current needs and future plans aligned with the NHS five year forward view and our bespoke commissioning strategy

The central Lancashire health economy (comprising both commissioners and providers) has identified significant workforce challenges across many specialties and disciplines. These challenges will prevent us from delivering our vision for healthcare in the future. While some are generic to the national workforce picture, others may be unique to our health economy.

We struggle to compete with Manchester and Liverpool to attract and retain the best medical and nursing graduates to this area despite the quality of training at our local acute provider ranking as one of the best available.

On top of this we have a legacy of under investment in the primary care workforce and premises compared to other areas of Lancashire.

We are a ‘City Deal’ area with an expected increase in our population of 14,000 residents in the next five years. This poses an obvious challenge and a need to focus on modernising our workforce and the services we provide across health care settings.

We want to encourage people to positively choose this area to work in, offer interesting and imaginative opportunities for staff and to provide the support needed to retain skills and capability locally. As a health economy we want to meet the needs of our patient population in a safe, effective and productive manner. This can only be achieved with a competent, confident and collaborative workforce.

The local workforce strategy needs to address current needs as well as future plans aligned with the NHS five year forward view and our local commissioning strategy.

To do this, we need to have a better understanding of the challenges we face based on more than just assumptions and perceptions, so that we can start to develop a sustainable approach to workforce planning for the next 15-20 years.

What we did

In November 2014, we convened as a multi-agency project group and commissioned two pieces of research to identify the workforce gaps that currently exist in our local health economy, and to help us to understand the things that we can do to encourage clinicians to want to work in our area and to stay in our area.

To do this:

- We looked at the workforce intelligence from primary and secondary care (including the acute sector)
- We discussed with a group of senior managers the barriers to clinicians working across organisational boundaries
- We looked at intelligence taken from recent patient engagement activities undertaken to develop the CCGs' 5-Year Commissioning Plan
- We held a series of focus groups to explore with clinicians (trainees and established doctors and nurses) the things that would encourage clinicians to stay in the locality, to work more flexibly across the wider system and for trainees to choose General Practice as their specialism
- We undertook in-depth telephone interviews with clinicians who had recently left the area

What we found: Quantitative research

Unreliable workforce data across the system

Health Education North West has developed a Workforce Repository and Planning Tool (WRaPT) to analyse health and social care providers' workforce data. The NHS data source for WRaPT is the Electronic Staff Record (ESR). However, we found that this data lacks the consistency and depth required to enable us to develop an accurate picture of the health care workforce across the two providers (noting this is a system wide issue), which impacted on the effectiveness of the WRaPT as a workforce planning tool.

There is therefore a clear need for providers to prioritise improving the workforce data held in ESR to provide better knowledge in relation to roles, competencies and behaviours of the workforce.

To achieve our project ambitions, we also need knowledge about the optimal skill mixes and behaviours with which to provide the best patient and staff experience, and knowledge of the rewards and incentives required to encourage clinicians to work in central Lancashire, thus ensuring that the required skills and behaviours are available at the right time, in the right place regardless of the employer.

The quantitative research undertaken indicates that there is little information relating to these important questions and of the impact of turnover rates and the actions taken to address high levels of staff turnover.

We still have little understanding of the current workforce gaps beyond vacancy rates

Almost 30% of GPs will reach retirement age in 10-years' time

Less than half the primary care nursing workforce is delivering long-term conditions care. 63% of those that are, are aged over 50 and due for retirement in the next 5-10-years

We must act as a partnership to ensure that we attract, develop and retain the talent required to meet local need and to deliver our vision

Lack of strategic workforce planning within organisations and across the wider system

The research suggests that much of the workforce planning of our healthcare providers is not as advanced as required to deliver the NHS 5-Year Forward View and is primarily based on historical intelligence, with little evidence of forward planning.

The project raises awareness of the importance of reliable, robust and effective workforce intelligence. It is clear that success in addressing these issues requires a concerted and cohesive approach, with strong leadership and the broad commitment and support of all partner organisations at the highest level.

Workforce gaps

The data we had confirmed to us that we have an aging general practice workforce with almost 30% of GPs reaching retirement age in 10-years' time. It also showed that less than half the primary care nursing workforce is delivering long-term conditions care, and that 63% of those that are, are aged over 50 and due for retirement in the next 5-10-years' time.

We also have higher than the national average numbers of administrative and clerical staff in primary care.

The highest vacancy rates in secondary care are amongst professional, scientific and technical, medical and dental staff.

The two main secondary care providers in our area reported almost 1600 leavers in a 12-month period.

Moving forward we must act as a partnership to ensure that we attract, develop and retain the talent required to meet local need and to deliver our vision.

What we found: Qualitative research

Barriers to working across organisational boundaries
A small group of senior managers considered the barriers that currently exist or are perceived to exist that prevent people from seeking out portfolio careers and / or secondment opportunities for career development.

People are unsure what opportunities exist across the wider system and are unclear about whose responsibility it is to manage this

Lack of robust and timely evaluation of pilot approaches and secondments both within individual organisations and across the local health economy, leads to a loss of learning

Patients don't want to have to see so many different clinicians when they move between primary and secondary care

The main theme emerging from these discussions was that people are unsure what opportunities exist across the wider system and are unclear about whose responsibility it is to manage this.

There is a perception that clinicians are worried about losing their specialism if they practice it in a setting other than the one usually associated with that specialism e.g. consultants practicing in the community rather than just within a hospital setting.

There is also a perceived divide between primary and secondary Care which often manifests itself into a lack of partnership working. This can cause barriers and makes it difficult for individuals to move across health care settings.

There is anecdotal evidence that secondments are used to cover vacant posts rather than as a tool to support portfolio career development, and that often secondments are supported by managers to address a staffing issue rather than being seen as an opportunity to enhance learning and to bring good practice and innovation back to the team.

There is also anecdotal evidence that secondees lose touch with their team if the secondment is for a lengthy period, and that this prevents clinicians from seeking out secondment opportunities.

There appears to be a lack of robust and timely evaluation of pilot approaches and secondments both within individual organisations and across the local health economy, so that learning is lost when pilots / secondments come to an end.

It was also generally understood that workforce planning was done on an organisational basis, adding to the silo tendencies that appear to exist across the wider system.

Patient expectations

The underlying requirement from patients from all groups was for continuity of care. Patients don't want to have to see so many different clinicians when they move between primary and secondary care.

They also want to have greater access to primary care (i.e. longer opening hours) and to have a greater choice about seeing clinicians that are of the same gender / culture as they are.

Ipsos-MORI research
The summary of the report findings and the 'voxpops' from the interviews with clinicians reaffirms some of the existing perceptions but also gives new insights into the issues facing our local health economy, some of which are set out below:

- There is little evidence to show that provider approaches to workforce planning is proactive
- Workforce planning across the local health economy is fragmented, with few collaborative links both within and across organisations
- Trainees are interested in portfolio careers as a career pathway but established clinicians are more dismissive about portfolio careers
- Despite the fact that the North West is the leader in primary care placements for Foundation trainees, they say that exposure to primary care comes too late to affect their career choice
- Historic perceptions or primary care are being reinforced by some established clinicians
- The 'business' side of being a GP making learners nervous about their skill sets
- The remoteness of some of Lancashire's communities creates fear amongst trainees that they could become isolated if they work in primary care. In secondary care some trainees perceive working in tertiary centres as a better option

Conclusions

There are suggested quick wins and longer-term strategy emerging from the research findings. These broadly relate to career marketing, inter agency-communication, workforce data-tracking, skill sharing, training and education and positive portfolio construction.

Key aspects of the findings include:

- An urgent need to improve the quality of the local health economy's workforce data, and to ensure that high quality data is routinely used to inform medium and long-term strategic workforce planning across the economy

- The need for a single locality based workforce plan aligned with CCG commissioning plans

- An urgent need to improve information for local students considering medicine as a career option –

There is little evidence to show that provider approach to workforce planning is proactive. Workforce planning is fragmented with few collaborative links both within and across organisations

Despite the fact that the North West is the leader in primary care placements for Foundation trainees, they say that exposure to primary care comes too late to affect their career choice

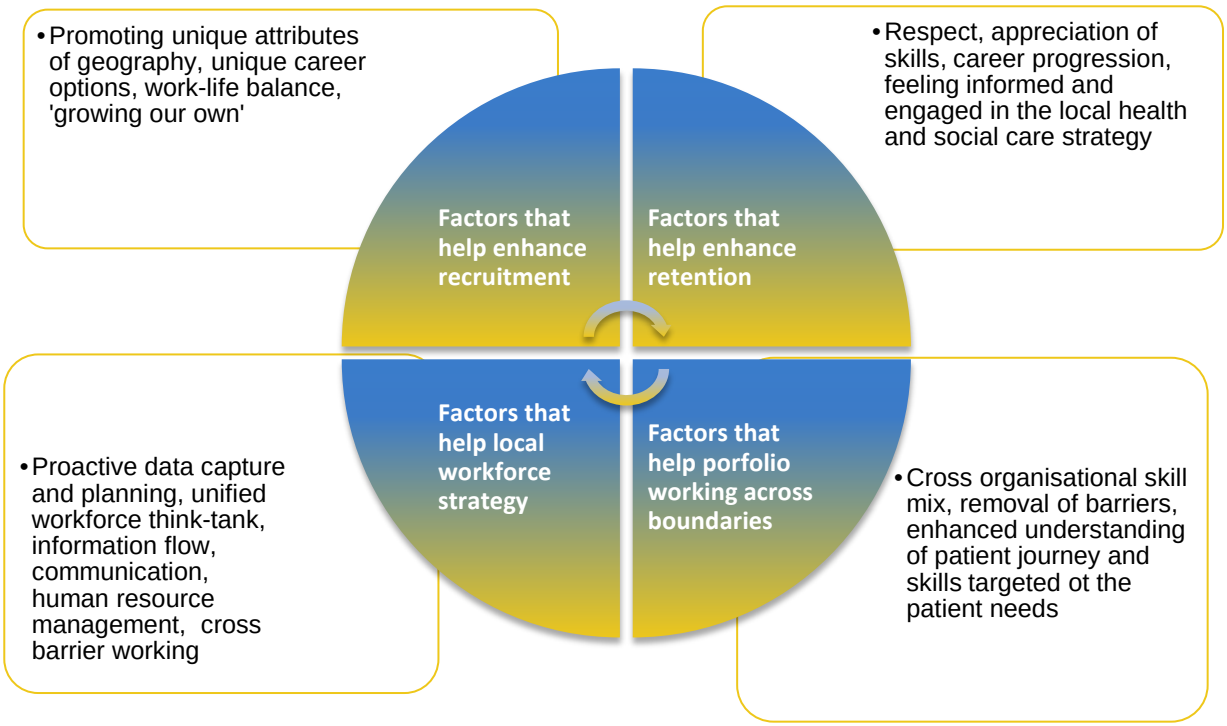
Quick wins and longer-term strategy emerging from the research findings broadly relate to career marketing, inter agency-communication, workforce data-tracking, skill sharing, training and education and positive portfolio construction

We need to improve the quality of the local health economy's workforce data, and to ensure that high quality data is routinely used to inform medium and long-term strategic workforce planning across the economy

engaging with 6th form colleges and promoting clinical careers, with an emphasis on primary care

- An urgent need for a local workforce think-tank to identify and eliminate perceived barriers relating to working across organisational boundaries, and to support skill sharing across sectors, enabling the health care workforce to work and to move seamlessly across the whole local health economy
- An urgent need to pilot portfolio options for doctors and nurses that champion 'cross-organisational' working and the NHS five-year forward view
- Better promotion and communication of career options within central Lancashire to become a contender in the competitive market to secure talent into the area
- An urgent need to develop streamlined nurse training models for the community and General Practice

The diagram below summarises the key things we need to include in a local health economy workforce strategy to **secure our workforce for the future**.



Phase 2 of the project to be delivered in 2015/16 will seek to address these issues by developing new approaches to workforce planning, training and employment, including the development of some pilot portfolio job roles for trailing in our area.

Workforce for the future - Section 3: Context and purpose of the research

Context

This health and social care economy (comprising both commissioners and providers) has identified significant challenges to the workforce across many specialties and disciplines.

We struggle to compete with Manchester and Liverpool to attract and retain the best clinical and nursing graduates to this area despite the quality of training at our local acute provider ranking as one of the best available.

On top of this we have a legacy of under investment in the primary care workforce and premises in comparison to other areas of Lancashire. We are a 'City Deal' area with an expected increase in our population of 14,000 residents in 5-years. This poses an obvious challenge and a need to focus on modernising our workforce and the services we provide across health care settings.

We want to encourage people to positively choose this area to work in, offer interesting and imaginative opportunities for staff and to provide the support needed to retain skills and capability locally.

We recognise that these issues are affecting other areas equally, and although the research carried out during Phase 1 of this Project was targeted within central Lancashire, the learning will be shared across the region and nationally.

Strategic context

The five year strategic plan of NHS Chorley and South Ribble and NHS Greater Preston Clinical Commissioning Groups has at its heart 'care closer to home' and the strategy to achieve this is to shift emphasis away from hospital based care. The workforce is a key enabler to making this happen and this project was developed to help us to identify and address the workforce challenges that put the achievement of our vision at risk.

Purpose of the research

We need to address the workforce challenges that exist today and in particular the gaps that exist in the clinical workforce and the difficulties we have in recruiting to and retaining expertise in key clinical posts.

We also need to 'future proof' our clinical workforce across the local health economy (within primary, secondary and acute care). This will require transformational activity to tackle organisational cultures that may act as barriers to the creation of a more flexible workforce.

Overall, we must ensure that we have the right levels and range of skills available to deliver our plans in the next 5-years, and to sustain this over at least the next 10 – 15-years.
We had an assumed knowledge of the workforce challenges facing us as a local health economy based on perceptions, but we wanted to test this out to ensure that we properly target future workforce planning, training and development in the areas that are most critical to achieving our vision.

Our perceptions told us that we had an aging primary care workforce and difficulty in recruiting to clinical posts within primary care. We knew our population would increase as a result of City Deal investment and that our population was also aging. These factors combine to place increased demands on primary care at the same time we are placing more reliance on primary care to deliver integrated healthcare to our local communities.

If we are to successfully deliver our vision, we need to move away from the existing siloed approach to workforce planning, and work together across the local economy to create and maintain a clinical workforce that provides more holistic and patient centric healthcare whilst at the same time ensuring that we always have the right levels and types of skills needed to meet local healthcare needs.

Success in the longer-term will be measured by increased recruitment and retention rates across the health economy clinical workforce, a reduction in clinical vacancies, and an increase in staff and patient satisfaction across the local health economy. Baselines will be established from the research undertaken and used to develop a Clinical Workforce Performance Dashboard to monitor these key indicators over time, once the findings of the research have been published and acted upon.

Workforce for the future - Section 4: Research methodology and findings

The project comprised of two work streams.

Work stream 1 largely focused on a **quantitative analysis** to identify the specific skills gaps that exist within the system and how this compares nationally.

Work stream 2 focused on **qualitative research** to help us to identify the things we need to do to address the issues identified in Work Stream 1.

The two work streams are inter-related, and work stream 1 has helped us to identify specific areas where piloting work to be done in phase 2 of the project should be targeted to achieve some ‘quick wins’ and the biggest impact.

Phase 2 of the project will identify specific opportunities for joint working and employment across sectors. We will seek to address the barriers to operationalising this, including the legal and HR implications of developing alternative employment contracts for joint appointments so that we can develop solutions to these.

From this, we will develop a suite of portfolio job plans, job roles and development programmes across health care settings to be piloted within the local health economy.

Workforce for the future - Section 4.1: Quantitative research

The aim of this work stream was to use existing workforce data to establish a baseline assessment of the gaps that exist today in the local health economy's clinical workforce, broken down by permanent, agency and contracted (fixed-term) staff.

We also wanted to identify the types of posts and skills that we have difficulty in recruiting to and in retaining suitably experienced and skilled clinicians, distinguishing gaps arising from a failure to recruit and those arising from a lack of succession planning and supply of the skills needed.

What we did: Primary care workforce data

The CCGs encouraged General Practice within the local health economy to complete the Primary Care Workforce Survey being undertaken by HENW, in order to provide the primary care workforce data we needed for the project. In view of the pressures on General Practice, the CCGs arranged with HENW for the closing date for completion of this survey to be extended to ensure that the return rate increased sufficiently to be statistically significant.

The overall CCG return rate for this survey within Lancashire as a whole was 55% (the range being between 16% and 92%). The return rate for NHS Chorley and South Ribble CCG was 56% and the return rate for NHS Greater Preston CCG was 63% giving a combined return rate for the local health economy in central Lancashire of just under 60%.

In December 2014 the CCGs received their individual workforce analysis from HENW, and this data was added to the data collected from secondary care (see below) to inform the quantitative research.

What we did: Secondary care (including acute) workforce data

The main source of the featured trusts' workforce data is the Electronic Staff Record (ESR). The Project Team explored the potential to use the Workforce Repository and Planning Tool (WRaPT) developed by HENW to report on secondary care workforce data. However, although the main workforce data report that affords a comparison of the established and actual workforce in Trusts had been developed, the reporting capability of the WRaPT was agreed with the developer to be limited at the time.

In addition, the source data from ESR was not available within WRaPT from the two Trusts to run accurate reports.

Lancashire Teaching Hospital and Lancashire Care Foundation Trusts therefore provided two standard ESR reports for inclusion in this research, as described below:

- The established workforce numbers coupled with the comparison data of the actual workforce numbers broken down into role categories across the Trusts' structures. This data was used to identify the vacancy rates for each provider, collectively based on nationally agreed professional role categories

- Standardised ESR leaver data over a rolling 12-month period

Providing this data caused some difficulties for both Trusts. One Trust for example was challenged by the reconciliation required between the ESR data and the Ledger information held between Human Resources and Finance.

Both trusts between them report almost 1,600 leavers in the last 12-month period. However in both cases, the reason for the employees leaving, captured in ESR, was limited in its ability to inform future recruitment and retention strategies.

Data relating to the current levels of core workforce competencies has also not been made available from either Trust as this information is not currently captured in the ESR.

One trust reported from 'NHS Jobs' all failed recruitment campaigns over a rolling 12-month period. However as with all the workforce data supplied by the Trusts, no analysis of the data was provided and neither trust was able to show how such data was used to inform strategic and operational workforce planning.

Both trusts gave consent for HENW to provide the narrative sections of their 2014 Workforce Planning returns and the local workforce intelligence contained within these documents included expected workforce planning ideologies. However insight from both documents was light in respect of any workforce analysis and the associated (current and / or future) workforce issues, risks and mitigation. Given the pace of change evident within the wider system, it is imperative that these annual returns are reflective of current and emerging challenges going forward.

What we found

Health Education North West has developed a Workforce Repository and Planning Tool (WRaPT) to analyse health and social care providers' workforce data. The NHS data source for WRaPT is the Electronic Staff Record (ESR). However, this data lacked the consistency and depth required to develop an accurate picture of the health care workforce across the two providers (noting that this is a wider system issue), which impacted on the effectiveness of the WRaPT as a workforce planning tool. There is therefore a clear need for providers to prioritise improving the workforce data held in ESR to provide better knowledge in relation to roles, competencies and behaviours of the workforce so they can benefit fully from the WRaPT and use it to aid workforce planning across the local health economy.

Despite the limitations of the data collection exercise set out above, the workforce assessment of the available evidence highlights the following:

Primary care workforce

- We have higher than average numbers of administrative and clerical staff in central Lancashire compared to the national average, providing the opportunity to explore skill mix development and a career framework across clinical and non-clinical roles
- 28% of the GP workforce will be aged 58-60 in ten years' time – this being cited by the Centre for Workforce Intelligence as the average retirement age for female and male GPs respectively
- A potentially high risk to the future capacity of nurses and direct patient carers, particularly with 59% of the nursing workforce being aged 50 or over
- The workforce is predominantly female (89%) and part-time, with 53% of women working 0.8 whole time equivalent or less and the degree of part-time working tending to increase as the workforce ages, suggesting a larger number of trainees in particular may be needed to ensure a full time equivalent level of workforce supply moving forward
- Less than half the nursing workforce are delivering long term conditions care and those that are, are predominantly aged 50 or over (c. 63%)

Secondary care NHS workforce

Vacancy rates (as at November 2014) for the clinical workforce across the Acute and Community NHS providers are broken down in the table below:

Professional Scientific and Technical	16.98%
Additional Clinical Services	3.63%
Allied Health Professionals	5.82%
Healthcare Scientists	6.64%
Medical and Dental	12.34%
Nursing and Midwifery Registered	4.36%

We are unable to differentiate between workforce gaps arising from a failure to recruit and those arising from a lack of succession planning and supply of skills

We have higher than average numbers of administrative and clerical staff provides an opportunity to explore skill mix development and a career framework across clinical and non-clinical roles

Almost 30% of GPs in central Lancashire will retire in 10-years' time

Less than half the nursing workforce are delivering long term conditions care and 63% of those that are, are predominantly aged 50 or over

The Acute and Community NHS providers across Chorley and South Ribble and Greater Preston report almost 1,600 leavers over a defined 12 month period

Problems are not due to insufficient commissioning of education and training places, but rather more deep-seated problems with attracting and retaining people to the professions and to the increasing demands on some services

The main issue within psychiatry is that whilst the number of training posts should support significant growth, levels of fill rate at Higher Specialist Training is consistently low and is now threatening this potential growth. Unless a different approach is taken, we will have insufficient supply to meet demand in the future

The National Institute for Health and Care Excellence (NICE) guidance recommends a maximum vacancy rate of 5% for nursing, Our Trusts are currently reporting an overall vacancy rate of 4.36% (see above).

The Acute and Community NHS providers across Chorley and South Ribble and Greater Preston report a total 1595 leavers over a defined 12 month period.

Data relating to the return to practice of healthcare professionals across central Lancashire was not available to inform this research.

The wide mix of professional staff delivering healthcare increases patient choice and the availability of essential skills, but also contributes to the lack of reliable data across the diverse workforce delivering healthcare to our population.

There is a range of different job titles and roles, which are not always the same for staff doing similar jobs, and job titles do not always accurately reflect how much therapy is provided, or which types of therapy are being offered. There are no agreed categories by which staff delivering healthcare are designated for the purpose of recording workforce data.

Comparability is an essential aspect of data quality, and data can only truly be comparable when the values available are applied consistently across different organisations.

In light of the limited data available, we are also unable to differentiate between workforce gaps arising from a failure to recruit and those arising from a lack of succession planning and supply of skills.

The trusts have a duty to ensure that they are planning for and recruiting the right numbers of staff with the right skills and behaviours to meet the current needs of their patients and the boards of provider organisations need assurance that current staffing levels are safe and appropriate.

However, because it takes at least three years to train a nurse, and longer for other professionals like GPs and hospital Doctors, Trusts also need to forecast future patient demand to inform decisions about future workforce supply.

Conclusions

Inconsistent and poor quality data from employers in primary and secondary care prevents the effective use of a single system (the WRaPT) to collate workforce data across the local economy to provide intelligence to inform future workforce planning, education, training and development for staff. It is therefore essential that we improve the accuracy of our workforce intelligence for the future, so that we can be proactive rather than reactive in our approach to workforce planning.

At the end of phase 1 of Work Stream 1 of this project, we still have little understanding of the current workforce gaps beyond vacancy rates. Workforce data relating to the core competencies of the current workforce is not captured and therefore not reportable, data on voluntary turnover and retention is limited and data relating to posts that are difficult to recruit to is also limited.

High medical vacancies have been identified as an issue for the north-west, with all of Cumbria and Lancashire healthcare providers reporting challenges in recruiting to medical roles at all grades especially in emergency medicine and accident and emergency departments.

In relation to the Emergency Care workforce, growth in the number of consultants nationally is reported to be amongst the highest of any speciality, yet still the service has struggled to keep pace with demand. It is suggested that these problems are not due to insufficient commissioning of education and training places, but rather more deep-seated problems with attracting and retaining people to the professions and to the increasing demands in this part of the service.

The psychiatry workforce is divided into six specialties and the main issue for all of these groups is that whilst the number of training posts should support significant growth, levels of fill rate at Higher Specialist Training is consistently low and is now threatening this potential growth. Unless a different approach is taken, we will have insufficient supply to meet demand in the future.

We also don't know the rate at which nurses are moving from acute secondary to community and primary care within central Lancashire and thus don't know what is being done to ensure that sufficient jobs are created in the community to meet current and future demand, and how individuals are incentivised and supported (if at all) to choose them.

It is recognised that post registration programmes enable nurses to look after the whole person, including psychiatry, mental health and physical therapies. However, whilst we recognise that it is important to create and invest in new roles, we recognise that the existing workforce will make up the majority of the future workforce.

National forecasting indicates that unless additional action is taken by commissioners and providers, nursing in the acute sector may grow at the community's expense.

The CCGs clearly have a pivotal role in working with providers to oversee the planning process for the shift from acute into community care and should therefore take the lead in developing a local health economy approach to workforce planning.

In order to achieve the workforce for the future project ambitions, we need better knowledge about the required roles, competencies and behaviours of the workforce across the whole system, and a clear understanding of the optimal skill mixes and behaviours with which to provide the best patient and staff experience.

We will also need further knowledge of the rewards and incentives required to encourage clinicians to work in and stay in central Lancashire thus ensuring that the required skills and behaviours are available at the right time, in the right place regardless of the employer.

In respect of service transformation, we already know that in order to improve the quality of care to patients, the local and national NHS system needs to change. However, the healthcare provision to our patients and their families is delivered by people not buildings and we understand that if we are to successfully transform the central Lancashire provision of healthcare then we will have to transform the way we educate, employ and deploy our people. Sometimes we can drive service transformation through the rapid expansion of existing roles (such as health visitors, or school nurses).

Based on our findings the required transformation for our patients will be achieved more quickly if commissioners and providers across the economy work together to create jobs that span primary and secondary care and seek to address the barriers that currently prevent this from happening.

We also need to consider investment in entirely new roles and professions, such as Physician Associates (PAs), who are trained to perform a number of duties, including taking medical histories, performing examinations, diagnosing illnesses, analysing test results and developing management plans, to help to address the lack of capacity in General Practice and to deliver more holistic care across different teams and settings.

The research undertaken suggests that much of the workforce planning of our healthcare providers is not as advanced as required to deliver the NHS 5-Year Forward View and is primarily based on historical intelligence, with little evidence of forward planning.

Whilst secondary care providers are required to submit an annual workforce plan to HENW, primary care providers are not required to do this. Currently therefore, we have two annual workforce plans developed in isolation by each of the two Trusts and no overarching workforce plan for primary care.

This lack of strategic workforce planning for the local health economy puts achievement of the vision for healthcare within central Lancashire at risk and needs to be urgently addressed.

We need to consider investment in entirely new roles and professions, such as Physician Associates (PAs), who are trained to perform a number of duties, including taking medical histories, performing examinations, diagnosing illnesses, analysing test results and developing management plans, to help to address the lack of capacity in General Practice and to deliver more holistic care across different teams and settings

Based on our findings the required transformation for our patients will be achieved more quickly if commissioners and providers across the economy work together to create jobs that span primary and secondary care and seek to address the barriers that currently prevent this from happening

Lack of strategic workforce planning for the local health economy puts achievement of the vision for healthcare within central Lancashire at risk and needs to be urgently addressed

Moving forward the development of a workforce plan for central Lancashire will enable CCGs to:

- Identify immediate gaps in key workforce areas across central Lancashire
- Plan to expand the future workforce in priority areas
- Secure investment in the existing workforce to help drive service transformation
- Develop a more strategic and cost-effective approach to staff retention

Workforce for the future - Section 4.2: Qualitative research

Work stream 2 focused on **qualitative research.**

What we did

The qualitative research looked at three distinct areas as follows:

What stops us from working more flexibly across the wider health care system?
This question was explored in a discussion group with senior managers from the local health economy

What aspects of care of importance to patients and the wider community have an impact on workforce planning?
Data from a recent patient engagement exercise undertaken by the CCGs to inform the development of their 5-Year Plan was analysed to provide evidence for this

What do established clinicians, trainees and clinicians who have recently left the area think will encourage / would have encouraged them to stay in Lancashire and to choose primary care as their specialism
As a national leader of quality research, Ipsos MORI was commissioned to lead on this element of the research and worked with the Project's Clinical Lead to establish a series of focus groups which included four distinct cohorts of the clinical workforce as follows:

- Doctors and nurses in training (yet to pick a specialty)
- Doctor and nurses in specialty training
- Doctors and nurses in established posts within our health economy
- Doctors and nurses who have recently left our health economy

An initial series of informal interviews took place with a variety of clinicians from the various cohorts, led by the Project's Clinical Lead. This helped to identify and develop the themes for the focus group discussions that took place later in the research.

The key themes to explore in more depth identified from this initial informal research included the following:

- Existing workforce perceptions of the market place
- Existing workforce perceptions on distinct silos of working
- Lack of a distinct health economy wide workforce 'think tank'
- The divide between primary and secondary care and the lack of understanding of blurred boundaries
- No clear leaders in the local health economy promoting a model for 'growing our own' doctors and nurses
- Future career choices and factors that influence them
- Factors that attract recruitment into a specific health economy - geography, work-life balance, culture, proximity to key aspects of life
- Factors that would enhance retention - respect, appreciation of skills, ability to develop portfolios, feeling engaged in health economy health and social care strategy, proactive and not reactive responses to workforce changes
- Steps stakeholders need to take to address barriers (both real and perceived) to cross organisational working and pooled skill mix

- As we need well over 50% of medical graduates to go into general practice, what are the factors that would enhance general practice recruitment with reference to our own locality?
- Factors that would enable improved practice nurse recruitment and training
- A future where the structure and organisation of the local health economy drives a unified workforce approach
- What improvements could we make in terms of information flow, communication, local recruitment, training, curriculum and human resource management to enable portfolio working?

Focus group cohorts were subsequently recruited to consider these issues and Ipsos MORI conducted interviews and group discussions among the various cohorts using standardised questions. In total, 22 clinicians took part in these discussions.

In addition, a series of in-depth telephone interviews with seven clinicians who had recently left the area was undertaken.

What we found: Barriers to working across organisational boundaries

A small group of senior managers considered the barriers that currently exist or are perceived to exist that prevent people from seeking out portfolio careers and / or secondments for career development.

The main theme emerging from these discussions was that people are unsure what opportunities exist across the wider system and are unclear about whose responsibility it is to manage this i.e. will it need to be undertaken in the clinician's own time or can it be managed within an existing job role. There are also perceived barriers based on how this will be managed contractually i.e. who is the employer when a clinician works across organisational boundaries?

There is a perception that clinicians are worried about losing their specialism if they practice it in a setting other than the one usually associated with that specialism e.g. consultants practicing in the community rather than just within a hospital setting.

However this was seen as an opportunity worth developing as it is clearly linked to patients' desire for greater continuity of care (see below). Although it is desirable for clinicians to retain their specialisms, knowledge and experience gained as a specialist would be improved if they are encouraged to seek out opportunities for carrying out their specialist work in different settings e.g. primary care, secondary / acute care, and in the community.

There is a perceived divide between primary and secondary care which often manifests itself into a lack of partnership working. This can cause barriers and makes it difficult for individuals to move across health care settings, often to the detriment of the patient

Developing a joined up approach to workforce planning would help to address the shortcomings in workforce data intelligence whilst creating opportunities to develop a care-based rather than a professionally led model that encourages clinicians to work more flexibly across the wider system

Existing workforce strategies tend be based on higher education advancement, often ignoring advancement for staff on bands 1-4 who are the staff most likely to have face to face involvement with patients on a daily basis

There is also a perceived divide between primary and secondary Care which often manifests itself into a lack of partnership working. This can cause barriers and makes it difficult for individuals to move across health care settings, often to the detriment of the patient.

Other examples where working across the wider system would be of benefit were identified, including allowing DBS checks to be transferable across organisations and for mandatory training i.e. equality and diversity training to be transferable across organisations.

There is anecdotal evidence that secondments are used to cover vacant posts rather than as a tool to support portfolio career development, and that often secondments are supported by managers to address a specific isolated staffing issue rather than being seen as an opportunity to enhance learning and to bring good practice and innovation back to the team.

There is also anecdotal evidence that secondees lose touch with their team if the secondment is for a lengthy period, and that this prevents clinicians from seeking out secondment opportunities.

There is a belief that organisations don't consistently encourage innovative ways of working and those that do often fail to robustly evaluate pilot projects and / or secondments, so that learning is lost when pilots / secondments come to an end.

Workforce planning is also done on an organisational rather than a locality basis (See Section 4.1 above), which reinforces silo thinking. Developing a joined up approach to this would help to address the shortcomings in workforce data intelligence previously highlighted whilst creating opportunities to develop a care-based rather than a professionally led model that encourages clinicians to work more flexibly across the wider system.

Existing workforce strategies tend be based on higher education advancement, often ignoring advancement for staff on Bands 1-4 who are the staff most likely to have face to face involvement with patients on a daily basis. These staff are usually only offered mandatory training, thereby losing the potential to make more effective use of a significant number of the existing workforce.

Developing a local economy workforce strategy and approach to workforce planning could focus on developing doctors and nursing staff within a competency rather than an organisational based framework, and should also seek to include staff at all levels within the economy.

What we found: Patient engagement - workforce implications

Research undertaken by the CCGs to inform the development of their 5-Year Plan in 2014 was reviewed to identify the issues identified by patients and the wider community within central Lancashire that have a bearing on the workforce.

The outcome of those discussions is shown in the table below.

Targeted group	Feedback with workforce considerations
Age: Young people	• Increase accessibility to practice nurses • GPs open later • Preference for gender specific clinics (more female clinicians)
Age: Older people	• People with long term conditions like continuity – seeing the same clinician helps them to manage their condition
Disability: Learning disabilities	• People with learning disabilities like continuity – seeing the same clinician helps them / their carer to manage their condition
Disability: Sight Loss	• People with sight loss like continuity – seeing the same clinician helps them / their carer to manage their condition • Additional time (double appointments) if required
Gender reassignment (gender dysphoric)	• Seeing the same person
Race: Black African Caribbean	• Seeing the same person – continuity of care • Empathy with us (black clinicians) specifically around mental health, care workers in care homes, nurses in hospitals • Services in one place • An understanding of our culture and diet and the conditions that are more prevalent i.e. high blood pressure, diabetes, prostate cancer, mental illness, sickle cell disease • Effective use of language support services – translators
Race: Asian	• Preference for a female clinician • Preference for clinicians with the same cultural values

Table: Patient engagement outcomes

These views have clear implications for the workforce. Diversity needs to be central to workforce planning and continuity of care can be achieved through the development of portfolio job roles that span primary and secondary care.

What we found: Ipsos MORI research

Context

The traditional model of healthcare deeply rooted in hospitals and primary care settings has faced radical changes over the last few years. This has been driven by public expectations and facilitated by an increasingly skilled primary care workforce, collaboration between specialists and generalists, and modern technology.

There has been an accelerating shift of services out of the traditional secondary care models into GP practices, community services and the new emerging integrated care centres. A hospital admission while vitally important in some cases can also be viewed as a failure of primary and community systems.

The clinical workforce has traditionally been sequestrated as those who work in the hospital and those in primary care. There have always been examples of professionals that have straddled the divide between primary and secondary care including Consultants and community nurses that outreach from hospital and GPs and primary care nurses that have in-reached into secondary care.

There is also a concentration of clinical workforce around tertiary centres and a higher concentration of health care professionals who want to work in big city based hospitals leading to difficulties in recruitment in areas outside major cities.

There has also been a steady decline in certain specialties, General Practice being the more obvious example while others such as Accident & Emergency and Radiology are also experiencing a decline.

The lack of regular cohorts of trained Practice Nurses in primary care will lead to a retirement 'time-bomb' and needs to be addressed with some urgency.

Patients and carers have consistently expressed an expectation of choice in how care is delivered and want high quality, cost-effective care delivered quicker and closer to home. This needs to be delivered by skilled clinicians and multi-professional teams who can place their patients in a psychosocial context and are trained to understand the patient journey and deploy their skills in the most appropriate setting that enables not only safe and effective but also efficient and cost effective care.

Diversity needs to be central to workforce planning

There has been an accelerating shift of services out of the traditional secondary care models into GP practices, community services and the new emerging integrated care centres. A hospital admission while vitally important in some cases can also be viewed as a failure of primary and community systems

There has been a steady decline in certain specialties, General Practice being the more obvious example while others such as Accident & Emergency and Radiology are also experiencing a decline.

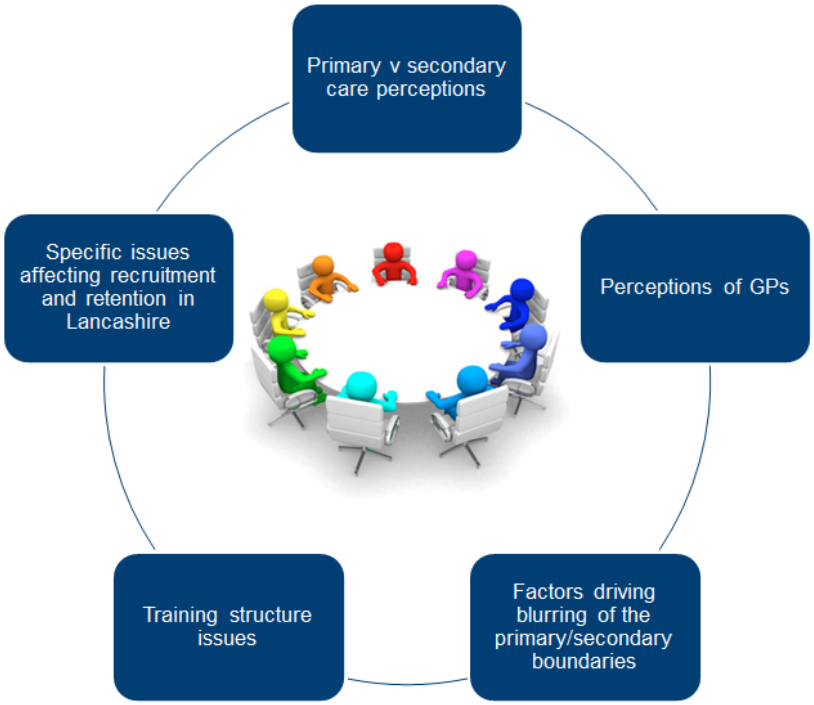
The lack of regular cohorts of trained practice nurses in primary care will lead to a retirement 'time-bomb' and needs to be addressed with some urgency

In order to keep up with the changes and ensure a regular supply of a workforce that understands and works with the emerging models of health care delivery, consideration needs to be given to:

- Extending and enriching the workforce
- Ensuring adequate recruitment to key clinical roles
- Identifying and addressing barriers to clinicians working across the whole of the health economy
- Enhancing the primary care workforce
- Identifying reasons why the health care workforce leave and relocate so that we can address this in a timely way as an aid to improving workforce retention

Ipsos-MORI research findings

The next section of the report is structured around the five key themes shown in the diagram below.



A series of focus groups was used to explore these issues with clinicians from primary and secondary care (doctors and nurses including both trainees and established clinicians), together with seven in-depth telephone interviews with clinicians who had recently left Lancashire. What they told us is set out as follows.

Primary or secondary care?

There are different influencers and drivers as to why medical professionals choose a career in primary or secondary care

Primary or secondary care?

Primary care

Primary care was seen as the frontline of the NHS amongst all of the workforce cohorts. As a result a number of positives and negatives were identified which characterise what it is like to work in this environment.

Positive	Negative
Varied – wide range of illnesses and contact with a cross section of patients	**Minor conditions** – illnesses such as colds, coughs, back pain etc. seen as relatively 'medically straightforward'
Challenging - wide knowledge required to treat all types of conditions 'the art of diagnosis and managing risk'	**Capacity** – lack of GPs/practice nurses is a long standing issue and primary care simply cannot be expected to carry any more responsibility
Chronic conditions – opportunity to manage the patient's condition over a period of time, rather than in secondary care where often only a symptom is treated	**Boring** – sometimes can be isolated, particularly in General Practice
Prevention – opportunity to influence lifestyle and prevent chronic conditions from acutely developing	**Fragmented** – primary care services are seen as fragmented and challenging to commission
Balance – seen as 'the closest to 9 to 5' as is possible working in the NHS	**Repetitive** – treating similar, minor conditions on a day-to-day basis
Less competitive – job-wise it is not perceived to be as competitive to enter into as secondary care	**Uncertain** – primary care is often subjected to constantly evolving initiatives to make it operate more efficiently
Holistic patient management – build up historic knowledge of patient and the factors that contribute to their conditions	

> I think being in primary care gives us an opportunity to have better relationships with the people we're working with, with the people we're looking after because you look after someone, you know everything from the day they're born and they're registered into the surgery until the day you either stop working in the surgery or for some reason they go away
>
> **Nurse**

> When patients come to the GP they come over a long period of time, even years. In hospital they come in and they get treated and they go out, and even if they come back in a couple of days later it's not necessarily the same team so potentially you never see them again and you never know the outcome, you never know what happens. It's nice to know outcomes.
>
> **F1/F2 Trainee**

One of the **key strengths associated with working in primary care** was the relationships which can often be built with patients. Treating patients from ‘cradle to grave’ was seen as one of the most rewarding factors of the role. For some, the on-going treatment of a chronic condition through to its successful resolution was cited as something which makes primary care particularly rewarding to work in.

On the negative side, patient expectation has increased over recent years. Patients have become more knowledgeable about particular conditions and often research symptoms on the internet, which means their expectations of primary care are very solution-orientated and they no longer necessarily think they require a diagnosis. This can contribute towards the ‘dumbing down’ of the role of medical professionals working in primary care as patients increasingly seek immediate remedies for their condition.

“A dumping ground”

During the research both primary and secondary care were described as ‘dumping grounds’ for patients. Primary care was seen as a ‘dumping ground’ because of the perceived expectation from other areas of the NHS that it will deal with conditions which do not require more specialist care or involvement.

Conversely, secondary care was also seen as a ‘dumping ground’ because of the number of referrals which are often made from primary care, some of which are not perceived as being appropriate nor necessary. Often this type of referral can be misinterpreted as a General Practitioner not having the skills to treat a condition themselves, or worse, a lack of ownership of the problem.

As a result there are conflicting views as to who has the responsibility for certain services, which evidently breeds frustration amongst the workforce as well as contempt from secondary care employees towards those in primary care and vice-versa.

Secondary care

Secondary care was perceived to offer more appealing career opportunities for medical professionals, particularly amongst the F1/F2 trainees, all of whom saw secondary care, and the specialist opportunities within, as a more attractive career path than primary. All of the trainees consulted had applied to follow a specialist path, and whilst some had also selected General Practice, this was only as a ‘fall back’ option should they not be successful with their first choice specialism. A career path in secondary care was seen as more challenging and competitive as well.

The table below lists the positive and negative perceptions of secondary care.

Positive	Negative
Dynamic/exciting – part of a busy, fast-paced environment	**Anti-social/lifestyle –** often requires shift work which is not conducive to a healthy work/life balance
Teamwork – normally work as part of a team, with other medical professionals as a 'safety net' and to get second opinions on certain conditions	**PET/beds/capacity** – pressure to discharge patients in order to free up capacity for other patients
Expert – opportunity to specialise and become a clinical expert	**Competitive** – to access certain specialisms as a career path
Challenging – perception that a role in secondary care is more challenging than primary	**Fragmented** – internal responsibilities are quite siloed, sometimes a 'not my problem' culture
	Stressful – not a rewarding, patient-focused environment

The perception of secondary care being a 'dynamic/exciting' place to work is formed during F1/F2 placements, the vast majority of which are in secondary care settings.

Trainees are exposed to a fast-paced working environment and also work alongside specialist doctors who can sometimes be outwardly critical of their counterparts in primary care. Currently, trainees do not experience a General Practice placement until the latter stages (last four months) of their F2 year, by which time they have already applied to follow a specialist path in secondary care. They do not therefore have the opportunity to form their own judgements about the potential of a role in primary care.

Some of the more experienced professionals did not share these same views towards secondary care as F1/F2 trainees, citing a stressful working environment and often a lack of supportive resource as key issues in secondary care. It was also not perceived as a particularly rewarding, patient-focussed environment at times as acute conditions are often treated without knowledge or understanding of a patient's medical history, and any on-going treatment then becomes the responsibility of, for example, a General Practitioner.

Retention in primary/secondary care

As well as recruitment issues a number of issues were identified which were seen as barriers and explained why doctors and nurses left their posts.

- **Stress of role – 'burn out'** – a lack of wider resource within the NHS has put greater pressure on those in post to take on additional roles and responsibilities, as well as, in a nurse's case, working additional shifts. Over time this pressure builds up and leads to burn out amongst the workforce

- **Lack of supervision** – another consequence of the lack of resource is the low ratio of staff to patients, which means that experienced staff cannot supervise newly qualified/junior staff

- **The ‘glass ceiling’** – in particular for nurses the pay scales are such that in order to progress they must take on additional responsibilities in return for an increase in wage. As a result nurses become less involved with patient care and more involved in management. Some nurses would prefer to remain a good quality, but senior, clinical nurse on a ward, but would not be financially rewarded for doing so.

No-one is interested in being a good clinical nurse on a ward

Nurse who has recently left post

Perceptions of general practice

There are negative perceptions of General Practice, which paint a negative portrayal of this career path.However, there are also positive experiences and messages which are often lost, particularly to those at the start of their career

Perceptions of General Practice

Both the current and future workforce identified negative perceptions associated with General Practice. This negativity is often further accentuated by regular negative press coverage. The net effect of negative perceptions fuelled by regular press coverage is that General Practice is often not seen as an attractive career path, with the proposed changes in commissioning creating further uncertainty about the future.

The table below outlines in more detail the issues which manifest to create these negative perceptions.

Internal	External
Non-General Practice doctors can peddle negative perceptions of General Practitioners by, for example, questioning the validity of a hospital referral CPD/career development – doctors and nurses often work in isolation and deliver their consultation in rooms with little interaction with other medical professionals	Negative press – concerning patients not being able to get appointments, need to extend opening hours, low recruitment coverage
Consultation time – the 10 minutes consultation 'slots' are seen as being too little to undertake a proper diagnosis	Pressure from politicians and patients for increased access
	Increasingly demanding patients – a 'here and now' culture which means patients expect to be treated immediately

From the public, it's like nobody appreciates the GP anymore. They either complain about you can't get an appointment, or when you get an appointment my GP missed this, and it's constantly in the headlines

F1/F2 Trainee

It's the best job in the world. It's the most interesting, it's the most varied, it's the most privileged

Experienced practice GP

I think there's quite a lot of articles like I've been reading about GPs writing about how it's not very good at the moment, and how the amount of admin is comparable to the amount of time they actually spend seeing patients, even on Facebook like the salaried GPs are saying it's no good, and some of them have been quite vocal about how negative it is

F1/F2 Trainee

Trainees, in particular, are heavily influenced by the internal factors listed above. Trainees spend much of their F1/F2 training in secondary care placements at the moment, only experiencing a General Practice placement in the last four months of their F2 year. This placement occurs after they have made a decision to follow a more specialist, non-General Practice career path. Therefore, trainees are not given the opportunity to counter some of the negativity surrounding General Practice.

“It’s the best job in the world”

The research did identify a number of positive elements of the role, which are often lost amidst the pessimism and unfavourable press coverage. These positives include:

- **Work/life balance/family friendly** – working in General Practice is perceived to be the closest to a ‘9 to 5’ as is possible within the NHS. Historically shift work has not been required which means less unsociable working hours compared to hospital based practitioners

- **Regular patient contact** – building a long-term relationship with patients and a better understanding of the genealogical history of a patient can be hugely rewarding for a doctor. Some respondents made reference to ‘the good old days’ of family doctors which generated two-way trust. It was felt that this had now been lost somewhat. Nevertheless, working with a patient to treat a long-term, chronic condition with a visible outcome is satisfying

- **Treat chronic rather than acute conditions** – for some this is seen as more rewarding and stimulating

- **Preventative care opportunities**, rather than the reactive nature of secondary care and other areas of primary care such as A&E for example

- **Care in the community** - patient centred, keeping a patient out of a hospital setting and giving them the most comfortable care possible goes to the heart of the future healthcare delivery vision

- **Valued** – by all that use the service, and at times by the teams in the hospital which use the service. Also, patients rely on and value access to their General Practitioner (despite the problems sometimes experienced with accessing available appointments)

- **Triage** – a valued service in primary care which really is the frontline of medical care. An effective triage service can relieve pressure on other areas of the NHS

- **Negatives surrounding secondary care**, particularly working in a hospital setting. For example hospital-based healthcare is seen as extremely pressurised and stressful. This pressure can lead to a lack of teamwork at times, which is not necessarily a rewarding environment to work in.

The allure of a portfolio career

A portfolio career is seen by the NHS as a way to address workforce gaps within primary care by broadening the skillset of those in primary care and making work within General Practice a more rounded experience.

The research highlighted the threat of burnout within the medical workforce. One way of countering this retention threat is the potential of a portfolio career.

The portfolio career concept was introduced by the moderator during the focus groups. The reaction was mixed based on where a participant was in their career.

Trainees did not know this opportunity existed, but once the concept was explained they were universally enthusiastic about the potential of such an opportunity. Monotony of a General Practitioner's role was identified as one key factor which turns medical graduates away from a career in General Practice. A portfolio career was seen as a counter to this and an opportunity to make the career more attractive.

In particular, developing a portfolio redresses one of the key turn-offs of a career in General Practice by providing an opportunity for frontline staff to develop operational and clinical/scientific ideas and theories of interest outside of the constant day-to-day pressures of the role. It also provides a greater opportunity to specialise, which for some is one of the key determining factors as to why they follow a career in secondary care.

Experienced professionals, however, were sceptical of the concept. Portfolio careers were seen as positive 'in theory' but concern was expressed that career progression would be disadvantaged by what was perceived as a 'career break'. Scepticism centred on how this concept would actually work in practice. In particular, there was concern as to how it would fit with an ever increasing workload and also the individual sacrifices in salary which might have to be made in terms of taking regular time off to pursue complementary interests.

The experienced workforce felt that this was a central government initiative which was not necessarily supported or promoted at a local, Trust level. There was a need to understand how this type of initiative would be practically administered, supported and delivered, at a local level.

> That's exactly what I said to someone last week that I wanted to do, but I didn't even know it was possible or how to do it
>
> **F1/F2 Trainee**

> A portfolio career can enrich a doctor's skill base by pursuing other interests alongside their practicing commitments, leading to a more contented and skilled workforce, resulting in higher quality employees for the NHS

Positive and negative reactions to a portfolio career

The diagram below gives some examples of clinicians' views about portfolio careers.

"That's exactly what I said to someone last week that I wanted to do, but I didn't even know it was possible or how to do it"

"There's a few people who are doing it like the course we both went to, the creator of that he was a dynamic entrepreneur, he's a GP, he has what we consider a portfolio"

"So this sort of thing is basically pushing innovation in a way as well which is one that the government's trying to do as well"

"Get the frontline staff to give us their ideas and we'll see if it can work"

"I think you're less likely to become bored as well if you're doing something different once or twice a week"

"I think it would draw more people towards GP, if there were more emphasis that this was another option as well, like that you could go down this route"

"You can get some examples of people who are doing the portfolio work, because that's how I became aware essentially; I know people who are doing this and they're happy"

"Let's say that you do have a portfolio career and you do decide to incorporate it into your hobbies, into your portfolio, the things that are not your hobbies are doing to catch up with you anyway"

"These are government things; they're not Trusts ideas, they're government ideas that are being pushed onto trusts"

"Medicine is all about experience that's how you get to be like the experts up at the top, so if you decide to only work three days a week and someone else is working five days a week and you both go for the same job, you're not going to get it because they're going to have more experience"

"The only way I'd go into that is if I saw someone who's doing it and it worked for them but I'd still be skeptical"

Blurring of the lines

Primary and secondary care is increasingly overlapping, with the aim of providing a better patient experience. Respondents identified three key drivers for this, but also some key delivery issues.

Blurring of the lines

Overall, there was acceptance and support of the direction of travel within the NHS, which aims to deliver a more patient-focussed service within the community. The research identified three principle issues driving the merging of primary and secondary care:

Practical – there is increasingly a lack of capacity within hospitals (PET issue) and this is only likely to get worse as patient demand increases

Patient expectations - patients are increasingly being empowered and given a choice as to where and how their care is delivered. The 'here and now' culture has increased the expectations on the healthcare system and this has been fuelled by the use of the internet to self-diagnose conditions based on visible symptoms. As a result patients no longer necessarily think they require a diagnosis. Also, treating a patient within a community setting can not only prevent hospitalisation of that patient, but it is also less stressful for the patient

Outside influence - both from politicians and private providers. Politicians are committed to 'improving the patient journey' and reforming the NHS to deliver more effective frontline care, with a focus on the community. Also, the increase in private providers delivering more cost effective and quicker care acts as additional competition, forcing the NHS to evolve its delivery approach to remain competitive

Key delivery issues

Whilst this direction of travel is supported by the workforce, the research identified some key delivery issues which are considered to be barriers to rolling out community focused delivery more widely:

Services can be too fragmented for effective community delivery – for example in some areas there is not the capacity or expertise to deliver primary/secondary care in the community.

> *"I think there's certainly an element of conflict in services because there's often a patient with a need and you may not be commissioned or competent to provide that service"*
> ***Community Nurse***

There are inadequate processes in place to deliver patient-focussed care in a community setting. In particular communication – knowing who to refer a patient to or how to seek specialist expertise – can be challenging.

"There's a frustration around actually how effective our systems are at developing services in the community so that they've got the right infrastructure around them to deliver safe patient care"
Community Nurse

Enhancing the workforce in a primary care setting is a challenge. Training for the patient journey is critical yet there is a belief among some that the opposite is happening with a 'dumbing down' of skilled services, particularly in the community workforce. For example replacing high level nurses (e.g. band 8a) with a lower grade (e.g. band 7) means that skilled community resource is not replaced to maintain continuity of service

"I think we've absolutely lost the key element of patient care in dumbing down nursing services, and I think it's one of the key things that we need to look at in workforce planning is around community progression and pathways"
Community Nurse

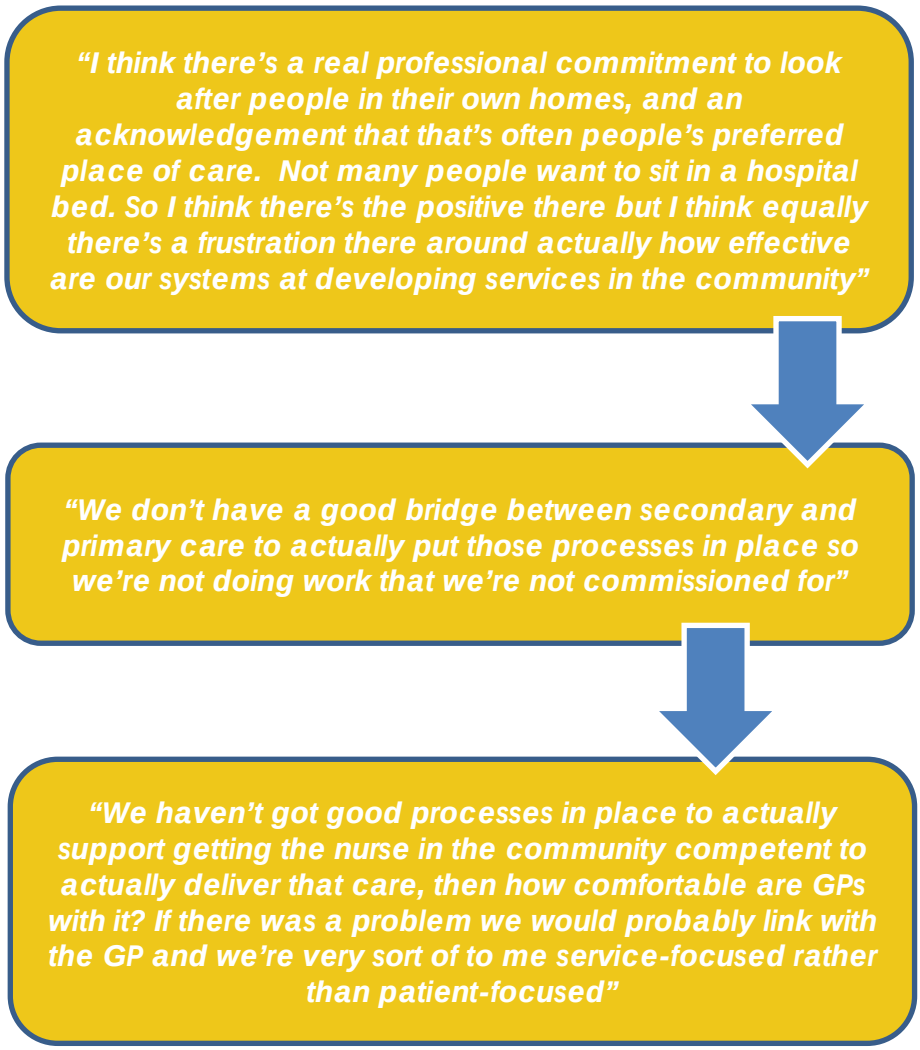
> I think it's the only direction they can take; they've got to try and shift patients out of the actual hospital building, just to create more space really because as people are living longer they're having more problems, more people are coming into hospitals and we've got to find a way of trying to shift it. It's not only for our benefit moving people out but it's for their benefit as well
>
> **Group 2**

Fundamentally, there are different outcome targets for patient care in both primary and secondary. It is therefore a significant challenge for medical practitioners to make these aims compatible with one another.

"There's still a very different mind-set in secondary care and we've seen it today in primary care. Primary care is all about managing risk whereas secondary care is about excluding risk, and that you use the technology and all the other bits to make that happen. In primary care it doesn't work like that"
General Practitioner

A community nurse's viewpoint

One of the community nurses articulated the conflict between delivering community based care and the practical, structural challenges of moving in this direction. This is outlined below.



There are some perceived structural issues within the NHS which means that delivering care in the community is not effective due to the systems and procedures, developed through decades of delivering in-hospital care.

It was felt the new commissioning groups, which put the General Practitioner at the centre of commissioning, could overcome this issue and provide the much needed 'bridge' between primary and secondary care.

However, the wider financial and staffing pressures on all areas of the workforce means that there might be a skills gap in getting adequately qualified and experienced staff to commit to community work. The historic lack of joined up commissioning means that doctors would have to be the main conduit between primary and secondary care moving forward.

Training

There are some structural and content weaknesses with current training specific to Lancashire which do not maximise recruitment into primary care

Training

F1/F2 trainees identified some issues with their training placements which gave them limited exposure to primary care, in particular General Practice. In their foundation training, students rotate around six placements, only one of which has to be a primary care placement. Moreover, this single primary care placement occurs at the end of the F2 year, by which time a student has already made their choice whether to follow a specialist, secondary care career path.

The report has already identified the challenge of negative perceptions particularly towards General Practice, which can be peddled by medical professionals within secondary care. At the moment, such viewpoints cannot be countered by a trainee's own experience via a well-timed, primary care placement.

There is perceived to be an imbalance in the number of primary care placements available compared to secondary. Despite this, trainees regularly apply for General Practice, but only as a 'fall back' option, as it is seen as less competitive than a more specialist, secondary care role.

> In Liverpool I spent a large chunk of the final year in primary care placements and community but, here F1 and F2 are all four month placements, and you have six placements and only one of those is primary care. So I'll do five secondary care placements and my last one will be General Practice and that's all I get
>
> **F1/F2 Trainee**

There is, however, no guarantee that an earlier General Practice placement will result in an upturn in primary care recruitment. General Practice is not seen by many as an effective learning environment due to the isolated nature of the role. Also, one of the advantages of training on a ward is the exposure of working with other medical professionals, which enhances their all-round knowledge and experience, as well as providing a sounding board for second opinions.

> *"I've spoken to people, F2s, who've done General Practice placements and they said they feel quite alone; if you have questions there's less people around you for support"*
> **F1/F2 Trainee**

The role of mentors in nursing

The withdrawal of a number of lead role positions in primary care has led to a perceived dumbing down of training for newly qualified nurses. Nurses have outlined that, upon qualification, they have often been placed on a ward as “another pair of hands” rather than to undergo any formal induction period.

There is limited supportive supervision, with preceptorship packages being the responsibility of each individual to complete, often at their own pace.

The result of this lack of initial induction training for newly qualified nurses is that many are unable to undertake the most basic procedures efficiently, which results in further, in-ward ‘dumbing down’ of nursing roles.

There is also an absence of accessible, senior nurses. Whilst ‘buddies’ are allocated, they can often be assigned to different shifts, which means that regular and meaningful contact does not happen.

These issues extend to nurses working in General Practice. General Practitioners do not always appreciate and understand the CPD for nurses. Formal training is the responsibility of each individual rather than a standard training criteria/programme across the whole Trust. Appraisals can be carried out either by a practice manager or by a General Practitioner, neither of whom are fully conversant with the requirements of up skilling nurses.

> There needs to be more mentorship, going back to how it was years and years ago like on a ward and you have a number of staff and they were shown how to do different procedures
>
> **Community nurse**

> It is left to the individual nurse and that’s the problem. It’s a very, very isolated job. I would say 7½ out of 8 hours you’re on your own with a patient in a room, so your professional standards are your own really
>
> **Practice nurse**

The following section provides a case study from a nurse about the challenges of operating in a General Practice:

Case study

The challenges of a nursing career in General Practice – Case study

- Firstly, GP is seen as a very difficult job to get into – it's not part of the nursing training curriculum and never has been
- Most GPs therefore want evidence of some experience before employing a nurse, but this is challenging to find
- Once a nurse is in post in GP, all the responsibility for training and development lies firmly at the GP's door, so there is no big organisation currently paying for investment in training with general practice
- In 2004 I did my specialist nurse practitioner degree and then I was at university for ten solid years completely funded by the organisation who was funding a GP to train the nurses to a very high level

"Anybody now wanting to come and join a practice wouldn't have a chance. There's no funding for you"

- When I came back into it four years ago I found there's no training, there is a 12 week basic course for new practice nurses; mine was a two year course
- If we take somebody out of the hospital they can't do smears; they can't do immunisations; they can't do all the very basic stuff that's required, to just be a very basic level Band 5 or 6, and all that funding comes from the GP purse, which is under ever increasing pressure from elsewhere
- Once they're trained and they've got the piece of paper a lot of nurses work in isolation, so unless they're self-motivated they generally don't have a nurse manager. This means no leadership, nobody monitoring them and no appraisals – in short no longer term development and monitoring support

The widening role of General Practitioners

In recent years General Practitioners have taken on additional responsibility when it comes to running their practices, in terms of managing budgets and staff. This extended role requires a General Practitioner to have additional skills including business acumen, finance and HR knowledge.

At present, General Practice training does not cover these 'non-care' skills despite them being a critical element of a General Practitioner's role in the modern day NHS. Furthermore the emerging role of clinical commissioning requires additional knowledge and understanding of competing for clinical contracts.

Introducing such skills into the training curriculum could be attractive to some prospective General Practitioners and add variety to the role which had previously not been as significant. Conversely, for some the need to understand these types of business related issues could also discourage them further. When presented with a prompted list of reasons for going into primary care, the emerging role of a General Practitioner as a commissioner and practice manager were seen as two significant crosses to bear for some rather than a challenging divergence of job role.

Stuck in a rut

There was an acknowledgement from some nurses within the groups that once you pick a specialism within a hospital you become focussed within that expertise and don't 'look up' again to see what else you could do, you become 'settled in your way'.

As a consequence, a career in primary care was not something they had ever considered. There was also a fear that you may make that transition from secondary to primary care and not like it. One of the trainee doctors within the group mentioned the taster sessions which are available to doctors allowing them to attend one or two day sessions which expose them to a different specialism or sector. It was agreed that a similar tasted day for nurses in a General Practice would be a good idea. There was also a suggestion that promoting primary care roles at a career stall in a staff canteen would at least turn your head and place the thought in your consciousness.

> I think it boils down to lack of education and understanding; we don't understand fully how the whole process works essentially but then I think we should do and I think we need to because then we're not managing the money and spending it on what you think is important
>
> **F1/F2 Trainee**

Lancashire

There are recruitment and retention challenges specific to Lancashire

Lancashire

The research identified some regional barriers specific to Lancashire which can affect recruitment and retention of the workforce.

It was acknowledged that the geographical spread of Lancashire presented some challenges to travelling between hospitals and also when delivering community-based care. In addition there can be barriers around public transport, which adds another challenge, in particular for trainees who require access to a vehicle to travel. Whilst using public transport is an option, travel can regularly be at unsociable hours to fit with early/late shift patterns, which timetables do not always fit in with.

Small, family run General Practice surgeries

There will be a need for small practices to work collaboratively together. The number of small GP practices in rural locations also presents a challenge, in particular concerning succession planning. Historically many doctors have established such practices and are now coming to the end of their careers with no plan as to who will take over operation of the practice and little prospect of attracting new blood.

> End of 1960s/early 70s - Lancashire had a larger number of South East Asian GPs recruited because of the dearth of provision, and they're now coming to the end of the careers and a lot of those were in small single-handed and two or three handed practices. A lot of them have now gone. There's only half the number of single-handed GPs than there were five years ago; a lot of them have been amalgamated into the big provisions in the mill towns and the medical centres. Their day has gone and I don't think anyone would not say that
>
> **Lancashire GP**

The view of trainees

There was a mixed response from trainees. One of the key career objectives for them was to guarantee a good work/life balance. As a result, there is naturally a greater attraction to city hotspots such as Manchester and Liverpool which are perceived to offer a more diverse social life.

"Obviously when we're not working we want to be socialising and so from that point-of-view Manchester obviously trumps"
Trainee

In addition the reputation of hospitals within the larger cities is also greater, the MRI in Manchester was considered 'glamorous' by some. They are perceived as large teaching hubs and there is an expectation that a trainee would as a result be exposed to a wide range of specialisms, as well as cutting-edge research.

However, on the flip side some trainees and more experienced professionals placed greater value on being part of a smaller, more intimate hospital. It was felt that this experience would give trainees a more hands-on experience than a large, multi-layered hub hospital. The greater 'team ethos' which can exist in smaller hospitals can actually be an advantage for professionals and it is not necessarily the case that 'bigger is better'.

Promotion of strengths

Certainly it was felt that there was insufficient promotion of the potential increased opportunities of working in a smaller hospital.

> *"From a training perspective you're probably hopefully going to get more exposure to different things than you may be seen to in what would in the past be classed as like a district general hospital, even though it is now a teaching hospital"*
> **F1/F2 Trainee**

Greater Preston Hospital is a specialist trauma centre of excellence, yet this is not always recognised amongst the medical workforce, and it was felt that this was not sufficiently promoted to prospective trainees.

Summary and recommendations
Emerging from the Ipsos-MORI Research

The following table provides a high-level summary of the research findings, presenting some options for 'quick wins' for consideration.

Issue	'Quick win' solution
Disproportionate spread of placements in primary and secondary care during F1/F2 training	Consider the balance of placements and also scheduling General Practice placement earlier in F1/F2
Negative perceptions of General Practice within secondary care setting	• Use experienced GPs to deliver 'a day in the life of' lectures • Promote the skillset required – 'the art of diagnosis and managing risk' • Partner local universities (e.g. UCLAN) and promote General Practice career • Identify clinical leaders (General Practice Champions)
Limited understanding, and training, for business / finance / HR functions of operating a practice	• Promote the possibilities of balancing career in frontline healthcare with business understanding • Introduce business module to foundation training course
Lack of awareness and understanding about portfolio careers and specialist opportunities	• Provide HR / careers advice function to increase understanding of the potential of portfolio career and the opportunities to specialise within General Practice – promote as core part of career path, not a 'bolt-on' element • Promote Trust-specific endorsement of portfolio careers rather than it being a government initiative
Medical graduates will target a specific hospital/Trust if it is known for a specialism of interest	• Promote the role of Royal Preston Hospital as a Major Trauma Centre across Lancashire and South Cumbria

However, there were other, deep-rooted issues which will be more challenging to overcome. These include:

- **Geographical** – whilst not necessarily a significant barrier to recruitment and retention, there are nevertheless geographical challenges. The proximity of Liverpool and Manchester (the 'bright lights of the city') are attractive for trainees, whilst the disparate spread of small, family owned / operated practices with little or no succession plan is a problem in terms of continuity of future care. Finding a way to counter what the larger teaching hospitals have to offer, by promoting the advantages of working as part of a small hospital / team, and promoting the opportunities to own / manage a GP practice in a small community is important

- **Countering negative press/perceptions** – negative press surrounding General Practice has led to negative perceptions of the career, not only in the minds of the public but also in the minds of medical trainees. As this report has identified there is a counter, more positive narrative which needs to be communicated, and a focus should be placed on promoting General Practice in Lancashire, the rewards of this career path and giving trainees experience of the role during their training. Inviting experienced doctors in to talk about the advantages of practice management / portfolio careers would be advantageous.

- **Funding / finance** – the main retention issues surround a lack of resources:

    - **Number of doctors/nurses** – staffing shortages puts extra pressure on the existing workforce to plug any resource gaps, which leads to low morale, the potential of not offering adequate level of care, and eventual 'burn out'
    - **Right mix of experienced and trainee/newly qualified doctors/nurses** – some newly qualified/trainee nurses have been expected to 'step up' and be another pair of hands on wards without having the necessary knowledge and experience
    - **Professionals with suitable experience** to deliver community-based care, often in isolation with minimal supervision

- **Identify and communicate the positive messages -** The research identified a number of positive messages which need to be better communicated to counter some negative perceptions about a career in primary care, and General Practice in particular. These include:

    - Opportunity to provide continuity of patient care over a period of time, which is rewarding

    - Treatment of the 'whole patient' rather than of acute conditions sometimes in isolation

    - CCG responsibilities / knowledge – whilst this will be unattractive for some trainees, for others the opportunity to learn about business, finance, and to develop these complementary skills, adds another dimension to the roll

    - Treatment of chronic rather than acute conditions

    - Work / life balance – "the closest to 9 to 5" in the NHS with less requirement for shift work

    - Greater Preston Hospital – smaller than the main teaching hospitals in large cities, and therefore a greater team ethos, which for a trainee means they could have greater exposure to a wider range of experience

    - Portfolio career options

    - Opportunities to specialise within General Practice

    - A role in primary care involves delivering on the front line of the NHS, and increasingly the opportunity to deliver patient care in a community setting

- **Communication channels -** Importantly, there are discussion forums which are well used by trainees as a means of sharing experiences of hospitals. One has recently become established and was referred to as being similar to 'Tripadvisor' because it reviews standards of accommodation at certain hospitals, lifestyle of the town / city etc. It is accessed via the Royal Colleges and therefore carries some kudos.

    - Trainees also communicate between themselves, using forums such as Facebook, to discuss working environments, state of hospitals, support structures etc. Further work is required to understand the structure and categories which are discussed and to monitor any discussions referencing Greater Preston Hospital.

Finally, some additional suggestions were made from the workforce which are illustrated below.

Workforce for the future - Section 5: Conclusions

Developing a local economy workforce strategy and approach to workforce planning could focus on developing doctors and nursing staff within a competency rather than an organisational based framework, and should also seek to include staff at all levels within the economy

The healthcare provision to our patients and their families is delivered by people not buildings … if we are to successfully transform the central Lancashire provision of healthcare then we will have to transform the way we educate, employ and deploy our people

National forecasting indicates that unless additional action is taken by commissioners and providers, nursing in the acute sector may grow at the community's expense

There is a need for a single locality based workforce plan aligned with the CCG commissioning plans that covers primary, secondary, community, mental health and social care. This will require a cohesive and proactive approach to health economy workforce numbers

Our workforce mission

The workforce data across the local health economy is unreliable, lacks the depth necessary to drive change and it appears that there is a lack of engagement from healthcare providers to develop their own workforce data to address this.

The data that is available tells us that we have higher than average numbers of administrative and clerical staff in the primary care workforce, and confirms our original perceptions that we have an aging primary care workforce and run the risk of further shortages in the future. Data also shows us that less than half the primary care nursing workforce is delivering long-term conditions care.

The highest vacancy rates in secondary care are amongst professional, scientific and technical, medical and dental staff, and there are high levels of clinicians leaving our area. Unfortunately we don't have any robust intelligence that tells us why this is, and are therefore missing opportunities to tackle emerging issues as they arise.

The health care provider approach to workforce planning is reactive, fragmented and siloed with few collaborative links both within and across organisations.

Senior leaders in the local health economy need to commit to working together to drive improvement in cross-organisational strategic workforce planning, using high quality intelligence and existing system capabilities to ensure that local healthcare services are future proof.

We need to improve, develop and routinely make use of a common core workforce dataset based on competencies to support more effective workforce planning, education commissioning and decision making in the future, and should make use of the local Clinical Senate and the Lancashire Health and Well-Being Board to raise awareness of the /importance of gathering local workforce intelligence, and of the benefits of further investment in the healthcare workforce.

Although trainees are interested in portfolio careers as a career pathway, most of those questioned had not heard of them. Established clinicians are more dismissive about portfolio careers, and are therefore less likely to raise awareness and promote them to trainees with whom they work.

Choices are driven by limited exposure to primary care and the historic perceptions of older established clinicians and exposure to primary care comes too late in trainees' rotation to change these perceptions.

The 'business' side of being a GP making learners nervous about their skill sets, but this could be tackled by developing the higher than average numbers of administrative staff within primary care in our area to take on these roles and by seeking opportunities to share skills across practices using a federated approach to staffing.

The remoteness of some of Lancashire's communities creates fear amongst trainees that they could become isolated if they work in primary care. In secondary care some trainees perceive working in tertiary centres as a better option.

The summary of the qualitative research findings and the 'voxpops' from the focus groups confirm existing perceptions whilst also providing new insights into the issues facing our local health economy.

There are suggested quick wins and longer-term strategies emerging from the research findings including:

- An urgent need to improve and develop a common core workforce dataset based on competencies to support more effective workforce planning, education commissioning and decision making in the future
- An urgent need to improve information for local students considering medicine as a career option – engaging with 6th form colleges and promoting clinical careers
- An urgent need to pilot portfolio options for Doctors and Nurses that champion 'cross-organisational' working and the NHS five-year forward view
- An urgent need for a local workforce think-tank to identify and eliminate perceived barriers relating to working across organisational boundaries, helping to share skills across sectors and enable the health care workforce to work across the whole health economy
- A single locality based workforce plan aligned with the CCG commissioning plans
- Better promotion and communication of career options to become a contender in the competitive

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We must improve the way we promote and communicate career options to become a contender in the competitive market to secure talent into central Lancashire

market to secure talent into central Lancashire

- An urgent need to develop streamlined nurse training models for the community and General Practice

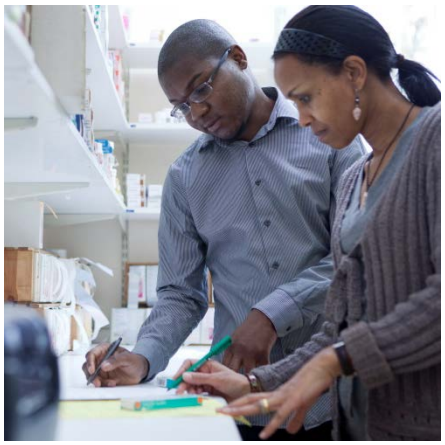
- A cohesive and proactive approach to health economy workforce numbers - less fire-fighting and more advanced planning by the health economy, delivered by the CCGs and its providers working closely with HENW, CLWEG and Local Education and Training Boards.

Workforce for the future - Section 6: Next steps

This research will be shared with strategic leaders and clinicians from this local health economy.

Part of that event will be used to seek commitment at the highest level from key partners to engage fully with regional initiatives i.e. WRaPT, Physician Associates, work experience / apprenticeship opportunities, streamlined nurse training models for the community and General Practice, and to agree the priorities for Phase 2 of the project.

This will include the development of Advanced Training Practices, work with schools / FE / HE to promote primary care and portfolio careers in clinical training, the development of pilot portfolio job roles (for doctors and nurses) to test out on trainees, supported by senior clinician mentors hand-picked for their inspirational leadership skills (possibly from other health care systems), to promote primary care as a career.



We will also be seeking commitment to develop cross-economy secondments as a career and portfolio development tool (including the resources to undertake proper evaluation of pilot projects and secondment opportunities.

We will seek to identify the patient pathways in central Lancashire that are most likely to depend on the posts that the research has identified to be difficult to recruit and or retain in the current numbers, with a view to:

- Mapping the current pathway with managers, staff and patients
- Identifying the actual competency and behaviours required to deliver a patient centric service
- Designing and piloting roles based on the identified competency and behaviour requirement to deliver the agreed patient centric provision

Phase 2 of the project will also review current recruitment activity (with a focus on the posts identified to be difficult to recruit to and or retain) with a view to the better promotion and communication of career options to become a contender in the competitive market to secure talent into central Lancashire.

This will include:

- Evaluating the efficiency and effectiveness of such campaigns
- Identifying the latest thinking and best practice in relation to staff recruitment
- Designing recruitment campaigns that are informed by this research

Other priorities to be addressed include:

- An urgent need for a local workforce think-tank to identify and eliminate perceived barriers relating to working across organisational boundaries, helping to share skills across sectors and enable the health care workforce to work across the whole health economy

- The development of a single locality based workforce plan aligned with the CCG commissioning plans that covers primary, secondary, community, mental health and social care. This will require a cohesive and proactive approach to health economy workforce numbers - less fire-fighting and more advanced planning by the health economy, delivered by the CCGs and its providers working closely with HENW, CLWEG and Local Education and Training Boards.

- The need to continue to capitalise on opportunities for sharing and learning with other projects and other health care systems

@workforcenhs