

GP recruitment and retention: the crisis in London

June 2003



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Chair's Foreword



The GP recruitment and retention scrutiny follows the work which the Health Committee has completed on 'Access to Primary Health Care' and 'Childhood Immunisation'. This scrutiny once again highlights the need for more health professionals of all disciplines to be engaged in the improvement of health services to Londoners.

General Practitioners are mostly the first point of contact for patients, therefore the growing vacancy rates in General Practice are a very worrying trend. The London Assembly's Health Committee has been investigating the vacancy level of General Practitioners in London; its causes and implications, and what might be done to solve the problem.

The Royal College of General Practitioners estimates that London needs to recruit six times more doctors if it is to match in any way the level of service needed to deliver the promises in the NHS plan. London does particularly badly in attracting GPs, which is especially important given the city's ageing population of doctors – almost half of all GPs in one London borough are more than 55 years old and half of those training here leave once qualified.

The current GP shortage, together with retirements and the number of GPs leaving the capital has serious implications for primary care services in London. Unless a further new core of doctors who will take up general practice as their main vocation can be identified, Londoners will face increasing difficulties accessing general practice, particularly in the inner city areas.

We do not need to wait to see the impact of the problems. In some parts of London, the Committee discovered that many surgeries are refusing to take any new patients onto their lists. We think the problem could be mitigated if an incentive scheme to encourage young GPs to stay in the capital was introduced, and the accreditation of refugee and overseas doctors living in London was speeded up.

By its nature this report is critical. But that is not our intent. Our purpose is to highlight the need to solve a growing crisis facing the capital in the hope that the health of Londoners is assured. The report contains 13 recommendations which we hope will improve the situation and the committee intends to return to the GP recruitment and retention scrutiny next year to further evaluate the situation.

I am grateful to members of the Committee and the in-house scrutiny team for their hard work and pay tribute to everyone who gave so generously of their time and expertise to inform the scrutiny.

A handwritten signature in black ink that reads "Elizabeth Howlett". The signature is written in a cursive style and is underlined.

Elizabeth Howlett

Chair, London Assembly Health Committee

The Health Committee

The London Assembly's Health Committee was established in May 2002. It has a unique role, in that unlike local authorities and other organisations, it can identify and investigate health issues that are of concern to London as a whole. The Committee is flexible in its remit, and is not bound to issues emanating from individual localities or health authorities.

The Committee can also work across agency boundaries and encourage participation from the voluntary sector, the private sector and local people, ensuring that these diverse views are reflected in its work.

In May 2003, the Assembly agreed the following membership of the Health Committee for the year 2003/04:

Elizabeth Howlett (Chair)	Conservative
Meg Hillier (Deputy Chair)	Labour
Richard Barnes	Conservative
Lynne Featherstone	Liberal Democrat
Noel Lynch	Green
Diana Johnson	Labour

The terms of reference of the Health Committee are as follows:

- To examine and report from time to time on:
 - the strategies, policies and actions of the Mayor and the Functional Bodies; and,
 - matters of importance to Greater London as they relate to the promotion of health in London.
- To liaise, as appropriate, with the London Health Commission when considering the Health Committee's scrutiny programme;
- To consider health matters on request from other standing committees and report its opinion to that standing committee;
- To take into account in its deliberations the cross cutting themes of:
 - the achievement of sustainable development in the United Kingdom; and,
 - the promotion of opportunity;
- To respond on behalf of the Assembly to consultations and similar processes when within its terms of reference.

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Executive Summary

The purpose of this scrutiny is to consider the issue of the current crisis in GP recruitment and retention in London. The current average GP vacancy rate in London is 7%. This is a shortfall of about 350 GPs, which is equivalent to all the GPs working in Harrow and Wandsworth. The NHS plan target identifies that an extra 255 GPs need to be recruited in London by 2004. The Royal College of GPs claim that up to 1500 extra GPs are required in London in order to fill current vacancies, meet the general practice requirements of the NHS Plan and provide a high quality service to patients in London. This is an increase of 30%, which is equivalent to all the GPs working in 8 London boroughs.¹ With a large number of GPs either resigning or retiring in the next five years the situation is likely to get worse.

Although the Department of Health and other organisations are trying to tackle this issue by implementing a number of schemes, such as EU recruitment, the problem remains acute. We believe that there is much more that could be done now to recruit more GPs and retain existing GPs. We have made some positive recommendations to the key health organisations to try and assist them in tackling this major problem in London. Our key recommendations are as follows:

➤ **Refugee and Overseas Doctors**

In the short term, we feel that more refugee doctors already in London and overseas doctors, including those from the Commonwealth, could be recruited as GPs. More advice, information, financial support and mentoring should be provided to these doctors to enable them to understand the accreditation and registration system and encourage them to become GPs.

➤ **Incentives for Medical Students**

The Department of Health should consider the possibility of implementing an incentive scheme to encourage newly qualified doctors to stay and practise as GPs in London.

➤ **Vacancy rate collection and monitoring**

The London Workforce Development Confederations must undertake regular surveys of GPs in their areas in order to establish the current vacancy levels for each Primary Care Trust and to identify the numbers of GPs planning to retire over the next five years.

They must also review their systems to ensure that the information they have on GP vacancy levels is accurate, up to date and is compiled in a uniform way. This will enable them to accurately plan for the GP workforce across London, and meet the needs of local communities, thereby ensuring that any crisis due to the lack of GPs is averted.

¹ Barnet, Brent, Croydon, Ealing, Islington, Kensington & Chelsea, Lambeth and Newham

1. Introduction

The Scrutiny Process

- 1.1 The London Assembly Health Committee agreed on 12 December 2002 to undertake a scrutiny on General Practitioner (GP) recruitment and retention in London. The aim of the scrutiny was to identify the scale of the problem and consider the implications for health care services in London. It was envisaged that this would also provide an opportunity to examine some of the strategies that are in place to address this problem.
- 1.2 The terms of reference for the scrutiny were:
- To examine the scale of the GP recruitment problem across London, identifying the areas of London where the problem is most acute;
 - To examine the current GP vacancy rate for each Strategic Health Authority;
 - To examine the number of closed GP lists within each Strategic Health Authority;
 - To consider the implications of GP retirement for health services in London;
 - To consider the current recruitment and training initiatives particularly for medically trained refugees²;
 - To consider the impact on recruitment and retention of salaried GPs and the new contract proposals
- 1.3 The Committee received written evidence from a variety of organisations including the Directorate of Health and Social Care (DHSC)³, Strategic Health Authorities (SHAs)⁴, the London Workforce Development Confederations (WDCs)⁵, London Primary Care Trusts (PCTs)⁶ and the London Deanery⁷. A full list of written evidence can be found in Annex B. The Committee also held three evidentiary hearings where they took oral evidence and a full list of the hearings and witnesses can be found at Annex C. The Committee is grateful to everyone who contributed to this scrutiny.

² A refugee is a person who has been recognised by the authorities as a refugee fleeing persecution under the UN Convention. This means that they are entitled to work, claim benefits and use public services.

³ The four Directorates of Health and Social Care (London; North; South; Midlands and East) are part of the Department of Health and are responsible for overseeing the development of the NHS and social care, assessing the performance of health and social care services, guiding senior NHS staff, improving public health and providing support to Ministers.

⁴ The five London SHAs are responsible for overseeing the performance and management of WDCs and PCTs within their areas and ensuring that national priorities are integrated into plans for local health services.

⁵ The five London WDCs (North East, North Central, North West, South West and South East) were established to oversee the planning and development of the healthcare workforce.

⁶ The thirty-two PCTs in London have the role of running the NHS locally and improving health in their areas.

⁷ The London Deanery co-ordinates the delivery and funding of postgraduate medical and dental education and training for the London NHS region.

2. The Scale of the Problem

- 2.1 The latest Department of Health (DoH) figures show that there are over 4,500 GPs, including Registrars and Retainers, working in London. However, despite the fact that every year approximately 350 GP registrars complete their training in London, insufficient numbers of new GPs are being recruited to work in the capital. Currently 50% of these GP registrars choose not to work in London.⁸ In addition to recruitment issues the National Health Service (NHS) also faces an on-going challenge to persuade more of those GPs currently here to remain working in London.
- 2.2 We recently received from the DHSC the latest vacancy rates, which gave an average GP vacancy rate in London of 7%, a shortfall of about 350 GPs, equivalent to all the GPs working in Harrow and Wandsworth. Unfortunately the figures for vacancies unfilled after 3 months were not provided. In October 2002 the DoH surveyed its workforce.⁹ The survey found that London Primary Care Trusts (PCTs) have an average of 3% long-term GP vacancies (unfilled after three months). This gives a shortfall in London of around 150 GPs, equivalent to all the GPs working in Enfield.

NHS Plan Target

- 2.3 The NHS Plan highlights the fact that the shortage of human resources is the biggest constraint facing the NHS today.¹⁰ The plan identifies that nationally an extra 2000 GPs need to be recruited. For London this equates to an extra 255 GPs.¹¹ A working group known as the Pan London Group was set up to identify ways in which the NHS plan targets can be met.¹² The North East London Workforce Development Confederation (WDC) told the Committee that significant progress has been made towards meeting these targets.¹³
- 2.4 The NHS plan target does not take account of the numbers of GPs retiring or leaving London to work outside the capital. Dr Lucy Moore, from the North East London WDC, said that when these additional numbers are taken into account the actual number of GPs needed is almost double the NHS target.¹⁴ This gives an estimated shortfall of over 500 GPs relative to the NHS target for London. This is equivalent to all the GPs, including Registrars and Retainers, working in Barking & Dagenham, Haringey, Kingston and Southwark.
- 2.5 The view of the Royal College of GPs is that this shortfall is even greater than that envisaged by North East London WDC. They argue that there needs to be an uplift of at least 30% in the current GP workforce (ie an extra 1,500 GPs for

⁸ Minutes of evidentiary hearing: 23 January 2003

⁹ Memorandum: British Medical Association

¹⁰ The NHS Plan July 2000

¹¹ Memorandum: Pan London Group

¹² The Pan London Group is made up of representatives from the Directorate of Health and Social Care (DHSC), the five London Workforce Development Confederations (WDC), the London Deanery, the London-wide Local Medical Committees (LMCs) and London Primary Care Trusts (PCT)

¹³ Memorandum: North East London Workforce Development Confederation

¹⁴ Minutes of evidentiary hearing: 23 January 2003

London) in order to undertake everything that is required in the National Plan.¹⁵ This is the equivalent to all the GPs working in 8 London boroughs: Barnet, Brent, Croydon, Ealing, Islington, Kensington & Chelsea, Lambeth and Newham.

GP Vacancy Rates

2.6 The five London Workforce Development Confederations (WDCs) have provided the following details of the vacancy rates and age profiles of GPs, including Registrars and Retainers, (which assists in identifying retirement patterns) in their areas¹⁶:

- **North Central London** has an average rate of 5.6% for GP vacancies in April 2003. Approximately a quarter of GPs are aged over 55 and could be in line for retirement within the next five years.
- **North East London** has an average rate of 8.8% for GP vacancies in April 2003. It is estimated that between 240 and 350 GPs will be needed in the North East sector over the next five years. In Barking and Havering 45% of GPs are over 55, the largest percentage in England.
- **North West London** has an average rate of 5.8% for GP vacancies in April 2003.
- **South East London** has an average rate of 9.5% for GP vacancies in April 2003. There has been some progress in recruiting GPs through international recruitment and Personal Medical Services (PMS).
- **South West London** has an average rate of 4.5% for GP vacancies in April 2003.

2.7 We have received from the DHSC, information on GP vacancy rates for each London PCT in April 2003 (refer to Table 1). However we are disappointed that the figures for vacancies over 3 months have not been provided for the vast majority of PCTs. The information that has been provided shows that vacancy rates are high. For instance, Bromley has 10% GP vacancies unfilled after three months. We feel that information on current vacancies and those vacancies that have remained unfilled after 3 months is vitally important if the situation is to be accurately assessed, monitored and improved. We cannot be sure that PCTs are keeping accurate records on vacancy rates or if WDCs are effectively monitoring the situation on a regular basis¹⁷. It is our opinion that the WDCs should request this information from the PCTs on a regular basis in order to accurately monitor the number of GPs in the capital.

¹⁵ Minutes of evidentiary hearing: 6 February 2003

¹⁶ Memorandum: Pan London Group

¹⁷ In recent correspondence, the DHSC has stated that the regularity and accuracy of information collected is a high priority for WDCs and PCTs

Table 1: GP Vacancy Rate in London

PCT	TOTAL NO. OF GP POSITIONS AVAILABLE	GPs IN POST	NUMBER OF VACANT POSTS	% VACANCIES	VACANCIES OVER 3 MTHS	% VACANT OVER 3 MTHS	AVERAGE LIST SIZE
Barking and Dagenham	80.5	73	7.5	9.3	N/a	N/a	2,188
Barnet	226	222	4	1.8	N/a	N/a	1,673
Bexley	129	115	14	10.9	13	10.1	2,022
Brent	203	203	0	0	N/a	N/a	1,811
Bromley	219	194	25	11.4	22	10	2,203
Camden	194	187	7	3.6	N/a	N/a	1,442
City and Hackney	183.6	171	12.6	6.9	N/a	N/a	1,595
Croydon	224	210	14	6.3	12	5.4	1,886
Ealing	213	198	15	7	N/a	N/a	1,860
Enfield	168.5	154	14.5	8.6	N/a	N/a	1,801
Greenwich	160	142	18	11.3	13	8.1	1,941
Hammersmith & Fulham	110	110	0	0	N/a	N/a	1,933
Haringey	179	169	10	5.6	N/a	N/a	1,824
Harrow	148	137	11	7.4	9	6.1	1,617
Havering	140.8	126	14.8	10.5	N/a	N/a	1,905
Hillingdon	175.5	161	14.5	8.3	N/a	N/a	1,801
Hounslow	132	119	13	9.8	N/a	N/a	1,739
Islington	142	135	7	4.9	N/a	N/a	1,660
Kensington & Chelsea	115	112	3	2.6	N/a	N/a	1,867
Kingston	118	112	6	5.1	N/a	N/a	1,724
Lambeth	221	205	16	7.2	11	5	1,832
Lewisham	174	162	12	6.9	8	4.6	1,755
Newham	190.5	171	19.5	10.2	N/a	N/a	1,653
Redbridge	144	124	20	13.9	N/a	N/a	1,880
Richmond and Twickenham	97	97	0	0	N/a	N/a	1,639
Southwark	175	158	17	9.7	7	4	1,906
Sutton and Merton	205	195	10	4.9	N/a	N/a	1,960
Tower Hamlets	161	155	6	3.7	N/a	N/a	1,550
Waltham Forest	154.8	142	12.8	8.3	N/a	N/a	1,872
Wandsworth	201	193	8	4	N/a	N/a	1,714
Westminster	136	132	4	2.9	N/a	N/a	1,890
LONDON TOTALS	4894.2	4562	332.2	7	N/a	N/a	1,908

Source: Directorate of Health and Social Care

The figures are for all GPs in London including GP Registrars and Retainers

The figures include vacant posts arising from the establishment of new PMS posts which are unlikely to be filled by now

The figures are valid for April 2003

Recommendation 1

In order to assist accurate workforce planning, London Workforce Development Confederations must undertake regular surveys of GPs in their areas to establish the current vacancy levels for each London Primary Care Trust and to identify the numbers of GPs planning to retire over the next five years.

Recommendation 2:

The London Workforce Development Confederations must review their systems to ensure that the information they have on GP vacancy levels is accurate and up to date. They must also ensure that each Confederation compiles this information in the same way, using the same data sets in order to facilitate pan-London comparisons and monitoring.

GP Closed Lists

- 2.8 The Committee heard from Andrew McDonald of the Directorate of Health and Social Care (DHSC) that formally “closed lists” did not exist.¹⁸ GPs may close their lists where they feel that the numbers of patients they have compromises the quality of the service they want to provide. However, if a patient wishes to be registered with a particular GP then they can apply to the PCT and ask to be registered there. PCTs have a legal responsibility to allocate patients to the list of a GP within their area. The patient would then be allocated to the nearest list by the PCT. If necessary a PCT can require a practice to take on patients. In this circumstance patient choice would be limited, but they would eventually be registered.¹⁹
- 2.9 Although the DHSC does not formally recognise closed lists, **we received the following information** from the five Workforce Development Confederations²⁰.
- Around half the practices in **North Central London** operate a closed list policy, although there are extreme variations across the sector (8-74%).
 - In **North East London** closed lists do not formally exist but a range of strategies have had to be devised to meet this emerging problem.

¹⁸ Minutes of evidentiary hearing: 23 January 2003

¹⁹ Minutes of evidentiary hearing: 23 January 2003

²⁰ Memorandum; Pan London Group

- A detailed survey for **North West London** carried out in October 2002 revealed difficulties with list closures in Brent, Ealing, Hillingdon and Hounslow associated with single-handed practices.
- Closed lists have not yet been consistently identified in **South East London**.
- The view of **South West London** is that there is no major issue over closed lists although there appears to be very restricted choice for patients moving within the South West.

2.10 There is an inconsistency with what we are being told by WDCs and PCTs and what we are hearing at a local level. We heard from a GP who works in a medium sized practice in the Deptford/New Cross area, who confirmed that most of the practices in his area had closed lists, including his own. He explained that the GPs in the area are negotiating with the PCT to see what can be done about the problem of closed lists.²¹ We also heard that in Sidcup virtually all GP lists are closed, and that newcomers to the area had to wait to be allocated to a GP.²² The Committee heard that 80% of GP lists in Barnet are closed.²³

2.11 The Committee is deeply concerned that public access to primary care is becoming increasingly restricted. We believe that, in general, people should be able to register with a GP of their choice, as close as possible to where they live. It can be also difficult to register all members of a family with the same GP in their area, which can be inconvenient particularly for families with young children. We appreciate the pressures on small GP practices struggling to recruit GPs and cope with large patient list sizes, however, we feel that the PCTs have been slow to be fully apprised of the situation. We believe that this is because they have not had adequate monitoring systems in place to enable them to anticipate the looming GP shortfall.

Recommendation 3:

London Primary Care Trusts should take a more rigorous approach to quantifying and monitoring the extent to which patients and whole families are having difficulty registering with GPs locally, and Strategic Health Authorities should monitor this situation to ensure that this is happening.

2.12 We also feel that PCTs should do more to inform the public about the process of registering with a GP. It seems that some people are not sure what to do and whom to contact if they cannot register with their local GP. PCTs could provide leaflets and telephone numbers for people who are trying to register with a GP and these could be obtained from GP surgeries, libraries and other public places.

²¹ Memorandum: GP in Deptford/New Cross

²² Memorandum; Sidcup Community Network

²³ Minutes of Access to Primary Care meeting: 25 September 2002

Recommendation 4:

London Primary Care Trusts should provide clearer information to the public about the process for registering with a GP, by issuing information for those seeking to register, which can be obtained from GP surgeries, libraries and other public places.

Why is there a current shortfall?

2.13 There are a number of reasons why we believe the current shortfall in London has emerged:

- Heavy workloads.
Average London list sizes are some 8% above the national average. Dr Neil Jackson, representing the Royal College of GPs, said that the average list size in London needs to be reduced from approximately 1900 to 1800 in order to have a manageable list of patients and to provide quality primary healthcare.²⁴
- Poor morale.
We heard that young doctors were deterred from entering general practice in London because of negative perceptions on issues such as workload, high patient expectations, long hours and a poorer quality of life than compared with colleagues working outside the capital.
- Increasingly complex case loads.
We heard that the ethnic and cultural mix of patients, particularly in inner city boroughs, has become more diverse. One GP wrote to us explaining that over the past 3 years he has registered patients from countries as diverse as Vietnam, Poland, Ivory Coast, Nigeria, Morocco and Albania.²⁵ Some of these patients are unable to communicate effectively in English, thereby making consultations with them difficult. This is further complicated by the fact that some of these patients have complex health needs.
- Buying into a Practice.
GPs are independent contractors responsible for buying or renting their own buildings, employing their own staff and running their practices as small businesses. The high cost of premises in London can make it difficult for young doctors to afford to purchase a share in a practice and can deter them from practising in London. Wandsworth PCT has said that high property values are affecting recruitment of new GPs because few young doctors want to take on such high levels of debt.²⁶

²⁴ Minutes of evidentiary hearing: 6 February 2003

²⁵ Memorandum: GP in Deptford/New Cross

²⁶ Memorandum: Wandsworth PCT

3. The Future for GPs in London

- 3.1 We recognise that the profession has to evolve constantly to meet the challenges of London's growing and increasingly diverse population. Some GPs might for example want to undertake research, or develop a special interest area. GPs may only want to work part-time or prefer to be employed on a salaried basis. Others might not want to commit to a particular version of general practice too early in their career. There is a much greater need for health authorities to be creative, flexible and attuned to the individual's requirements in order to encourage more recruitment to the profession and to improve retention of London GPs.

Making the GP profession more attractive

- 3.2 We heard from Dr Neil Jackson that the profession is trying to market general practice so it is more attractive to undergraduates. A recent London Deanery survey revealed the scale of the problem, with the number of pre-registration house officers interested in becoming GPs down from 18% to 13% in 2003.²⁷ Dr Jackson said that undergraduate training programmes are moving into a more community focused training area, which raises the profile of general practice. He explained that 60% of young registrars are female and they are interested in flexible working hours, personal safety, schooling and housing.²⁸ We are aware that male registrars are also interested in these issues and improving their quality of life.
- 3.3 Dr Stephen Nickless²⁹, a locum GP in North London, stated in his evidence that some GPs would stay in London if they were offered part time salaried "portfolio GP" jobs with the freedom to do other work in hospitals, the community and in research. We consider that the Department of Health and WDCs should explore the practicalities of offering this as an option to see if it would encourage GPs to remain in London.

Recommendation 5:

The Department of Health and London Workforce Development Confederations should explore the feasibility of introducing part time salaried "portfolio GP" jobs in London with the flexibility to undertake additional work in hospitals, the community and in research.

Easing workloads through mixed skill teams ...

- 3.4 We heard that more needs to be done to examine the possibility of using other health professionals to assist GPs in their work duties. We examined this issue in

²⁷ Minutes: 6 February 2003

²⁸ Minutes: 6 February 2003

²⁹ Memorandum: Dr Stephen Nickless

our “Access to Primary Care” scrutiny. There we emphasised the need to enhance the skill levels of health care staff and give more responsibilities to other healthcare practitioners such as nurses and pharmacists. The report shows that this can make a significant impact in reducing GP workloads.³⁰

... *and new ways of working*

- 3.5 We also considered other new ways of working. The Advanced Access Programme supports practices by enabling them to look at how to use existing capacity more efficiently. Key features of this system include developing a better understanding of patient demand, handling patient demand in a more resource efficient manner, and better contingency planning so that unplanned changes in demand can be handled more effectively. Advanced Access has been adopted by a large number of practices across London. The DoH feels that this programme is successful in the practices where it is being used, but the DoH have no data on the number of practices in London currently using it.

Recommendation 6:

London Primary Care Trusts should continue to support and evaluate the implementation of Advanced Access and evaluate its impact on public accessibility to GP services.

³⁰ Access to Primary Care report Greater London Authority April 2003

4. Policies and Initiatives

4.1 The current Department of Health strategy to boost GP numbers is to:

- Improve recruitment and retention of GPs;
- Undertake international recruitment of GPs; and,
- Provide support for refugee and overseas doctors.

St Georges Graduate Entry Programme

4.2 The Committee heard about an innovative Graduate Entry Programme³¹ designed to draw in people who at a later stage in their careers decide that they would like to become a doctor. Every year the Graduate Entry Programme at St Georges Medical School accepts 70 students, from a variety of different career backgrounds. The four-year course involves problem-based learning and takes place in small groups. Overall, there is high exposure to general practice in years one, two and four, and practising GPs are involved in teaching programmes.

4.3 We welcome this programme and believe that given the large numbers applying for available places a phased expansion of the scheme should be considered by the Department of Health. We recognise that not all graduates will choose to become GPs, and of those that do, not all will choose to stay in London. One way of encouraging newly qualified doctors to stay and practise as GPs in London could be through an incentive scheme. The scheme could provide some level of financial support to them while they are studying in exchange for them committing to work as GPs in London for a period of years after qualification. This could also include working in different areas across the capital thereby broadening their experience.

4.4 Professor Peter McCrorie of the St Georges Medical School, supported this proposal. He drew on recent experience in Australia where an incentive scheme has been introduced to boost recruitment of rural GPs.³² We would like the DoH to give this further consideration.

Recommendation 7:

The Department of Health should consider the possibility of implementing an incentive scheme to encourage newly qualified doctors to stay and practise as GPs in London.

³¹ Minutes of evidentiary hearing: 23 January 2003

³² Minutes of evidentiary hearing: 23 January 2003

- 4.5 A further graduate training strategy could be to support part-time learning programmes whereby students earn a salary whilst being attached to a general practice where they will gain practical experience. We believe this also merits further consideration.

The new GP contract

- 4.6 We wish to avoid being drawn into the continuing current debate over the reform of the GP contract. But as changes are likely to impact on the ability of London to recruit and retain GPs, we will continue to monitor the situation closely.
- 4.7 One of the problems from the London viewpoint is that the new GP contract will be a national contract. At the moment there is no London weighting for GPs, although there are extra resources for GPs working in deprived areas. It would be for the Strategic Health Authorities (SHAs) or London Primary Care Trusts (PCTs) to propose changes under the national pay negotiations.

Recommendation 8:

Given the significant changes that have occurred in London's growing and increasingly diverse population, the particular challenges facing GPs in London should be supported by the Department of Health through extra resources.

5. International Recruitment and the Accreditation of Refugees and Overseas Doctors

International Recruitment

- 5.1 A major London-wide initiative is international recruitment. The Pan London Group liaises with the DoH International Recruitment team and supports the intensive work required by PCTs and practices preparing to recruit internationally. The DoH has a “morally responsible” international recruitment policy i.e it has a list of developing countries from which it does not actively recruit because those developing countries need the doctors more urgently. However, doctors from these countries do still apply for jobs in the UK.
- 5.2 The Pan-London Group has focused its current recruitment drive mainly on European Union countries. This work has been funded by the WDCs and the DoH and will build on the success of the South East London/French recruitment scheme. The present targets are to recruit approximately 15 French GPs and 40 Spanish GPs within the NHS Plan target date of March 2004. We welcome the support of the London Deanery in setting up this programme, particularly with its quality assurance practice support and for providing education and induction programmes.³³ However, we remain concerned that the high-level English tests that are taken by refugee doctors in order to practise are not taken by EU doctors. **We would welcome Department of Health assurances that all EU doctors who practise in the UK are proficient in English.**

Refugee and Overseas Doctors

- 5.3 The five London Workforce Development Confederations, with support from the London Deanery and with funding from the Department of Health (DoH), are actively pursuing the employment of medically-trained refugees. Dr Penny Trafford is leading the Refugee Health Professionals’ Steering Group, a scheme set up to produce 50 new clinical attachments.
- 5.4 The Committee heard that there are over 800 refugee doctors registered with the BMA who want to work in the UK, particularly London. The Committee is concerned that the health community is not doing enough to guide these doctors into full time general practice. Often these refugee doctors will come from communities with a significant presence in London. Employing these doctors within their communities will ease work pressures in some of the most deprived boroughs and enable the profession to be more responsive to the needs of these communities.
- 5.5 There are also many doctors from overseas, particularly from Commonwealth countries such as Australia and New Zealand, who are fully trained and qualified as GPs and would like to work as GPs here in London. However, they are also finding it difficult to obtain accreditation and registration to practice here in London. These doctors whose first language is English are even expected to sit

³³ Memorandum: Pan London Group

the IELTS (International English Language Testing System) English test, which doesn't seem to make sense. We feel that this important resource of Commonwealth doctors should be utilised by the health authorities in London.

Recommendation 9:

The General Medical Council should consider establishing a separate accreditation system for Commonwealth doctors who would like to register and practise as GPs in London.

Accreditation and Registration

- 5.6 We heard that refugee and overseas doctors, including those from Commonwealth countries, have to sit several tests and obtain a job offer before they can be registered by the General Medical Council (GMC) to practise as a doctor in the UK.³⁴ The process is as follows:
- There is an English test called the IELTS (International English Language Testing System) which tests competency in reading, writing, listening and speaking. Even doctors whose first language is English, such as those from Australia, have to sit this test.
 - After passing this test doctors then have to sit the PLAB (Professional and Linguistic Assessment Board) examination, which is in two parts. The first part is a written test consisting of multiple choice and modified essay questions. The second part is more difficult and is called an Objective Structure Clinical Examination. This consists of clinical scenarios and real live situations in general practice.
- 5.7 Having passed these examinations a doctor will then have to obtain a job offer **before** the GMC will grant registration to enable them to practise in the UK. However, this registration is limited registration, and only allows the doctor to work in supervised employment posts, usually in hospital training posts and not in General Practice. Doctors can progress from limited to full registration after 12 months' satisfactory service in hospital posts.
- 5.8 It costs about £1000 for a refugee or overseas doctor to go through this accreditation and registration process. Plainly, this can be a significant sum for those who may be beginning a new life in this country without savings or access to bank loans. Doctors recruited from EU countries do not have to go through this accreditation process.
- 5.9 One witness informed the Committee that he had found the GMC's accreditation system very difficult to access. He believed that the system hindered rather than helped refugee doctors in getting registered. For example, he had received job offers as a senior house officer and presented the GMC with

³⁴ Memorandum: General Medical Council

the evidence they required including clinical attachments and support from top consultants in the UK, but the GMC still turned him down. He then passed the English test but failed the PLAB test and because two years had elapsed and he was told that he had to re-sit the English test.³⁵ The GMC has subsequently reviewed their policy on this and will now accept other forms of proof, which show English competency. This is discussed further at paragraphs 5.21 and 5.22.

- 5.10 We heard from Dr Jackson that although there are many support systems in place to help refugee doctors there are significant barriers preventing them from getting registered. These include the cost of the English tests and PLAB examinations, trying to prepare for these examinations whilst working, and trying to obtain a job in the NHS before the GMC will consider registering them.
- 5.11 There is support from across the health community for more resources to help refugee doctors. Dr Jackson³⁶ said that it cost approximately £220,000 to train a medical student compared to an average £5,000 to support a refugee doctor through the re-qualification process and to GMC registration. Despite the apparent value for money few refugee and overseas doctors succeed in gaining employment as a GP. However, we recognise that WDCs are beginning to focus on this problem. For example, we heard from North East London WDC about the Refugee Health Professionals Project (RHPP), which started in July 2000. The RHPP provide advice and support to refugee health professionals in Waltham Forest and Redbridge and help them with the GMC's registration process. A GP vocational training scheme for 3 refugee doctors will begin in February 2004 which will be funded by the NELWDC and the London Deanery. The training scheme will be run at Whipps Cross hospital so it will link with the RHPP in Waltham Forest. There are also other GP training schemes taking place across London. There is a scheme funded by WDCs and the London Deanery starting in August to train 3 refugee doctors at the Homerton hospital and 3 refugee doctors at Chase Farm hospital. This year, the London Deanery is also running 50 clinical attachment placements (10 in each of the five London WDCs), which involves 6 weeks in GP surgeries and 6 weeks in hospital.
- 5.12 We have a large potential GP workforce on our doorsteps and with proper planning and funding many of these doctors could be quickly brought into the system.

Recommendation 10:

The Pan London Action Group, General Medical Council, British Medical Association and other key organisations should work together to be more proactive in drawing in trained and qualified refugee doctors, Commonwealth doctors and other overseas doctors into London's practices.

³⁵ Minutes of evidentiary hearing: 6 February 2003

³⁶ Minutes of evidentiary hearing: 6 February 2003

- 5.13 A practical option, with little call on financial resources, would be to encourage doctors who have been through the accreditation process to act as mentors to refugee and overseas doctors. We support this proposal, as these mentors would be able to offer practical support and advice about the accreditation process to the refugee and overseas doctors in a friendly and informal atmosphere.

Recommendation 11:

The Pan London Action Group, General Medical Council, British Medical Association and refugee organisations should consider the merits and practicalities of implementing a mentoring scheme for refugee and overseas doctors.

- 5.14

Case Study of an Overseas Doctor: Dr Linden James

The Committee received evidence from Dr Linden James³⁷ about his experiences in trying to obtain training and registration to work as a GP in London.

Dr James is a non-UK trained doctor with over three years experience as a GP in his native country of Guyana. He has passed the IELTS English test and the two PLAB examinations. He applied to work as a GP in London but was informed that he needed to undertake GP training in a UK setting. After completing several periods of clinical training in UK hospitals he applied to the London Deanery for GP training, but he was unsuccessful with this. He has since applied unsuccessfully for nearly 100 positions as a Senior House Officer (SHO). However, he has been able to get Locum jobs at SHO level. He is planning to apply once more to the London Deanery for GP training but if he is unsuccessful again he has decided that he will leave the medical profession and pursue a career in another profession.

Dr James has said that he would like to make use of his medical skills and experience to work as a GP in London and help ease the burden in primary health care especially in the inner city.

Role and Objectives of the General Medical Council

- 5.15 We are concerned that it appears that unnecessary hurdles are placed in the path of refugee doctors and those from overseas, including the Commonwealth, seeking registration to full-time jobs. We questioned the General Medical Council (GMC), to see whether this is the case. In particular, we looked at the methods for assessing professional experience and linguistic competency.

³⁷ Memorandum: Dr Linden James

5.16 Finlay Scott³⁸, Chief Executive of the GMC, said that the GMC's objectives are to protect, promote and maintain the health and safety of the community by ensuring proper standards in the practice of medicine. He said that the GMC had four functions:

- To promote high standards of medical education;
- To foster good medical practice through the definition of standards;
- To keep up-to-date registers of qualified doctors; and,
- To deal firmly and fairly with doctors whose fitness to practise has been called into question.

Registration and Certification

5.17 Finlay Scott said that the GMC was currently striving to streamline the routes to registration. He argued that registration with the GMC is in fact a "speedy event"³⁹. However, he pointed out that in order to work as a GP in the UK an applicant has to be certificated by a body called the Joint Committee on Postgraduate Training for General Practice (JCPTGP) and it was gaining this certification that could take up to three years rather than the GMC registration process.

5.18 The JCPTGP is an independent body with statutory responsibility for general practice training in the UK. All doctors working in general practice must hold both full registration with the GMC and possess a Certificate of Prescribed Experience or a Certificate of Equivalent Experience issued by the JCPTGP. These certificates effectively give a doctor a licence to practise as a GP. So not only do applicant doctors have to satisfy the GMC as to their professional and linguistic competence, they also have to satisfy the JCPTGP.

5.19 The GMC confirmed that it was possible for doctors with the relevant experience to bypass the examinations, which the GMC sets and take a direct route to full registration. They would then have to satisfy the Joint Committee who would assess their training to decide whether or not they would give them a Certificate of Equivalent Experience, which is what is required to obtain a GP post. Sometimes the Joint Committee may like them to have some experience in a UK context and recommend that they spend several months in a GP environment before the certificate is awarded.

5.20 In evidence to the Committee Amanda Watson, Director of Registration at the GMC, said that last year the GMC revised its own guidelines and decided to reduce the amount of experience required by a doctor to gain full registration from 24 to 12 months.⁴⁰ This requires changes in law, and supplementary changes in NHS regulations. This still means doctors cannot work in the GP environment on limited registration during the 12 months period and can only apply to the Joint Committee after that 12 months has elapsed. **Action: We will**

³⁸ Minutes of evidentiary hearing: 4 March 2003

³⁹ Minutes of evidentiary hearing: 4 March 2003

⁴⁰ Minutes of evidentiary hearing: 4 March 2003

write to the Department of Health to establish the timetable for the implementation of the NHS regulations.

- 5.21 Furthermore the GMC added that they would not necessarily force applicants to re-sit an English test, which they had passed previously. The GMC would consider other forms of proof that the person has kept their language skills up-to-date or improved them. This proof could include residency in the UK, employment in the UK, or using those language skills in their everyday business and postgraduate education where the language of instruction is in English.
- 5.22 The GMC should make it clear to candidates that this other proof could be taken into account, rather than making them re-sit tests they have previously passed. **We have subsequently heard from the GMC, after they attended our evidentiary hearing, that they have altered their guidance on the English test accordingly and have published this on their web-site.**

Provision of Information

- 5.23 Overall, we have found it a most challenging experience to obtain a clear understanding of what refugee or overseas doctors need to do in order to practise as a GP. In response to questioning from the Committee the GMC acknowledged that it should make its information about registration more accessible and more easily understood. The GMC already publishes fact-sheets on its website about the routes to registration and the requirements, and provides an on-demand reception service without the need for a prior appointment, a telephone answering service, and advice and counselling for doctors who are seeking routes to registration.⁴¹
- 5.24 **We have subsequently heard from the GMC, after they attended our evidentiary hearing, that they have amended the information they provide on their web-site.** The GMC informed us that they plan to collect feedback from users about their web-site over the coming months and will use the results to build on and improve the registration service they provide via this medium. We would be grateful if the GMC could inform the Committee of the improvements they intend to make to their web-site and the provision of information, after taking account of the feedback from the users.

Recommendation 12:

After taking account of the feedback from the users, the General Medical Council should inform the Health Committee of the improvements they will make to their web-site and the provision of information.

- 5.25 **We have also subsequently heard from the GMC that they have agreed to join the Pan London Action Group, which is looking at refugee doctor**

⁴¹ Minutes of evidentiary hearing: 4 March 2003

issues from a London-wide perspective. We welcome this positive step. The GMC suggested that it might be appropriate for the Department of Health to take on the co-ordinating responsibility because they have an over view of the whole system including the employment opportunities within the NHS. There are a number of groups providing information, advice and financial support to refugee doctors but it does seem to be fragmented and in need of better co-ordination from a single point. The Department of Health through the Pan London Action Group could liaise with the GMC, BMA and refugee organisations to see if this work could be better co-ordinated.

Recommendation 13:

The Department of Health through the Pan London Action Group, should explore with the General Medical Council, British Medical Association and refugee organisations better ways for co-ordinating and improving the information, advice and financial support given to refugee doctors.

What further improvements could be made?

- 5.26 The GMC identified three areas where they can continue to make improvements. These are:
- To continue to improve the supply of information to people in this country and abroad who are interested in working as GPs in the UK;
 - To ensure that there are no unnecessary barriers to registration with the GMC and that they continue to update their routes to registration; and,
 - To focus on the obstacles that may be preventing individual doctors who are registered with the GMC from securing certification by the Joint Committee.
- 5.27 It is important that the GMC maintains standards for doctors and protects patients but there should be some flexibility in the accreditation system to allow more refugee and overseas doctors, including those from the Commonwealth, to be registered by the GMC. The NHS Regulations should be brought into force as soon as possible to allow doctors on limited registration to work as GPs. Many refugee doctors would like the opportunity to work in their own communities as they obviously share the same language and culture and this would resolve some of the difficulties in gaining access to healthcare experienced by people living in those communities. This could be done in addition to the existing programmes for recruiting doctors from EU countries.
- 5.28 We believe that refugee doctors are a valuable resource, on which the profession focuses insufficiently. We believe that re-directing effort into supporting and mentoring this pool of skilled workers would make a significant contribution to boosting GP numbers in London, reducing overall GP workloads and enhancing the quality of primary care available to Londoners.

Annex A: Recommendations and Actions

Recommendation 1:

In order to assist accurate workforce planning, London Workforce Development Confederations must undertake regular surveys of GPs in their areas to establish the current vacancy levels for each London Primary Care Trust and to identify the numbers of GPs planning to retire over the next five years.

{London Workforce Development Confederations}

Recommendation 2:

The London Workforce Development Confederations must review their systems to ensure that the information they have on GP vacancy levels is accurate and up to date. They must also ensure that each Confederation compiles this information in the same way, using the same data sets in order to facilitate pan-London comparisons and monitoring.

{London Workforce Development Confederations}

Recommendation 3:

London Primary Care Trusts should take a more rigorous approach to quantifying and monitoring the extent to which patients and whole families are having difficulty registering with GPs locally, and Strategic Health Authorities should monitor this situation to ensure that this is happening.

{London Primary Care Trusts and Strategic Health Authorities}

Recommendation 4:

London Primary Care Trusts should provide clearer information to the public about the process for registering with a GP, by issuing information for those seeking to register, which can be obtained from GP surgeries, libraries and other public places.

{London Primary Care Trusts}

Recommendation 5:

The Department of Health and London Workforce Development Confederations should explore the feasibility of introducing part time salaried “portfolio GP” jobs in London with the flexibility to undertake additional work in hospitals, the community and in research.

{Department of Health and London Workforce Development Confederations}

Recommendation 6:

London Primary Care Trusts should continue to support and evaluate the implementation of Advanced Access and evaluate its impact on public accessibility to GP services.

{London Primary Care Trusts}

Recommendation 7:

The Department of Health should consider the possibility of implementing an incentive scheme to encourage newly qualified doctors to stay and practise as GPs in London.

{Department of Health}

Recommendation 8:

Given the significant changes that have occurred in London's growing and increasingly diverse population, the particular challenges facing GPs in London should be supported by the Department of Health through extra resources.

{Department of Health}

Recommendation 9:

The General Medical Council should consider establishing a separate accreditation system for Commonwealth doctors who would like to register and practise as GPs in London.

{General Medical Council}

Recommendation 10:

The Pan London Action Group, General Medical Council, British Medical Association and other key organisations should work together to be more proactive in drawing in trained and qualified refugee doctors, Commonwealth doctors and other overseas doctors into London's practices.

{Pan London Action Group, General Medical Council and British Medical Association and key organisations}

Recommendation 11:

The Pan London Action Group, General Medical Council, British Medical Association and refugee organisations should consider the merits and practicalities of implementing a mentoring scheme for refugee and overseas doctors.

{Pan London Action Group, General Medical Council, British Medical Association and refugee organisations}

Action:

We will write to the Department of Health to establish the timetable for the implementation of the NHS regulations.

{Health Committee}

Recommendation 12:

After taking account of the feedback from the users, the General Medical Council should inform the Health Committee of the improvements they will make to their website and the provision of information.

{General Medical Council}

Recommendation 13:

The Department of Health through the Pan London Action Group, should explore with the General Medical Council, British Medical Association and refugee organisations better ways for co-ordinating and improving the information, advice and financial support given to refugee doctors.

{Department of Health, Pan London Action Group, General Medical Council, British Medical Association and refugee organisations}

Annex B: Evidentiary Hearings and Written Evidence

1. Evidentiary Hearings

Evidentiary Hearing 1, 23 January 2003

Witnesses:

Ralph McCormack – Chief Executive, Havering PCT
Dr Peter McCrorie – Director of Graduate Entry Programme, St George’s Hospital
Andrew McDonald - GP Recruitment and Retention Project Manager, DHSC
Dr Lucy Moore – Chief Executive, North East London WDC

Evidentiary Hearing 2, 6 February 2003

Witnesses:

Dr James Heathcote – Bromley GP, member of the Bromley PCT Professional Executive Committee and Chairman of the Bromley Local Medical Committee

Dr Neil Jackson – representative of the Royal College of GPs and Dean of Post Graduate GP Education at the London Deanery

Dr Genc Rumani – refugee doctor from Albania

Evidentiary Hearing 3, 4 March 2003

Witnesses:

Finlay Scott – Chief Executive and Registrar, GMC
Amanda Watson – Director of Registration, GMC

2. Written Evidence

Written evidence was received from the following organisations:

Bexley PCT	Fred Milson
British Medical Association	New Cross GP
Dr Cindy Cohen GP	North Central London WDC
Linda Dufie-Appiah	North East London WDC
Ealing PCT	North West London WDC
Enfield PCT	Dr Stephen Nickless
General Medical Council	Pan London Action Group
Greenwich PCT	Dr Genc Rumani
Gail Haythorne	Sidcup Community Network
Havering PCT	Jack Sindhu
Dr Linden James	Small Practices Association
Dr Patrick Kiernan	South East London PCT
Lambeth PCT	South West London PCT
Lewisham PCT	Fred Stride
London Deanery	Sutton and Merton PCT
London-wide Local Medical Councils	Wandsworth PCT
Dr Fathima Mahomed	

Annex C: Medical Practitioners - Definitions

An **Unrestricted Principal** is a practitioner who is in contract with a Health Authority to provide the full range of general medical services and whose list is not limited to any particular group of persons. Most people have an Unrestricted Principal as their GP.

Restricted Principal is a practitioner who is in contract with a Health Authority to provide either the full range of general medical services but whose list is limited (e.g. to the staff of a particular hospital or other institution), or to provide maternity medical services and contraceptive services only.

A **PMS Contracted Doctor** is a practitioner who is in a contract with a Health Authority to provide the full range of services through the PMS pilot contract and like Unrestricted Principals they have a patient list.

A **PMS Salaried Doctor** is a Doctor employed to work in a PMS pilot either by the PMS Contractor or by the PMS Contracted Doctor, and who provides the full range of services and has a list of registered patients.

An **Assistant** is a fully registered practitioner employed by a principal to act as his/her assistant.

A **GP Registrar** (previously called 'trainee') is a fully registered practitioner who is being trained for general practice under an arrangement approved by the Secretary of State.

A **Salaried doctor** (Para. 52 of the Statement of Fees and Allowances (SFA)) is a doctor employed by an Unrestricted Principal, at the discretion of the Health Authority, under the practice staff scheme.

Other PMS doctors work in PMS pilots and are the equivalents of Assistants or Salaried doctors (Para. 52 of SFA) in GMS.

GP Retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GP Retainer is allowed to work a maximum of 4 sessions of approximately half a day each week.

A **UPE** is an Unrestricted Principal or Equivalent, that is, a PMS Contracted or PMS Salaried Doctor.

A **Trainer** is a practitioner who has been approved as suitable to supervise and train practitioners in general practice.

A **Single Handed UPE** is one who has no partners, although he/she may have an Assistant or a GP Registrar. In this bulletin a single-handed UPE is defined as a partnership of one.

Estimated whole-time equivalent (WTE) UPEs (Unrestricted Principal or Equivalent) are calculated based on the results from the 1992-93 GMP Workload Survey, using factors of:

full time = 1.0 WTE;

three quarter time = 0.69 WTE;

job share = 0.65 WTE

and half time = 0.6 WTE.

WTE GP Retainers have been estimated using a factor of 0.12 per session.

A **Partnership** is a financial arrangement between two or more practitioners.

A **UPEs' List Size** is the number of persons for whose treatment the UPE is responsible. For UPEs in Partnerships, the **average list size** is the total number of persons for whom the partnership is responsible divided by the number of UPEs in that Partnership.

A **Dispensing Doctor** is one who is authorised to prescribe and dispense prescriptions for patients who either have difficulty reaching a chemist due to inadequate means of transportation or who live in a rural area.

Practice Staff: doctors are able to employ a wide range of staff to assist them in the provision of general medical services. Their Health Authority may reimburse a proportion of the cost of employing these staff through either the SFA or the PMS Contract.

Annex D: Orders and Translations

For further information on this report or to order a bound copy, please contact:

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ਜੇ ਤੁਸੀਂ ਜਾਂ ਕੋਈ ਤੁਹਾਡਾ ਜਾਣ-ਪਛਾਣ ਵਾਲਾ ਇਸ ਰਿਪੋਰਟ ਦਾ ਅਗਜ਼ੈਕਟਿਵ ਸੁਮਾਰੀ ਅਤੇ ਸੁਝਾਵਾਂ ਦੀ ਨਕਲ ਵੱਡੇ ਅੱਖਰਾਂ ਵਿਚ, ਬ੍ਰੇਅਲ ਵਿਚ ਜਾਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮੁਫਤ ਪ੍ਰਾਪਤ ਕਰਨਾ ਚਹੁੰਦਾ ਹੈ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ ਸਾਡੇ ਨਾਲ 020 7983 4100 ਤੇ ਟੈਲੀਫੋਨ ਰਾਹੀਂ ਸੰਪਰਕ ਕਰੋ ਜਾਂ assembly.translations@london.gov.uk ਤੇ ਸਾਡੀ ਈ-ਮੇਲ ਕਰੋ।

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Haddii adiga, ama qof aad taqaanid, uu doonaayo inuu ku helo koobi ah warbixinta oo kooban iyo talooyinka far waaweyn ama farta qofka indhaha la' loogu talagalay, ama luuqadooda, oo bilaash u ah, fadlan nagala soo xiriir telefoonkan 020 7983 4100 ama email-ka cinwaanku yahay assembly.translations@london.gov.uk

Annex E: Principles of Assembly Scrutiny

The powers of the London Assembly include power to investigate and report on decisions and actions of the Mayor, or on matters relating to the principal purposes of the Greater London Authority, and on any other matters which the Assembly considers to be of importance to Londoners. In the conduct of scrutiny and investigation the Assembly abides by a number of principles.

Scrutinies:

- aim to recommend action to achieve improvements;
- are conducted with objectivity and independence;
- examine all aspects of the Mayor's strategies;
- consult widely, having regard to issues of timeliness and cost;
- are conducted in a constructive and positive manner; and
- are conducted with an awareness of the need to spend taxpayers money wisely and well.

More information about the scrutiny work of the London Assembly, including published reports, details of committee meetings and contact information, can be found on the GLA website at <http://www.london.gov.uk/approot/assembly/index.jsp>

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