



## A Future Workforce Strategy for General Practice

October 2014

### Background

*Ten years ago in Yorkshire and the Humber for every GP leaving the workforce there were 1.7 GPs entering the workforce. This allowed for changing working patterns, population growth and allowed our NHS to respond to growing demand. Whilst the number of GPs entering the workforce has grown slightly, the number of GPs leaving the workforce has grown significantly year on year, nearly doubling over the decade. As the headcount of GPs entering the workforce in the last year is only just in balance with the number of leavers, this no longer allows for changes in working patterns, population growth or increased demand for GP services.*

*This has resulted in the number of full time GPs per 10,000 patients in Yorkshire and the Humber falling from an average of 5.88 in 2009 to 5.73 in 2013. If the impact of this fall was shared equally across our region, it would mean an average sized practice of 10,000 patients losing between one and two GP clinical sessions each week. In fact the GP undersupply is not equally distributed, so the more likely impact scenario is that one in five practices has been unable to replace a leaving GP.*

*As demand for primary care will not reduce to accommodate this change, our primary care workforce strategies are changing instead.*

Primary care has been highlighted as a key strategic priority by the Local Education and Training Board in Yorkshire and the Humber due to a number of specific challenges. Nationally there is a drive to move services and care out of secondary care, into primary care and the community. There are increased pressures on primary care relating to an ageing population with more co-morbidity. There is also a drive to see extended opening hours within primary care. Demand modelling indicates a doubling of the requirement for General Practice consultations in the next 20 years.

It is clear that a range of strategies are needed to address the overall picture with design solutions that pay particular attention to meeting patient expectations of access to care closer to home, with increased integration of services and greater provision of services out of hours and at weekends. This will need strategies that build capacity and infrastructure in community and general practice environments, developing roles that have the competences

and skills to carry out more routine patient care, freeing up other clinicians to carry out more specialised and/or targeted care.

We need to build on what we have achieved in the past 5 years. In 2009 we published our five year workforce strategy 'Workforce Ambitions 2009-2014'. We accurately predicted the increase in GP retirements in our region and we have done what we said we would do. In particular we have:

- **Increased primary care training capacity, especially in our underserved areas.** For example there are now almost twice as many GP trainees in Hull as there were in 2008. We have increased the training of nurse mentors in primary care with 90 primary care nurses completing their mentorship training in 2012/13 and 160 in 2013/14.
- **Developed multi-disciplinary training opportunities.** Our network of advanced training practices now covers the whole region, involves 118 practices and is on track to deliver 289 undergraduate nurse placements in 2014/15.
- **Improved Primary Care Workforce Data.** In 2009 we recognised that there was an imperative to underpin our decisions with high quality data on the GP workforce, so we developed the GP Workforce Tool
- **Funded HEYH education and training provision for Primary Care Nurses, Allied Health Practitioners and Health Care Assistants.** More than 2,300 staff from primary care accessed this provision in 2013/14.

### **Workforce profile**

Workforce information obtained through the workforce planning tool, confirms there continues to be a high retirement age profile in traditional general practice roles over the next 5 years; showing that Yorkshire and the Humber has large numbers of GPs, Practice Nurses and practice administrative staff over the age of 55 years. There is an uneven distribution of existing workforce in terms of workforce capacity and capability. There is also a variation in organisational resilience to workforce challenges. The most serious workforce challenges are in practices serving either our rural remote or urban deprived communities.

### **Recruitment to GP training posts**

Despite the national decision to increase the numbers of GP training opportunities available from August 2014 in order to meet the Government target to expand GP training, applications to GP training nationally have dropped by 15% this year. This has meant a reduced fill rate in areas away from the South Coast. HEYH advertised 329 GP Registrar (GPR) training opportunities to achieve the HEE Mandate target set for August 2014. The fill rate at the end of Round 2 was 70%, leaving 90 unfilled GPR posts. The impact of this shortfall has been felt most acutely in our more under-doctored GP workforce communities of North East Lincolnshire, Hull, Scarborough, Calderdale, Kirklees and Doncaster.

Given the combined effect of increased retirement and reduced recruitment, it is necessary for HEYH to work closely with partners to take urgent action. The impact of the low fill rate in Yorkshire and the Humber for GPRs for August 2014 will compound the workforce shortages in many of our hard to fill areas of the region.

## The vision for our primary care workforce

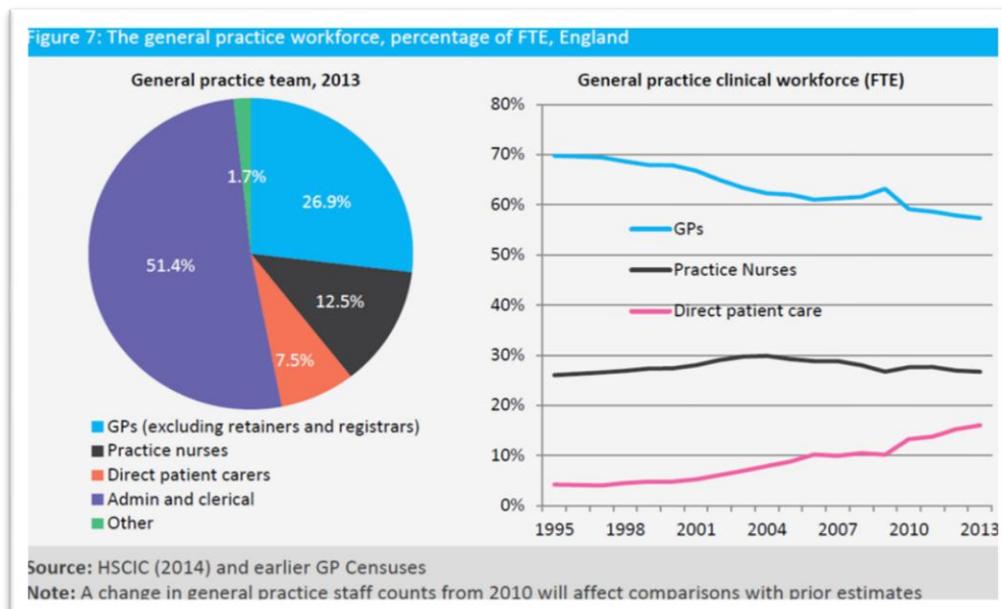
We have identified 3 simplified scenarios for a GP practice clinical staffing ratio that we need to prepare for based on the mix of 3 categories of clinical worker:

- The GP
- The Practice Nurse and/or Advanced Clinical Practitioner
- The Healthcare Assistant (Direct Patient Care band 1-4 support worker)

	GP	Practice Nurse/Advanced Clinical Practitioner	Healthcare Assistant
The conservative model (replacing like for like)	4	2	1
Practices under pressure (evolutionary change)	3	3	2
The extreme scenario (workforce transformation)	1	2	4

There is no single workforce solution. Some practices in areas with lower retirements and healthy local recruitment to training pathways may choose to continue to configure their workforce to historical norms. We believe that most practices will find themselves under increasing workload pressure and will need to see their workforce skill mix evolve through necessity. A few practices will be closer to an extreme scenario that will demand more radical workforce transformation and a complete redesign of primary care clinical pathways.

*The changing skill mix of the General Practice Clinical Workforce*



Over a period of at least 20 years, General Practice has not simply relied on replacing like for like staff in traditional roles. Increased investment in skills training to create new roles as

well as offering personal development and career progression for existing staff has been important to improve retention and morale, as well as to provide better succession planning.

The benefits of federation (either formally or informally) with other practices is increasingly acknowledged. Federation enables practices to share resources and to focus more on the delivery of a high quality service, extend opening hours and to co-operate in developing a local general practice workforce through shared investment and shared use of existing training capacity.

There needs to be a multi-faceted approach. Looking at just one particular aspect of the workforce in isolation is not a realistic option. An approach that looks at the skill sharing in the workforce and skills development would appear to be the most sensible approach. Clearly defined roles and standards of training for all working within primary care are essential in ensuring high quality and safe care is provided to patients when they are often at their most vulnerable and when it is needed.

The Calderdale framework can help in identifying an appropriate skill mix and improved career structures. Locality based workforce plans of 5-10 years should be developed at practice, CCG and area team level; incorporating short, medium and long term solutions. These plans should enable staff to develop the right skills to meet the needs of our patients that, together, we all serve. Plans will need to involve LMCs, RCGP faculties and our Higher Education Institutions as key partners.

## Strategies

HEYH has been working closely with colleagues from across primary care to develop and invest in five core strategies to address some of the key challenges presented across Yorkshire and the Humber.

<b>1. Maximising the supply of GPs and Practice Nurses</b>	<b>2. Enabling Skill Mix: distributing the practice workload differently</b>
<b>3. Bringing other professionals/healthcare workers into the practice</b>	<b>4. Developing new roles as alternatives to the existing GP workforce</b>
<b>5. Making it happen – the enabling works</b>	

### **1. Maximising the supply of the existing workforce**

#### **a). Exposure to primary care and marketing existing training opportunities**

We are investing in mentoring of medical undergraduates with GPs and using widening access schemes that offer 6th form students applying to medical school work experience placements in General Practice. The National Foundation Career Destination Survey in 2012 shows that whilst the average UK medical school produces sees 24.4% of its graduates enter GP training, HYMS see 31.4%, Leeds 29.8% and Sheffield 33.5% of their graduates enter GP training.

We offer taster sessions for FY1 medical students to spend some time in primary care and are engaged in careers events. In 2014 we piloted a pre GP employment initiative to support unsuccessful applicants to GP training with employment opportunities within our region. We believe that supporting unsuccessful applicants to GP training will develop applicants to improve successful applicant numbers in future years, whilst keeping our hospital training capacity in use and delivering service. General Practice is the only specialty that looks after unsuccessful applicants to specialty training in this way. In 2014 we also participated in a third recruitment round, offering GP training opportunities for February 2015 start for applicants who may not have achieved foundation competence by August 2015. Health Education Yorkshire and the Humber has joined with CCGs to improve marketing for our harder to fill areas, including highlighting career development opportunities in General Practice in these areas.

Our Advanced Training Practice network of 10 hubs and 118 practices is growing each year. We will deliver 700 undergraduate nurse placements a year in primary care within five years. We have seen placements in GP practices change the career intentions of undergraduate

nurses and change the attitudes of GP employers towards employing newly qualified nurses in primary care. There are a growing number of practice nurses working in General Practices in Yorkshire and the Humber as a direct result of their undergraduate placement in an Advanced GP Training Practice. Our network of advanced training practices has helped develop competency frameworks for a range of clinical support workers in primary care. In addition to developing undergraduate nurse placements, our ATPs have also developed placements for band 1-4 staff, allied health professions and social care workers. The ATPs have also offered preceptorships, enabling newly qualified nurses to go straight into work in General Practice in our region, something that was hitherto unheard of.

#### **b). Reducing training attrition**

We are targeting additional training and support towards those at greatest risk of poor progression through GP training. Targeted interventions include: the placement of lower scoring applicants to their preferred geographical area where they have more support, developing expertise in teaching clinical skills for the examination and exam preparation support for trainees. Whilst this is resource intensive, it gives a good return on investment as we have some of the best exit examination pass rates when compared to our trainees' entry scores through national GP selection tests.

#### **c). Return to practice and retention initiatives**

We have developed and funded an Induction, Refresher, Returner scheme to support GPs who have been out of UK General Practice to return to work in our most under-doctored areas. We continue to support a GP retainer scheme. A national campaign was launched Sept 2014 to encourage nurse to return to practice. In Y&H information regarding the launch was sent to Chief Nurses in CCGs for circulation to enable expressions of interest from General Practice to be linked to the programme. A briefing paper about the initiative has also been shared with the ATPs. Whilst practices have yet to express an interest in the nurse return to practice initiative, we are including information about the scheme in our feedback pack for practices supplying workforce data using the GP workforce tool.

## **2. Enabling Skill Mix: distributing the practice workload differently**

**a). The Calderdale framework.** HEYH have invested in the roll out of the Calderdale framework. This is available to GP practices and CCGs expressing an interest in the model. It enables general practices to work through a framework to help them identify the most appropriate skills required to provide a safe and effective service, taking a whole team approach from beginning to end, to ensure ownership as a practice of the solutions and skill mix identified.

**b). Developing new capabilities in existing primary care staff.** We have enabled Practice Nurses and Health Care Assistants to access HEYH funded education and training provision available at ten universities across Yorkshire and the Humber as well as the Primary care training centre and Rotherham Respiratory Group. Evidence demonstrates a significant number of primary care staff are accessing this provision.

Access to the e-learning GP Platform (e-TREVOR) will also be available on 2014. This initiative has been developed by the CSU in conjunction with the HEYH e-learning club and

will provide a web-based e-learning for general practice staff.

**c). Apprenticeship opportunities.** HEYH have supported Apprenticeship Hubs which are now widely established and have better links with practices to support them access programmes for health care assistant and business administration apprenticeship roles. In 2014 there were at least 120 apprenticeships in General Practice providers.

**d). Workforce Transformation.** Health Education Yorkshire and the Humber has held workshops, conferences and engaged in CCG led locality events on workforce transformation. Many of these events have focused on doing general practice work differently.

### **3. Bringing healthcare workers into General Practice from other care settings and organisations**

This includes Pharmacists, Physiotherapists and Paramedics. There is potential to utilise unfilled GP vocational training capacity to develop placement capacity for Allied Health Professionals wishing to orientate to primary care and enhance contextual skills in the General Practice setting.

We are funding 20 two year placements for advanced clinical practice (AHPs and nurses) working in general practices. We have received over 50 expressions of interest from practices interested in this initiative.

Just as we were one of the lead areas for Broad based Training, Yorkshire and the Humber has contributed to plans for recognising transferable competences for doctors from other specialties who wish to train as GPs having started in a different specialty training programme. It is expected that there will be a shorter training pathway for these GP trainees who will bring competences from other specialty training.

Health Education Yorkshire and the Humber will support integration of care, as proposed in The NHS Five Year Forward View.

### **4. Developing new roles as alternatives to the existing workforce**

**Physicians Associates:** We have commissioned training for Physicians Associates with an expectation that we will deliver placement capacity in primary care and that on graduation PAs will work in our region. We are working with CCGs to secure employment opportunities in practices for PAs on graduation. We have been working with a beacon practice that has employed several PAs.

**Other new roles:** At our engagement events and workforce transformation events there was interest in a new role for a band 1-4 support worker who might work alongside GPs and other practitioners to increase efficiency and take share some of the administrative workload from the GP in order to maximise patient throughput.

## 5. Making it happen – the enabling works

**a). Workforce Planning Tool.** The tool is currently being used by 52% of Yorkshire and the Humber practices and with increasing interest from Area Team, CCG and General Practice. Practices that are using the GP database tool are able to create better informed workforce plans by analysis of their local practice data and comparisons with other similar practices/CCG areas. This data can be used to model workforce needs for the future, identify risks and opportunities and provide the evidence to demonstrate resource requirements, including additional financial investment. HEYH continue to work with practices to refine this tool and support its use.

**b). Advanced Training Practices.** The advanced training practices will continue to develop new primary care placement capacity for undergraduate nurse and allied health professional placements, band 1-4 support workers and preceptorships.

**c). Local partnerships.** In the North Yorkshire and Humber area a Primary care workforce development group was formed early 2013 to tackle local priorities facing the primary care workforce with representation from the LMC, HEYH, CCGs, HEIs, Hull York Medical School, Area Team and practices. This is now being replicated in other localities, feeding into the partnership council network.

CCGs are working locally with practices in order to address some of the issues around recruitment and retention. Some are offering financial incentives to release Practice Nurses to undertake mentor preparation programmes and aid their development, bursaries for GPs to fund Masters and doctorate level education.

CCGs have supported the development of Advanced Training Practices and adoption of the GP Workforce Tool. CCGs with urgent locality GP workforce issues have been proactive in promoting workforce transformation action in these localities.

### Ongoing Challenges and Risks

The financial constraints and workload pressures now faced by General Practice are acute. The reorganisation of the primary care commissioning landscape from PCTs to CCGs and Area Teams has meant that practices have spent time/energy becoming familiar with the new organisations and organisational interfaces. Many practices have not been aware in the need to invest or sustain their medical and non-medical training/supervision infrastructure. Release of staff for training is an issue for most practices. Some practices recognise a risk that where they invest in skills development for individuals, neighbouring practices may “poach” experienced trained staff. The opportunity cost of staff development therefore needs to be recognised. Where these obstacles have been overcome we have seen a “virtuous spiral” where practices move from “why would we invest in training our workforce?” to “why wouldn’t we invest in training our workforce?”

Practices across Yorkshire and the Humber are at different stages of development and organisational maturity with respect to workforce insight.

### ***Stages of GP Organisational Maturity with Respect to Workforce Planning***

- (1) “Passive/Non engaged” - Practices that have not submitted a workforce risk or who see no workforce solutions within their own sphere of influence.
- (2) “Reactive” - Practices that address workforce issues as and when they arise within each of their staff groups, but in a “silo” way.
- (3) “Anticipative/Responsive” - Practices that look ahead to future retirements/ or workforce changes, and consider shifts of skills/work within the organisation between different staff groups.
- (4) “Contributive/Proactive” - Practices that not only look ahead and look at changing work patterns, but who work at a level above their own organisation in partnership to train primary care workers for the wider community.
- (5) “Generative/Co-productive/Innovative” - Practices at a level indicated in (4) but who also contribute to innovative or new solutions for the primary care workforce.

## **What Health Education Yorkshire and the Humber needs from our local partners**

Health Education Yorkshire and the Humber will deliver on the strategies outlined in this document. Health Education Yorkshire and the Humber alone cannot address the perceived need for additional investment in general practice, the attractiveness of working in general practice as a career option, nor the attractiveness of working in a particular geographical location. We therefore need our partners to play their part. We need practices/CCGs/Area Teams to create and share their GP workforce plans and to develop greater organisational maturity with respect to workforce planning.

### ***Practices/ Providers of primary care***

We need practices to supply workforce data, placement capacity and employment opportunities for the workforce that is trained locally. Where practices federate, we would like to see provision of placement capacity and engagement with training given a high priority, so that primary care invests in and develops its own staff.

### ***Commissioners of Primary Care (Area Teams)***

We need commissioners of primary care to align contracts/incentives with patient need, especially with respect to workforce retention. This includes appropriate incentives/levers to ensure supply of accurate workforce information. Where workforce solutions require transformation, commissioning investment decisions (for example regarding estate) need to be aligned so that the transformed workforce can be accommodated.

### ***Commissioners of Secondary Care (CCGs)***

We need commissioners of secondary care to signal shifts in commissioning intentions and to share proposals on the development of integrated care solutions where this has an impact

on education and training commissions. In addition CCGs may be the catalyst for federation and are key stakeholders and system leaders.

***Other Providers of Primary Care Training placements, including Secondary Care Providers and other partners***

We need other providers of primary care training placements to continue to provide placement capacity for training the primary care workforce. This capacity needs to be delivered even as services shift and new models of care delivery are developed.