Providing for the future:

Briefing following GPNSAG workshop held on Tuesday 10th February 2015 looking at general practice clinical workforce needs and supply in Wales

29 May 2015

RCGP CYMRU WALES Royal College of General Practitioners Coleg Brenhinol Meddygon Teulu

GIG CYMRU NHS WALES

Grwpiau Cynghori Arbenigol Cenedlaethol GP
GP National Specialist Advisory Group

Objective of briefing paper

1. This briefing paper aims to provide an overview of the general practice clinical workforce challenges faced by Wales and a summary of a workshop hosted by the Royal College of General Practitioners Wales (RCGP Wales) on behalf of the General Practitioner National Specialist Advisory Group (GPNSAG). This workshop was attended by key stakeholders across primary care in Wales (please see the Appendix for a full list of attendees). Workforce within this paper refers to general practitioners (GPs), nurses and health care support workers (health care assistants).
2. This paper outlines:
   a. The background and context of general practice workforce issues in Wales
   b. The objectives of the workforce workshop
   c. Initial results from workshop analysis
   d. Proposals for improving the collection of workforce data
   e. Proposed recommendations *(for discussion and review with GPNSAG)*

Background

3. There is a strong perception that the capacity of the general practice workforce to meet the changing and increasing demands of patients is insufficient. However, there is a limited amount of objective evidence to support this assertion; this paper seeks to provide an overview of some of the supply and demand issues in Welsh general practice.

4. Demand for general practice services is increasing, and this is causing additional workload pressures for GPs and their teams. An indicator for this is the patient reported ease of getting an appointment at their GP surgery. The number of patients reporting that it was either 'fairly difficult' or 'very difficult' to obtain a convenient GP appointment in Wales has increased from 33.5 per cent in 2013 to 37.7 per cent in 2014.[1] From the GP perspective, a survey conducted by ITV Wales and RCGP Wales found that 84 per cent of GPs feel excessive pressure from day to day.[2]

5. There is also strong evidence that the care general practice is required to deliver is becoming more complex. The impact of long term conditions is growing in Wales. One-third of the adult population reports having at least one long term condition. The prevalence of long term conditions increases with age: two-thirds of the population of Wales aged 65 years or older report having at least one chronic condition, while one-third report multi morbidities. The demand from patients with long term conditions is forecast to rise as the number of people aged 65 years old and over is projected to increase by around 181,000 or 32 per cent between 2010 and 2026.[3]

6. Mirroring the population, the general practice workforce is also ageing. Deloitte's Centre for Health Solutions argued that the greatest supply challenge facing

[1] StatsWales (2013 and 2014) *National Survey for Wales.* Accessed at: https://statswales.wales.gov.uk/Catalogue/National-Survey-for-Wales
[2] ITV Wales and RCGPWales (2015) *The Welsh GPs who plan to quit and work abroad because of excessive pressure.* Accessed at: http://www.itv.com/news/wales/2015-03-09/the-welsh-gps-who-plan-to-quit-and-work-abroad-because-of-excessive-pressure/
[3] Auditor General for Wales (2015) *The Management of Chronic Conditions in Wales – An Update.* Accessed at: http://www.wao.gov.uk/system/files/publications/The%20Management%20of%20Chronic%20Conditions%20in%20Wales%20-%20An%20Update.pdf

primary care is the average age profile of GPs. The proportion of GPs aged 55 years old and over in Wales was 23.0 per cent in 2014.[4] Additionally, the practice nurse workforce is also ageing. A review of the UK primary care workforce in 2009 found that a disproportionate number of primary care nurses is expected to retire within five to ten years.[5]

7. Despite the expected increase in retirements over the next few years. GP recruitment into the profession has also been falling. In 2014, only 22.3 per cent of Foundation Programme graduates entered general practice training and this is a growing problem.[6] In 2013, 97 per cent of all GP training places in Wales were filled but in 2014 this fill rate dropped to 93 per cent. The distribution of these missing places has also grown. In 2013, only one GP training scheme did not fill its training places (Aberystwyth had 33 per cent of its places filled). However, in 2014, five GP training schemes did not fill their training places:
   a. Carmarthen: 90% (percentage of places filled)
   b. Bangor: 83%
   c. Wrexham: 71%
   d. Pembrokeshire: 67%
   e. Aberystwyth: 50%[7]

   Emigration is also an issue: in 2014, approximately 40 Welsh foundation school graduates chose to practice outside the UK.[8] Furthermore, 53 per cent of the 500 GPs surveyed by ITV Wales and RCGP Wales said that their practice faces significant GP recruitment issues. Recruitment challenges are confounded by low morale of the current workforce as 36 per cent of the GPs responding to the survey stated that they would not choose general practice as their career if they had to choose now (with 29 per cent answering 'maybe').[9]

8. These challenges to workload, ageing workforce and poor recruitment have also correlated with a decline of investment in general practice. Research undertaken by Deloitte shows that funding to general practice across the UK as a share of total NHS funding has decreased from 10.3 per cent in 2004/5 to 8.39 per cent in 2011/12.[10] In Wales, the funding has fallen from 8.5 per cent of total NHS funding in 2005/06 to 7.8 per cent in 2012/13. It is important to note the welcome announcement by Welsh government of the additional £40 million of funding for primary care announced by the Government in late 2014. However, this £40 million is allocated to primary care and not specifically general practice.

9. Given these five issues of increasing workload, greater complexity, ageing workforce, poor recruitment and under-investment, there is an urgent need for all stakeholders within primary care to align resources. It is only through

[4] Health and Social Care Information Centre (2015) General and Personal Medical Services, England - 2004-2014, As at 30 September. Accessed at: http://www.hscic.gov.uk/catalogue/PUB16934
[5] Deloitte Centre for Health Solutions (2012) *Primary care: Today and tomorrow, improving general practice by working differently*.
[6] Foundation Programme Destination Report 2014 (2014) UK Foundation Programme. Accessed at: http://www.foundationprogramme.nhs.uk/pages/home/keydocs
[7] Welsh Government (2014) *FOI Request by Royal College of General Practitioners*. Request received on 10th December 2014.
[8] Foundation Programme Destination Report 2014 (2014) UK Foundation Programme. Accessed at: http://www.foundationprogramme.nhs.uk/pages/home/keydocs
[9] ITV Wales and RCGP Wales (2015) *Unpublished survey data.* Sample size of 500 GPs. Published material: http://www.itv.com/news/wales/2015-03-09/the-welsh-gps-who-plan-to-quit-and-work-abroad-because-of-excessive-pressure/
[10] Deloitte (2014) *Under Pressure: The funding of patient care in general practice.* Accessible at: http://www.rcgp.org.uk/campaign-home/~/media/Files/PPF/Deloitte%20Report_Under%20Pressure.ashx

collaborative working that we can ensure that the primary care workforce has sufficient capacity to deliver services suitable for the changing Welsh population.

Workshop objectives

10. A workshop to discuss the workforce challenges in Wales was held on Wednesday 10th February, it was arranged by RCGP Wales on behalf of GPNSAG. A range of primary care stakeholders were invited from across Government, professional bodies and frontline healthcare professionals. The main purpose of the meeting was to estimate the workforce needs of the population and to discuss various methods to determine current workforce numbers. The qualitative output of this workshop has been analysed quantitatively in this paper to form indicative estimates of workforce numbers and workload. The results outlined here are presented to inform the debate further. They should be treated as informative and there should be resources invested to challenge the assertions made with more robust approaches.

11. It is important to acknowledge that the future model (or indeed models) of care are not yet determined and could vary significantly between different localities. New operating models for primary care services will have significant implications for primary care workforce planning. However, given the length of training for healthcare professionals it is of utmost importance that estimates of potential shortfalls are not delayed, as this could have significant impacts on patient care in the future.

12. The scope of this briefing paper predominantly focussed on GPs and nurses working in general practice. However, we recognise that other professionals will form part of the solution in different parts of the country.

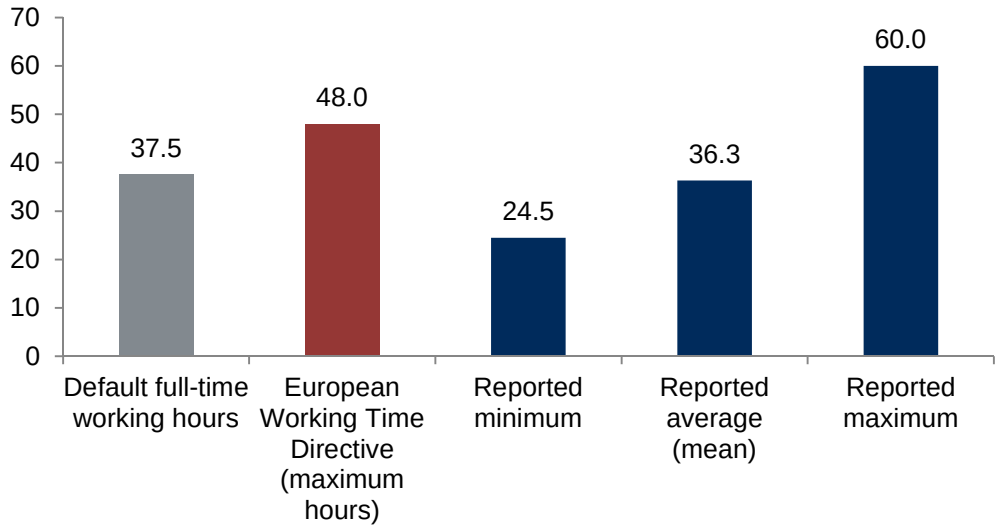
Initial results

13. RCGP Wales believes that for general practice to play its critical role in caring for patients in the future NHS, it is important that there are enough GPs and other healthcare professionals; that these healthcare professionals have sufficient time, both in and outside the consultation, to provide the interventions needed; and that they receive sufficient training to develop the capabilities required to deliver the high quality services that patients, carers and families rightly expect. The workshop focussed on understanding current issues of workforce numbers and workload, as well as forecasting ideal numbers of healthcare professionals in the future.

Current in-hours workload

14. In 2013, Wales had 2,026 headcount GPs (excluding registrars and retainers), of which 1,901 were Whole Time Equivalents (WTE).[11] The definition of WTE for this data set is unclear.[12]).[13] In 2014, this number of GPs had fallen to 2,006.[14] However, in Scotland and England this is based on 37.5 hours. The workshop attendees provided estimates of how much time is spent working in a clinical session per week, this is presented in Figure 1. Whilst the reported average is broadly in line with 37.5 hours, the working hours proposed by workshop attendees do not take into account hours worked by GPs outside of clinical sessions. For the purposes of this paper clinical sessions include direct patient interactions and any work arising from patient interactions. Therefore the figures presented in Figure 1 do not reflect non-patient related activity performed by GPs. Furthermore, these estimates do not include any out-of-hours commitments that GPs may have.

Figure 1. Estimated clinical sessional hours worked per GP per week



15. Estimating the number of patients that GPs are seeing during the working week has also been calculated using the workshop input. The basis for the calculations were the reported patient contact time per session and the average lengths of telephone and face-to-face consultations. These inputs are outlined in Table 1. The reported percentage of a session spent on direct patient interaction varied from 71 per cent to 82 per cent. In order to estimate the number of consultations conducted by a GP per day, three different scenarios of practice patient-contact models were developed:
    a. Scenario 1: (Face-to-face consultations only)

[11] StatsWales (2014) *Health and Social Care General Medical Services.* Accessed at: https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/General-Medical-Services

[12] The datasets do not outline the definition of WTE. However, in Scotland and England this is based on 37.5 hours. There have been issues with the England collection of Full Time Equivalent data, where this has been overstated. The Health and Social Care Information Centre conducted a consultation to propose a solution for this anomaly. See: https://consultations.infostandards.org/workforce/gp-census/supporting_documents/GP%20Workforce%20Consultation%202014%20FINAL.pdf

[13] StatsWales (2014) *Health and Social Care General Medical Services.* Accessed at: https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/General-Medical-Services

[14] Health and Social Care Information Centre (2015) General and Personal Medical Services, England - 2004-2014, As at 30 September. Accessed at: http://www.hscic.gov.uk/catalogue/PUB16934

b. Scenario 2: (75% face-to-face; 25% telephone)
c. Scenario 3: (50% face-to-face; 50% telephone)

Table 1. Key inputs to estimate the number of consultations currently being conducted

Workshop question	Reported average (mean)	Reported minimum	Reported maximum
What is a session (no. of working hours)?	4.3	3.5	6.0
In a clinical session: How many hours are spent directly interacting with patients (Face-to-Face and telephone)? (hours)	3.5	2.5	4.5
What is the average length of consultation? - Face to Face (minutes)	10.7	8.0	13.0
What is the average length of consultation? – Telephone (minutes)	5.8	2.0	9.1

16. In order to estimate the number of consultations per day two methods were used:
    a. Method 1: Multiplying the reported number of consultations conducted per session by two (assuming two sessions per day)
    b. Method 2: Dividing the reported number of consultations conducted weekly by five (assuming five working days)

    There is some variation between the methods with Method 1 generally estimating a larger number of consultations per GP. The results for both methods are presented in Figures 2 and 3.

Figure 2. Reported number of consultations conducted by GPs per day (Method 1)

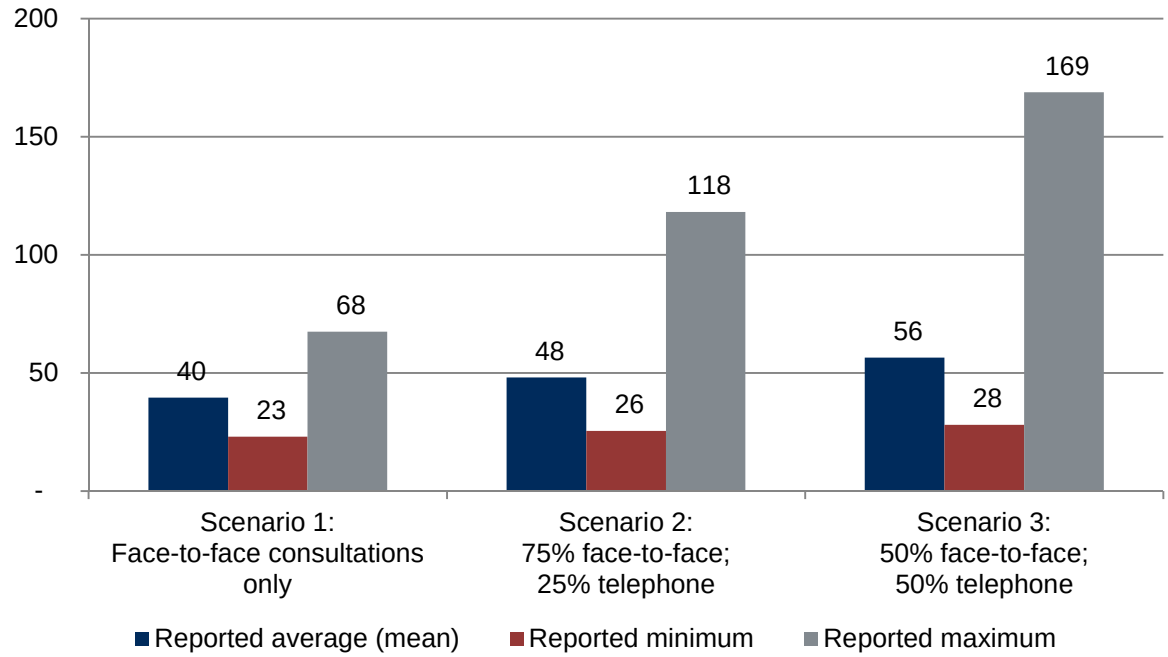
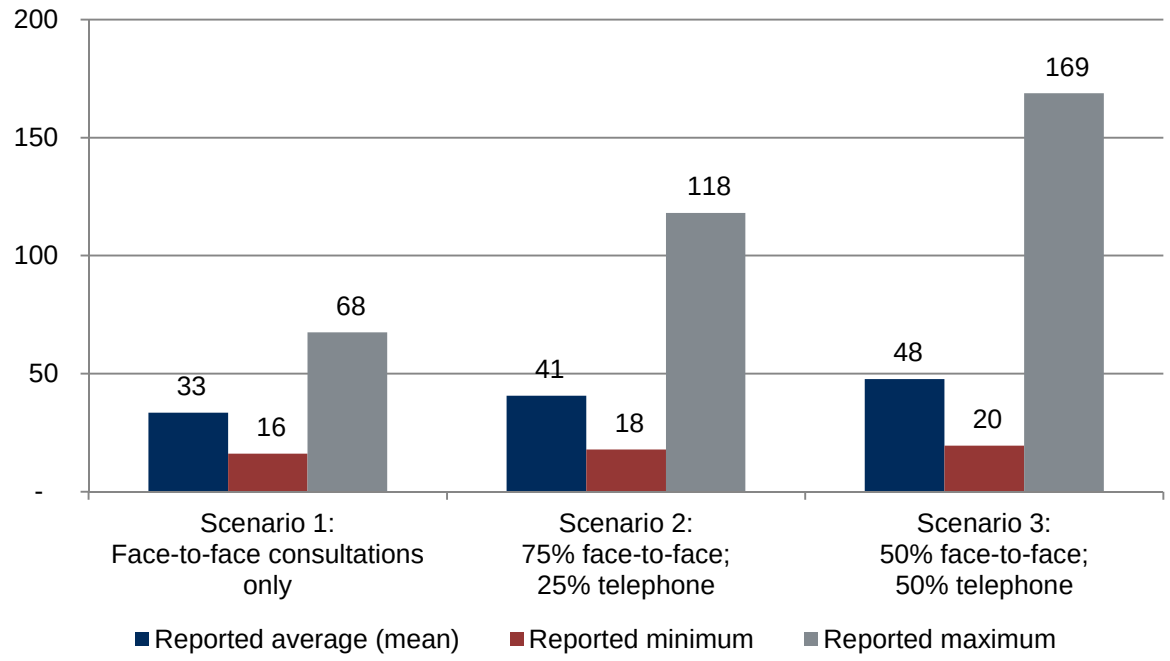


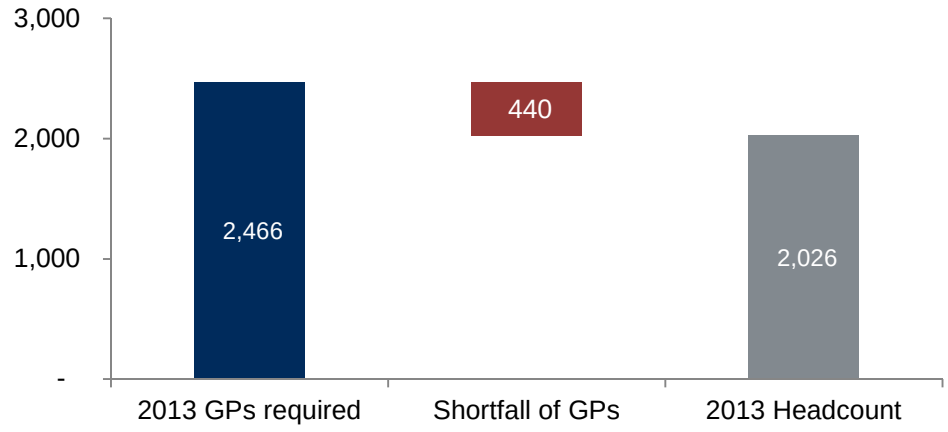
Figure 3. Reported number of consultations conducted by GPs per day (Method 2)



Number of healthcare professionals required

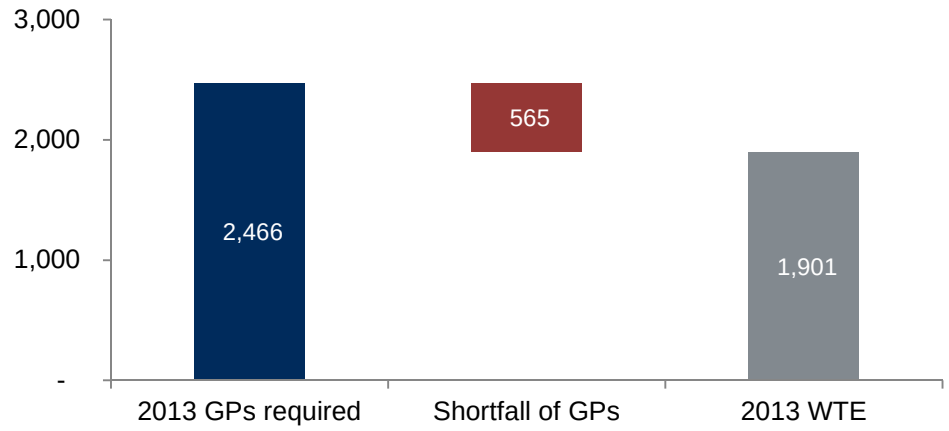
17. There was a clear consensus that the ideal number of general practitioners per 5,000 population should be four.[15] Therefore, using the ONS mid-2013 estimates of population it is possible to estimate the shortage of GPs in Wales. Based on Welsh Government figures of headcount GPs there is a shortfall of 440 GPs. However, if you use the Welsh Government figures of WTE GPs there could be a shortfall of up to 565 WTE GPs. These estimates are shown in Figures 4 and 5 respectively. The figures are calculated using 2013 data as that is the last year with official estimates for WTE.

Figure 4. Estimated shortfall of GPs in 2013 (headcount)



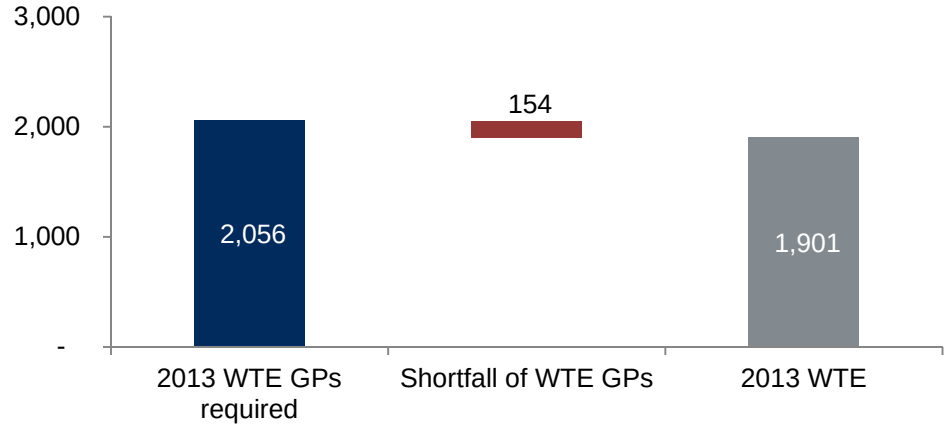
[15] Clarification from attendees should be sort as to whether the coverage per 5,000 population was for headcount or WTE.

Figure 5. Estimated shortfall of GPs in 2013 (WTE)



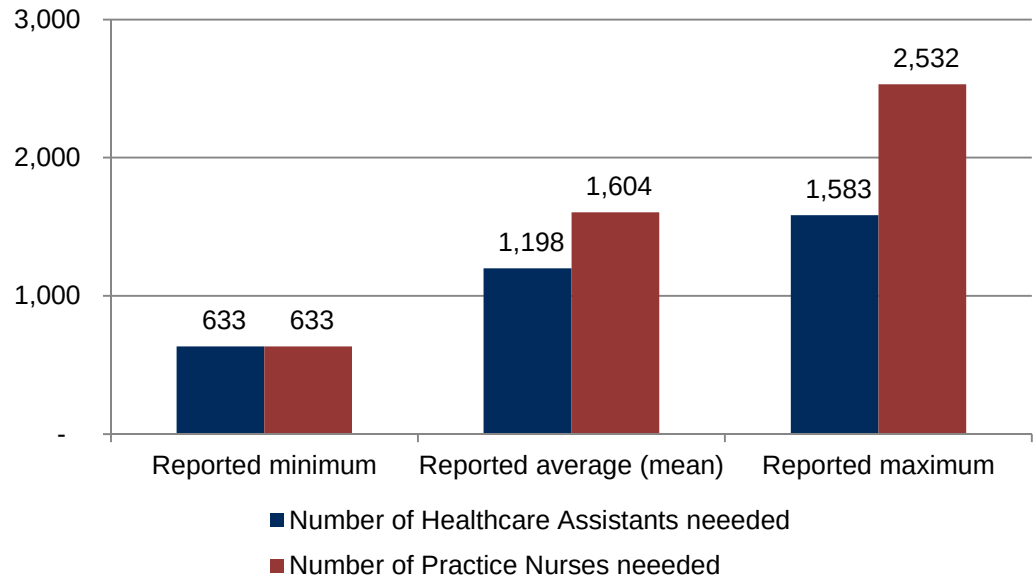
18. However, within the workshop estimates of GP coverage based on registered patient list size were also provided. The optimal number of WTE GP per registered patient ranged from one GP per 1,000 to one GP per 2,000. This differs from the estimates above due to variations between registered patient lists and recorded populations. Therefore, using the 2013/14 Quality Outcomes Framework patient list sizes (3.17 million), the number of WTE GPs required varies from 1,583 to 3,166. Figure 6 presents the average estimate, which suggests a shortfall of WTE GPs of 154. Therefore the overall estimates of current GP shortage varies from 154 WTE to 565 WTE.

Figure 6. Estimated shortfall of GPs in 2013 (WTE)



19. Figure 7 outlines the estimates of practice nurses and healthcare assistants required in 2013. It is difficult to determine whether there is a shortfall in the number of practice nurses and / or healthcare assistants as there is a lack of accurate workforce data for these healthcare professional groups.

Figure 7. Estimated number of practice nurses and healthcare assistants required in 2013



GP Out of Hours services

20. In contrast to the in-hours figures, there was a clear divergence on the number of GPs required for Out of Hours (OOH) work and further work should be undertaken to ascertain exactly how many GPs are required for OOH work in Wales. Please see Figures 8 to 11.

Figure 8. OOH GPs required 'Before midnight' - outliers included

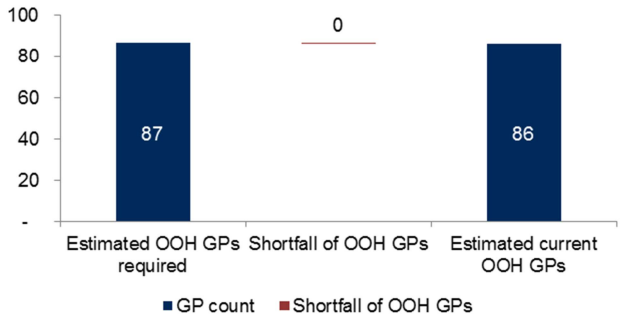
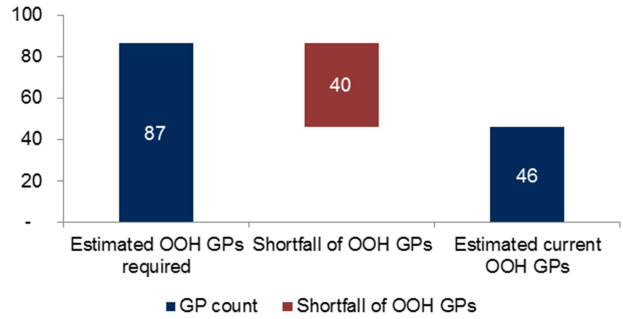
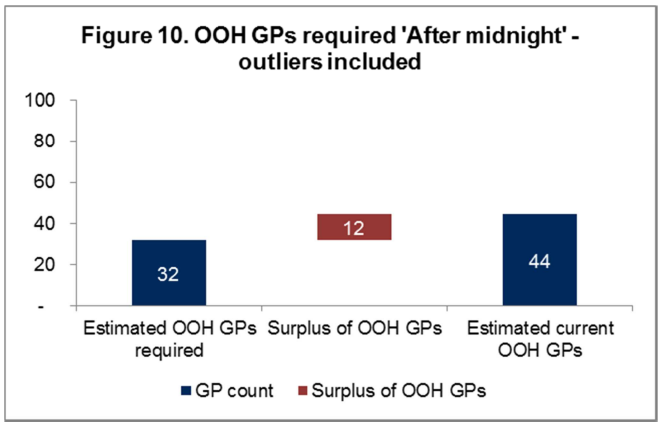
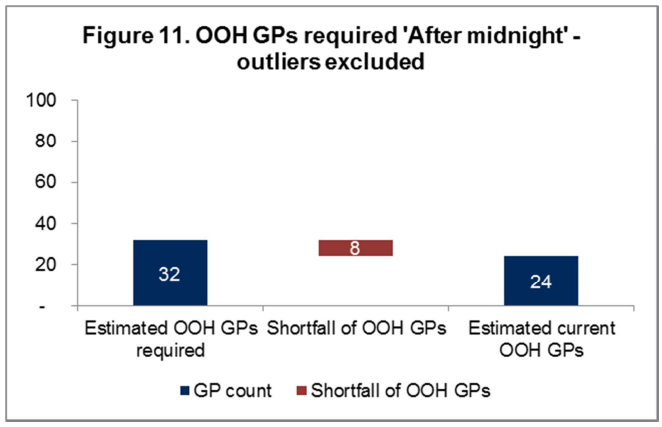


Figure 9. OOH GPs required "Before midnight' - outliers excluded







21. There are a few reasons for this divergence: OOH models across Wales vary considerably in their use of the multidisciplinary teams. Some service use GPs as their only clinicians, others use a much more diverse range of staff, including triage nurses, advanced nurse practitioners, advanced paramedics and others. Furthermore, even when the multidisciplinary teams are used, the way in which non-medical colleagues are deployed varies widely; from "expert triage" systems with the most experienced clinicians at front of house to nurse led triage. In addition, consultation patterns vary considerably across Wales, with some OOH services effectively acting as walk in centres for holiday makers and dealing with the over spill from struggling practices, while others concentrate on the core business of dealing only with urgent health care problems that cannot wait until the next working day.

22. Despite the variability in the figures, it is important that workforce planning takes into account the approximately 70% of the time that is covered by the OOH services. In contrast to older GPs who often did OOH work on top of their practice commitments, there are anecdotal reports of younger GPs choosing to reduce in-hours commitments when taking on OOH work. This will have significant implications for workforce planning.

Proposals for improving the collection of workforce data

23. There was some discussion in the workshop about the best methods to obtain better workforce data to inform better workforce planning. It is imperative that any workforce data collected includes other members of the practice team. Various approaches were proposed:

    a. **Survey of GPs working in Wales.** A survey of GPs could be conducted using the workshop questions as a basis for specific questions about GPs current workload and viewpoints on the future GP requirements. The concerns about this approach is that it is only a one-off snapshot, it could be resource intensive. Furthermore, the success of any survey would be highly contingent on response rates. There are risks of responder biases in the data, for example, those who work longer hours are more likely to respond to the survey compared to those that work less hours, or that those who work longer hours don't actually have the time to complete the survey. There is also an

accuracy risk in the data driven by the difference between perceived and actual workload.

b. **Mandatory workforce data collection as part of annual appraisals.** The benefit of this approach is that over time it would allow the development of longitudinal comparisons. Further work would need to be conducted to evaluate the legal implications of creating an additional mandatory element of GP appraisals. Specific solutions would be needed for locum GPs and other healthcare professionals, especially those who work across different practices.

c. **Use of data analytics to generate workforce data.** There could potentially be an automatic solution to workforce data collection by obtaining extracts from practice data software e.g. EMIS. The initial use of data would be poor but as the process improves and people become aware of what the data is being used for, it may improve. There are significant consistency of use issues and ownership challenges to obtaining extracts from practice data. It is noted that there is a discrepancy between appointment systems and patient record systems. However, it was proposed that practices could be paid to drive up quality of recording by allowing them to qualify for a Direct Enhance Service payment. Tracking of data on locums could be completed via shared services. The benefits of data extractions is that they could allow trend analysis and might be able to be performed more than once a year. However, the use of this data for activity measurement could be misleading as the counting of contacts does not reflect the content of them. It is vital to ensure that any collection of activity data does not turn into a performance management tool.

Proposed recommendations *(for discussion and review with GPNSAG)*

24. The issue of demand versus capacity in the health service is not new; it has not arisen overnight and neither can it be solved quickly. Sustainable solutions must be found to increase workforce capacity and enable general practices to continue to deliver the level of service that their patients expect now. Looking to the future, GPs must take on the challenge of providing more complex care, spending longer with their patients and communities and taking on new roles and responsibilities. In order to create a primary care workforce fit for the future, the following steps should be considered:

a) Workforce planning

i. Increased collection of workforce data for all healthcare professionals
ii. Quantitative forecasting of workforce numbers
iii. Evaluation of the relevant competencies for different health and care roles

b) Recruitment

i. Cultural change to encourage recruitment to general practice
ii. Stabilisation of GP careers
iii. Greater exposure to general practice at undergraduate and foundation school level
iv. Review of incentives to attract locum doctors
v. Review of underlying reasons why Welsh graduates emigrate to other countries

vi. Incentivising practices to recruit / commission a wider variety of health care professionals in new roles

c) Training

i. Increased GP training capacity, especially in our underserved areas
ii. Increased nurse training capacity with co-ordinated structure and funding
iii. Funded education and advanced training provision for current and new Health Care Assistants
iv. Funded education and training provision for administrative and practice manager roles
v. Review of funding for GP training
vi. Review of training content for health professionals who will have a more active role within the future delivery of primary care

d) Retention

i. Invest in occupational health and GP morale
ii. Establish clearer workload management guidelines
iii. Career structures for non-GP primary care workforce members

Appendix

List of attendees

Name	Role
Paul Myres	Chair, RCGPWales. Chair GPNSAG. .
Malcolm Lewis	Sub Dean & Director of General Practice Education
Charlotte Jones	Chair, GPC Wales
Rebecca Payne	RCGP Membership Officer
Clare Evans	Head of Primary Care Services Operations & Delivery PCIC Clinical Board, Cardiff and Vale
Gwyneth Thomas	Health Statistics and Analysis Unit, WG
Richard Quirke	Deputy Medical Director, Cwm Taff HB
Jonathan Richards	Clinical director Primary Care Cwm Taf
Eileen Munson	Senior Lecturer Professional lead for General Practice Nursing. Community and Public Health
Simon Scourfield	NHS Wales Informatics Service - Primary Care
Joe Hunt	NHS Wales Informatics Service -Primary Care
Karen Gully	Senior Medical Officer (General practice and primary care) Welsh Government
Dr Neil Statham	Chair Gwent LMC
Dr Alan Stevenson	Morgannwg LMC Executive Member
Sarah Morgan	Bro Taf LMC rep Cardiff and Vale
Westley Saunders	Bro Taf LMC rep Cwm Taf
Dr Fraser Campbell	Assistant Medical Director (Primary Care) for BCUHB
Professor Joyce Kenkre	Professor of Primary Care, University of South Wales
Dr Sue Fish	Medical Director, Hywel Dda HB
Dr Mark Walker	Medical Director BCUHB
Ceri-Ann Hughes	work force development, WG
Nicola Edmunds	Manager, RCGPWales
Eurwen Petitti	Policy Officer, RCGPWales
Matthew Chisambi	Senior Research Officer, RCGP UK

Apologies

Grant Duncan
Tony Calland
Brendan Lloyd
Liam Taylor
Catherine Woodward

Attendee comments

Organising the practice case load

- Our practice runs sessions for three to four hours. We have a 'GP-first', telephone triage system and book people back into sessions
- Unfortunately, some doctors using telephone triage had invited everyone back as a means of controlling their workload. We now monitor the quality of call backs and to avoid this 'gaming' of the system
- We run an open surgery in the morning that starts at 7.30am, this means that our patients never complain of access because if they want to see us urgently, they can
- We tend to operate a larger patient load in the mornings versus the afternoon
- We try to organise our appointments so that we finish the day with Medicine Use Reviews, this is because by the end of the day we are worried about patient safety and effectiveness of consultation due to work load
- Unfortunately, we are unable to offer patients any choice on continuity, bar our most vulnerable patients
- The benefit of telephone triages is that some consultations can be over in a minute, which wouldn't happen face-to-face

Perceptions on workload

- There should be lower patient list sizes, we are seeing a constant growth in demand
- Patients are increasingly presenting with more complex conditions
- We need to promote the usage of self-referrals i.e. direct to pharmacist, dentist and physiotherapists etc. Not having this option creates unnecessary workload for general practices
- We need address the perception that GPs work 9 – 5, it is simply not the case
- There is a strong need to articulate what safe levels of patient contacts are. Seeing up to 18 patients per session, with only one day off a week can lead to situations where I don't feel competent to see patients
- We try to operate a one issue per consultation system but at the end of the day if someone presents you with multiple challenges it is difficult to turn them away
- We need to have 30% more time in order to conduct our roles safely
- I have uncertainty around practice sustainability
- The role of the GP as an owner of the practice should be acknowledged. We have to run a business, which can't overspend, the time and pressure it takes to run a financially sound business, whilst delivering frontline patient care is understated
- We need allocation of patient-related administrative time and patient contact time, at the moment I'm doing all my case-related work e.g. letters, in the evening
- If you drop the amount you can do during a session, you can improve the quality of care but you also have worse coverage

Other members of the primary care workforce team

- There is a substantial range in competency between nurses and health care assistants (HCAs)
- We are having huge recruitment issues for HCAs

- We need training for all professionals, there needs to be a real terms increase in nurse training

Out of hours (OOH)

- The incentives for GPs to conduct OOH, given their workload during the week are minimal
- There needs to be increased provision for other health professionals conducting OOH with the supervision of GPs
- The indemnity insurance should be paid separately, GPs usually have to front the cost, which is another deterrent
- Should we consider market force pricing for OOH?
- A pilot for advanced nurse practitioners to cover OOH was started, however, it wasn't followed through and there is a significant risk that those previously interested professionals could be lost
- We need to manage the quality of OOH requests, there should never be an incident where repeat prescriptions are delivered in OOH
- The practice must play a greater role in reprimanding patients who are poor users of OOH e.g. repeat prescriptions

Use of data

- There are consistency of use issues and ownership challenges to obtaining extracts from practice data software e.g. EMIS
- There is a discrepancy between appointment systems and patient record systems
- We could pay the practices to drive up quality of recording by allowing them to qualify for a Direct Enhance Service payment
- The initial use of data would be poor but as the process improves and people become aware of what the data is being used for, it will improve
- We need to extract information on locums via shared services
- Using data extractions would allow trend analysis, which would be very useful
- Counting contacts as activity is creating a stick to beat GPs with, my worry is that the counting of contacts does not reflect the quality of them
- We must ensure that any collection of activity data does not turn into a performance management tool
- You need to collect activity and workforce data together you can't separate the two
- We need to understand the numbers of other workforce staff

Recruitment

- In other workforce shortages you would flood the market but you cannot do this for GPs because at a fundamental level it is unattractive