COGPED

Committee of GP Education Directors

COGPED Workforce Report 4.4.17

Parliament

https://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/inquiries/parliament-2015/financial-sustainability-nhs-16-17/publications/

Just reducing the growth in secondary care budgets is challenging.

NHS Providers said that there are some "real challenges" about whether primary and social care services are strong enough to move care out of hospital and reduce demand to the extent that is needed.

Here is the transcript of the oral evidence given to the public accounts committee

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/access-to-general-practice-progress-review/oral/48644.pdf

At one point Simon Stevens states:

"It is worth reminding ourselves of the fantastic efficiency that primary care represents—over 90% of patient contact is in primary care, and a year's worth of GP care costs less than two A&E attendances."

House of Commons Library has published this briefing on integration of care

http://researchbriefings.files.parliament.uk/documents/CBP-7902/CBP-7902.pdf

DH

DH launches a consultation on medical school expansion.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/600835/Medical_expansion_rev_A.pdf

Some suggestions for answers to the questions asked: put the expansion in those medical schools that produce the doctors who choose the most undersupplied career pathways and site them, where possible, in areas of greatest workforce need. Widen participation. Recognise the international evidence that charging medical students a higher price for training than other graduates leads to career choices in craft specialties and secondary care.

DDRB

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/602319/58665_DDRB_Book_Accessible.pdf

Recommends small increase to Trainers' grant in line with the general contract uplift.

National Audit Office

Improving patient access to general practice 5.1.17

https://www.nao.org.uk/wp-content/uploads/2017/01/Improving-patient-access-general-practice.pdf

Acknowledges that improving access without workforce is "challenging".

"NHS England and Health Education England's efforts to increase the GP workforce are at particular risk from falling retention and increases in part-time working. To provide good access practices need the right numbers of GPs, with inflows of GPs matching changes in demand and outflows. The time taken to train clinical staff, and increasing demand, mean supplying sufficient numbers is challenging."

NHS England

Allied Health Professionals into action

Overview of potential for AHPs, including to help primary care/general practice.

https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf

"The GP Forward View includes commitments to the greater use of non-medical clinicians in primary care. There are well developed models for paramedics, physiotherapists, occupational therapists and other AHPs to work alongside family doctors and practice nurses. Improved direct access to AHPs will avoid placing demands solely on any one profession or part of the system, improve access for patients and increase capacity within the system.

Services need to be designed in ways which harness the clinical expertise of AHPs to improve patient/service user outcomes and to maximise cost effectiveness. More importantly, AHPs working in primary care will improve responsiveness to people's preferences, lifestyles and goals. Self-referral, primary care based AHPs and AHP supported self care all have the potential to transform services whilst saving the system significant costs and can offer alternatives to urgent and emergency services."

Health Education England

Important General Practice Nursing report from Pete Lane's group here:

https://www.hee.nhs.uk/printpdf/our-work/hospitals-primary-community-care/primary-community-care/general-practice-nursing-workforce-development-plan

Letter to select committee from HEE: https://www.parliament.uk/documents/commons-committees/Health/Correspondence/2016-17/health-education-england-to-chair.pdf

Enhancing Junior Doctor's lives: https://www.hee.nhs.uk/printpdf/our-work/developing-our-workforce/supporting-doctors-training/enhancing-junior-doctors-working-lives

NHS Digital

3 sets of data published since last COGPED workforce report

http://www.content.digital.nhs.uk/catalogue/PUB23221

http://www.content.digital.nhs.uk/catalogue/PUB23694

http://www.content.digital.nhs.uk/catalogue/PUB23693

Also numbers of registered patients

http://www.content.digital.nhs.uk/catalogue/PUB23139

We aspire to grow the workforce by 5,000 doctors working in General Practice by 2020. The baseline number are we using for FTEs appears to be the lower "rebased" numbers published 18 months retrospectively in April 2016.

The FTE numbers of substantive GPs per 100,000 registered patients continues to fall.

When you look at the numbers it is apparent that in some areas with lead employers they may be counting GP trainees in hospital posts.

The change in counting methodology for FTE GPs allows individual GPs to be counted as up to two full time equivalents, depending on hours worked. Working our GPs longer is not a sustainable way of growing the GP workforce

There are over 9,000 doctors (including trainees) who are counted as >1 FTE.

This includes over 1,000 doctors counted as >1.28 FTE (the previous maximum permissible FTE that an individual GP could be counted as.)

47 individuals are counted as 2.0 FTE GPs.

There have been no national statistics on GP vacancies for several years.

RCGP commentary is here:

http://www.rcgp.org.uk/news/2017/march/workforce-figures-are-a-huge-blow-but-5000-target-still-worth-fighting-for-says-rcgp.aspx

NIHR

http://www.nihr.ac.uk/funding-and-support/documents/current-funding-opportunities/hsdr/17_08_Comm-Brief-GP-Workforce_Final.pdf

Call for research into skill mix and productivity for GP workforce.

"Research is required to identify what skill-mix is required in what circumstances; as well as the clinical outcomes, resource use and savings within the healthcare economy, and patient experience of consultation in these services."

Kings Fund

A good critique of STPs. Essentially you need to invest in primary care capacity before making changes to direct more work to primary care. The flaw is that most of the savings required to invest in primary care require the work to shift before the capacity investment primary care.

https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf

"Proposals to reduce capacity in hospitals will only be credible if there are robust plans to provide alternatives in the community ***before*** *the number of beds is cut."*

Also useful from Kings Fund is their quarterly monitoring report

http://qmr.kingsfund.org.uk/2017/22/overview

Despite the focus in the budget on GPs to reduce A&E admissions and the implication that it is failure of access to primary care that has contributed to A&E demand, this paper points at the acuity/complexity of patients as the cause of pressures in A&E.

Nuffield Trust

This is a "must read" for a reality check.

https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf

"There is widespread hope – both within the NHS and amongst national policy-makers – that moving care out of hospital will deliver the 'triple aim' of improving population health and the quality of patient care, while reducing costs.

Our analysis suggests that some STPs are targeting up to 30 per cent reductions in some areas of hospital activity, including outpatient care, A&E attendances and emergency inpatient care over the next four years. Yet this is being planned in the face of steady growth in all areas of hospital activity – for example a doubling of elective care over the last 30 years.

Our analysis suggests that the falls in hospital activity projected in many STPs will be extremely difficult to realise. A significant shift in care will require additional supporting facilities in the community.

Many initiatives we examine place additional responsibilities upon primary and community care, at a time when they are struggling with rising vacancies in both medical and nursing staff, and an increasing number of GP practices are closing. ***Addressing these issues is a necessary precursor to success."***

This also from Nuffield: Delayed transfers of care are strongly linked with increased A&E waits and relate to reduced capacity in community social care.

https://www.nuffieldtrust.org.uk/resource/what-s-behind-delayed-transfers-of-care

The Health Foundation

My four main workforce solutions are (i) streaming/vacating/outsourcing (ii) skill mix (iii) increasing the time spent training others in the team (iv) merging/federating/achieving economies of scale

Unfortunately all of these strategies potentially reduce personal continuity of care.

This paper is therefore an important reality check

http://www.health.org.uk/sites/health/files/ReducingAdmissionsGPContinuity.pdf

http://www.bmj.com/cgi/doi/10.1136/bmj.j84

So, there is nothing to distinguish cause and effect, but we need to be aware that our workforce solutions may reduce personal continuity and have an impact on the rest of the system.

Centre for Health Economics

An overview of the economics of health inequality which mentions attempts to narrow the health inequality gap through investment in primary care workforce.

https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP142_economics_health_inequality_NHS.pdf

Note that there is nothing to support the message from NHS England that GP weekend appointments will narrow health inequalities, an example of this:

https://twitter.com/NHSEngland/status/848588440178393094

BMJ

Stick or twist?

We know that messing about with GP contracts, re-organisation of the building blocks of primary care at provider and commissioner levels makes primary care a less attractive career option to the future medical workforce. Here the pendulum swings the other way as the perceptions of Junior Doctors is that their new contract impacts more on acute services.

http://bmjopen.bmj.com/content/bmjopen/7/1/e013756.full.pdf

"Doctors reported that contract-related issues have affected their career plans. The most notable effect is a move away from acute to community-based specialities, with the former perceived as more negatively affected by the proposed changes. It is concerning that young doctors feel undervalued, and this requires further investigation."

RCGP

GP Forward View interim assessment. Focuses less on progress towards important GPFV workforce targets, but on STP plans (or lack of) for primary care sustainable transformation.

http://www.rcgp.org.uk/-/media/Files/Policy/2017/RCGP-GP-Forward-View-Interim-assessment-2017.ashx?la=en

NAPC

A manifesto for the primary care home serving larger populations of 30-50,000 registered patients.

http://www.napc.co.uk/control/uploads/files/1490953667~NAPC_Does_the_primary_care_home_make_a_difference_March_2017.pdf

Lots of claims and probably some confirmation bias, but this idea seems to have currency.

Nursing Times

Scottish study based on Alaska model shows that advanced nurse practitioners can role substitute for GPs

https://www.nursingtimes.net/7015973.article?utm_source=newsletter&utm_medium=email&utm_campaign=NT_EditorialNewsletters.Reg:%20Send%20-%20Nursing%20Times%20Daily%20News&mkt_tok=eyJpIjoiTXpkaVptWTVZV1kzWWpSaCIsInQiOiJSMFgwVlVUR1pGSUhrQURLYkJudDBLQVVZODlZMnpsMFdJMmljS3l2N2pMazB3NE5oVDhwXC9pWFpZQVNzOEpNZzQ4eWU5QzhhM2twbmxSTmR5U0d0d091YkIxellSYlJONmhObzlVdDMwRDJHOFFUb2IwOWkySkdObWtENUFlaGkifQ%3D%3D

Bit of a long link this is shorter but protected

https://www.nursingtimes.net/news/primary-care/scottish-pilot-suggests-anps-viable-alternative-to-gps/7015973.article?blocktitle=Latest-news-for-primary-care-nurses&contentID=231