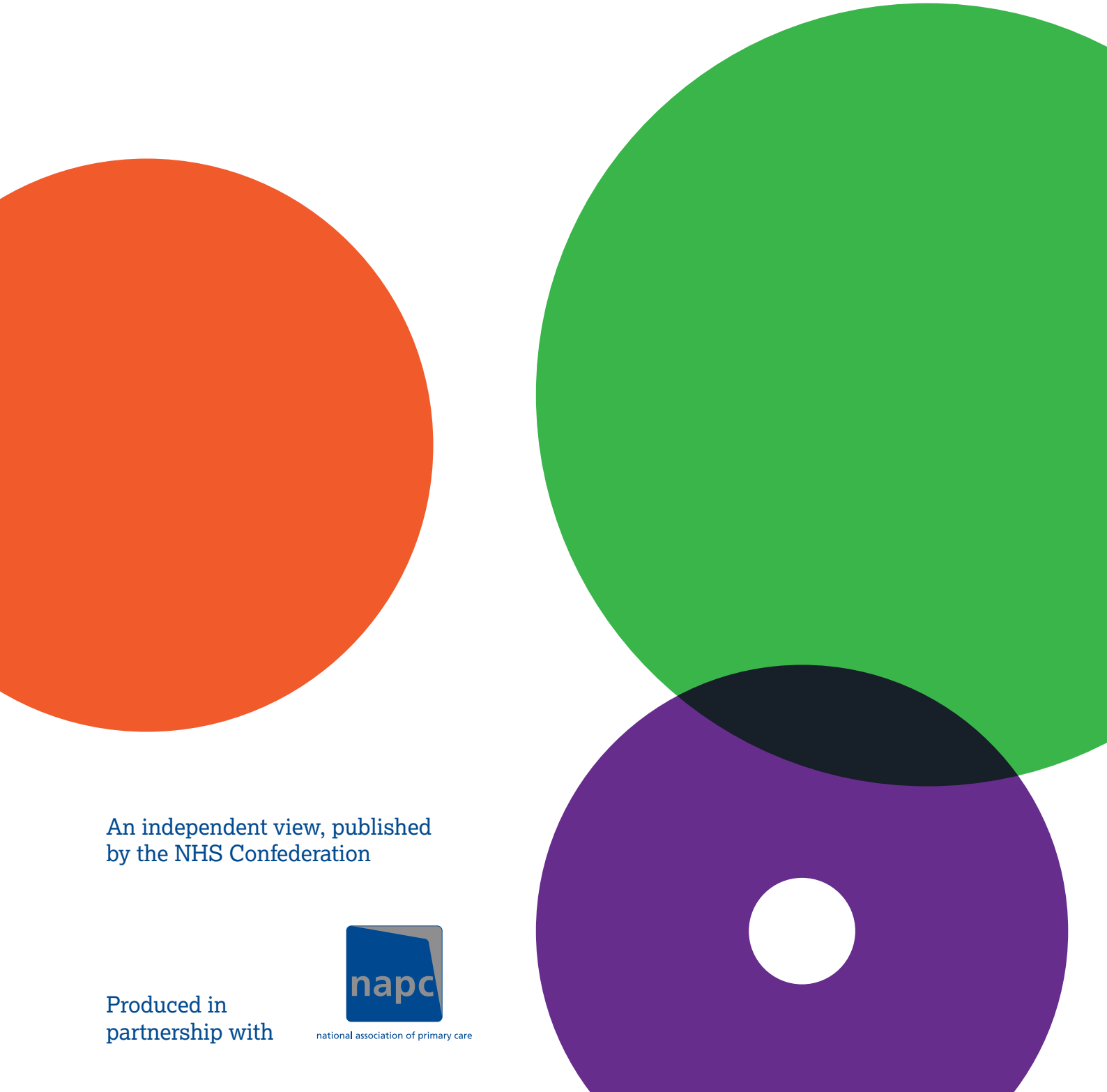
NHS CONFEDERATION

Not more of the same

Ensuring we have the right workforce for future models of care



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Introduction

Both Conservatives and Labour have promised more GPs in their pre-election manifestos. These promises are undoubtedly linked to calls from bodies like the Royal College of General Practitioners (RCGP), who have estimated that England needs more than 10,000 more GPs by 2022 to meet increased demand. The RCGP warns of a GP workforce crisis with consequences such as practice closures and even longer waiting times for appointments. This worrying situation has led politicians to make promises about workforce numbers that, while helpful in the short term, could risk leading to more of the same in terms of a service model in the medium to long term.

The authors believe any increase in the number of GPs must be accompanied by more sophisticated approaches to recruitment and retention, as well as a fundamental review of the model of care in which GPs operate.

This paper sets out some considerations for developing a primary care workforce which is fit for purpose now and in the future. It argues that workforce planning and modelling assumptions in primary care need to incorporate new, emerging and more sustainable models of primary care. There is a danger that the demand induced, supply side modelling we are currently using will inevitably predict a blanket increase in the numbers of particular workforce groups; in other words, "more of the same." It is our belief that using current modelling assumptions without paying attention to a fundamental change in the model of care delivery across a population will not add sufficient value, may promote greater health inequity and may lead to a system of care which is fundamentally unsustainable.

This paper has been written following the discussions of a small group of both members and staff of the NHS Confederation and the National Association of Primary Care (NAPC). It does not necessarily represent the views of the NHS Confederation or its members.

"Any increase in the number of GPs must be accompanied by more sophisticated approaches to recruitment and retention, as well as a fundamental review of the model of care in which GPs operate."

The need for change

The need for change is clear. It is driven by the changing health and social care needs of the population, in which people have increasingly complex healthcare and lifestyle-related co-morbidities which require long-term care. This requires a new approach to the delivery of care which is able to accommodate the growing demand for access and coordinate care around patients, families, carers and communities. Workforce development and education and training strategies must be aligned to emerging and future service delivery models.

Primary care is where the majority of people access health and social care. Growing demand in this sector has a major impact on the rest of the health and social care system in terms of quality and effectiveness. Primary care organised around general practice has a pivotal role to play within the system but, like the entire NHS, it must be transformed to face challenges, including:

- a rise in multi-morbidities, which require clinicians to manage uncertainty and complexity. Growing numbers of patients with long-term conditions require an approach that promotes self-management
- a requirement for general practice to network with other primary care providers and the wider health and social care system, in order to share resources and increase capacity and capabilities to provide enhanced services
- patient expectations of a more inclusive and shared decision-making model with their GP.

> "Primary care organised around general practice has a pivotal role to play but it must be transformed to face challenges."

The current situation

The recent Keogh Review of urgent care[1] made several significant recommendations for change in the out-of-hospital sector, including:

- being more accessible to patients, reflecting changes in expectation and lifestyles
- providing continuity – wanted by physicians and patients alike
- using technology as an enabler for diagnosing and managing patients
- viewing patients as partners in managing their own care
- promoting wellness as a protection against disease, and delivering care in a team-based, integrated manner.

To meet these recommendations, services are changing:

- primary care is increasingly being delivered through larger, federated models of collaborative working between GP surgeries, to increase capacity and capability
- the space between primary and secondary care is being filled by services that support the avoidance of admissions to, and facilitate early discharge from, secondary care
- models of integrated and accountable care are being developed and evaluated[2]
- partnership and financial arrangements between health and social care are becoming essential for successfully managing care around the needs of individuals.

But, as currently constituted, the out-of-hospital system and its workforce is not prepared for these changes. Below, we outline how the workforce can be altered by focusing on:

- achieving population health outcomes
- alternative professional roles
- changes to GP training curriculum.

"As currently constituted, the out-of-hospital system and its workforce is not prepared for these changes."

Create a workforce for achieving population health outcomes

We are convinced that approaches to workforce planning and education and training strategies should be based on achieving population health outcomes. Key to this is being able to define a 'population', understand its needs and provide the things that matter to people, such as integrated care, tools for self-management and a focus on wellbeing, as well as excellent and responsive services when they are ill.

What is a 'population health' approach?

A population health approach is having an interest in the health and wellbeing of local populations or communities as well as individuals and families.

This approach focuses on: the distribution of health within populations; being proactive about preventative care for the healthy and those at risk; caring for those who are already ill; and thinking about the health of those who do not regulary see their GP.[3]

General practice is well positioned to take a population health approach because:

- it is the most accessed part of the NHS
- the registered GP list provides GPs with a stable cohort of patients who reside in a broadly defined geographical area
- GPs are uniquely positioned because they work in local practices, where they are able to use their knowledge of their patients, contacts and community.

The key components of a population health approach to improving population outcomes and reshaping the workforce are outlined below.

The Joint Strategic Needs Assessment should be one of the tools used when designing the primary care workforce

The exact nature and make-up of the workforce will differ according to localised population needs; the population health needs in Bognor, for example, are not the same as those in Brent. At the moment, we are not good at defining the workforce requirements locally, aggregating them regionally and using this information nationally to better inform what and how we train the primary care workforce.

The shape of the primary care workforce should reflect local diversity and local needs. The Joint Strategic Needs Assessment (JSNA) can play an important part in building an accurate picture of the local population's health and wellbeing needs, including those of seldom heard groups in the community. The JSNA provides a robust base of information about local needs, as well as the resources and assets which are available.

The recommendations of the GP Taskforce[4] to expand GP training so that 50 per cent of foundation doctors apply for GP specialty training are to be welcomed. In the short term this needs to be supported with effective and positive approaches to return to practice and continuing professional development opportunities for the established GP workforce.

Further increases in GP training numbers must, however, be based upon an assessment of local need, taking into account emerging service models, defined population needs and outcomes, a focus on appropriate capabilities to enhance population outcomes, and the appropriate workforce skill-mix required to improve population outcomes and reduce inequalities.

Develop skills in risk profiling

While most primary care professionals already understand risk profiling to be a fundamental part of their role, there are many different factors impacting on the ability of general practice to focus more on wellbeing and prevention in this way; notably, the availability and use of high-quality data and risk profiling tools. Patient profiling and segmentation can be a powerful tool for identifying individuals at risk of developing a disease or of deterioration in an existing condition. The ability to identify potential need and intervene early can help in the short term, for example by preventing unscheduled hospital admissions, and in the longer term by reducing the overall burden of disease in a population. Tools such as shared patient records across the health and care system can help better monitor and tailor interventions.

We recognise the challenges in establishing effective disease and risk registers, including getting information on lifestyle indicators, like smoking and body mass index, which can predict the risk of future illness. Obtaining this kind of data across whole populations will clearly require imaginative approaches to identifying those at risk and collaborative working with other healthcare professions and partners from across the wider system. Clinical commissioning groups, which are expected to have a detailed understanding of their local populations' health needs, have an important part to play in this, for example in commissioning risk and population profiling tools. Importantly, we also need to ensure that those working in primary care, including GPs, get the support and training to be able to use these tools effectively.

Ensure that primary care can facilitate the outcomes that patients want

The primary care workforce should value the outcomes that are most valued by people themselves. It is vital that the conversation that clinicians have with people changes from "What is the matter?" to "What matters to you?".[5] Currently, conversations with patients focus on illness or injury, not on the person. This dehumanises them, by identifying them as their disease group.

Current performance and outcome measures are largely focused around diagnosing, treating, managing or curing diseases. In many cases, these measures are of limited value to individuals and people would prefer outcome measures based around wellness, quality of life and experience.[6]

Clinicians will need to think about patient outcomes in a different way. This will require enhancement of the GP training curriculum, which is not currently geared to preparing GPs to coach for health or have conversations with patients that enable them to identify what outcomes (not always medical outcomes) patients would like for themselves. Whilst many clinicians can do this, it is not widespread enough amongst different professionals within primary care, such as practice nurses and physicians' assistants.

Self-care needs to be part of joined-up health and social care training and development

As well as more participation by patients in defining their own health and wellness outcomes, we also believe in harnessing the power of people to improve their health through self-care. There is significant evidence, from Nesta and other organisations, that supported self-care improves outcomes and reduces costs. This is reinforced by the NHS Confederation who, with the Local Government Association, has called for:

> a national sector-led programme to be set up which would give self-care parity with direct care delivery and which would support health and social care organisations to adopt participation and self-management approaches for all those people who would benefit... This should embrace all potential providers, including the third sector, social enterprises and private sector providers.[7]

"It is vital that the conversation that clinicians have with people changes from 'What is the matter?' to 'What matters to you?'"

Focus on alternative professional roles

There is an urgent need to focus on alternative professional roles that support integration, increase capacity and reduce admissions by freeing up GPs' time to manage increasing complexity. Such roles include primary care physicians' assistants, primary care paramedical staff and specialists (for example, community paediatricians, geriatricians and gynaecologists). We welcome the Shape of Training recommendations,[8] which offer the opportunity for specialists with relevant qualifications and appropriate credentials to work in community and primary care settings, thereby enhancing the care of patients closer to where they live.

Changing service models, enhanced skill-mix, and regulatory change have the potential to meet the challenges of increasing capability and capacity in out-of-hospital services, improving quality for managing those with chronic and multi-morbid conditions and ensuring primary care physicians continue to provide generalist care to those most in need. The financial consequences of a differing approach need to be costed to understand its impact.

Traditional workforce model	Possible alternative workforce model
Demand met by increasing traditional workforce groups, for example, GPs	Demand met by developing new roles, for example, primary care physicians' assistants, primary care paramedics
Demand-led workforce planning models	Workforce planning based on population health needs
Impact of technology, patient empowerment and wellness on workforce plans is unclear	Impact of technology, patient empowerment and wellness factored into workforce planning
Training curricula do not need significant changes	Training curricula will need changes to promote new competencies, for example, health coaching, quality improvement, understanding population health and health economics
Regulatory changes are not required	Regulatory changes are required to support specialists working within the primary/community environment
Predicated on the biomedical model with care centred around health professionals and resources	Predicated on the patient-centred model with care coordinated around the needs of communities and patients

Development of the GP training curriculum

The GP training curriculum[9] could be developed and enhanced. Changes might include training in understanding population health and health economics, supporting behaviour change through health coaching and enhanced leadership to support coordinating and managing teams.

GPs' training needs to include health economics

To promote the alignment of financial and clinical knowledge we need primary care professionals who are able to understand and appreciate the quality and cost basis for their decisions.

We also need GPs who are aware of the skills in their team and have a knowledge of, and links with, the wider health and wellbeing workforce.

More inter-professional learning

We need to ensure that primary care training does not take place in a vacuum – it should work with the rest of the health and care system. It needs to have links with and knowledge of social care as well as the voluntary and community sector and its workforce. We need team players – if care is going to be delivered by multi-disciplinary teams, experts and generalists, then different professions need to be able to work together and understand each other. Inter-professional training will ensure that relationships and mutual respect are engendered across professions which can often seem to have very different cultures and structures.

Community-based provider education networks (CEPNs) are supporting the development of high-quality placements and educational opportunities in local communities. CEPNs are groups of primary and community care providers that come together with partner organisations (including local universities) to collaborate regarding workforce, education and training and expansion of placements. The membership of CEPNs could include (although not be limited to) GP practices, community pharmacies, community dentists, community optometry, community service providers, acute providers and higher education institutions.

Community-based provider education networks (CEPNs)

CEPNs are supporting workforce planning locally, developing educational opportunities, supporting quality management and innovating in terms of education and training.

It is anticipated that by 2018/19 the development of primary care education roles within Health Education England supported by CEPNs will:

- support significant increases in primary care placements for undergraduate nurses
- increase opportunities for primary care placements for community pharmacists and support evolution of the role of the community pharmacist
- work with secondary care and higher education institutions to develop new roles such as primary care physician associates and paramedics
- maintain and develop pre-certification GP training and offer the whole range of educational interventions required to support return to practice as well as post-certification continuing professional development opportunities for established GPs
- be linked in with the emerging Health Education England research and innovation strategy to support and learn from best practice
- support and deliver education related to new service models in relation to integration around patient needs, wellness and enhanced.

Leadership

We don't just need a workforce that is able to work as part of a team. We need people who are good at leading change, leading multi-disciplinary teams and working across the boundaries of health and social care.

The working environment

The environment in which GPs work needs to change. Currently, many surgeries are run down and are not designed in a positive or ergonomic way that encourages wellness to visitors or is attractive and practical for staff. Furthermore, many primary care premises are not physically capable of offering the range of services that could stop people from needing to go into hospital.

Encourage medical generalism

Medical generalism is uniquely important to meet the current demands on the health and care system. The key strengths of medical generalism are:

- **seeing the whole** – seeing the 'bigger picture' and the patient's life circumstances
- **knowing the community** – understanding the needs of particular parts of the population to make health needs assessments, address health inequalities and commission services accordingly, and proactively intervene to prevent health problems.

Medical generalism is key to maximising population-level outcomes. Whilst general practice is the most generalist of all medical specialties, other medical professionals may also, depending on their training and the setting of their practice, act as generalists.

There is a risk that training might undermine generalism. For example, the mandate to Health Education England[10] specifies training in certain areas which could skew training towards specialisation rather than enhance generalism.

"We need people who are good at leading change, leading multi-disciplinary teams and working across the boundaries of health and social care."

Conclusion: making it happen

The short-term need to develop the primary care workforce is clear. Medium- to long-term workforce planning requires an alternative approach – a patient-centred, population-based model. This requires an enhanced skill-mix, new capabilities, and regulatory and training curricular change. Financial modelling is also needed to understand the impact of such a change.

The development of a future model for workforce requires a whole-system approach. This is already happening in London and Kent, Surrey and Sussex local education and training boards (LETBs) through the community education provider network model.

In designing a new system, it is crucial to consider the following requirements:

Purpose

The new models of healthcare delivery will need to meet growing demands for access, keep people healthier for longer by preventing illness and promoting wellness, meet changes in patient expectations, and deliver care to people with often complex conditions as part of a team, in an integrated manner.

Environment

The setting that care takes place in is important, recognising that an attractive environment has positive effects on the workforce as well as on the wellbeing of patients. Accessibility and the availability of a variety of different services at one location is also desirable.

Capabilities

The primary care workforce, including GPs, should be capable of taking a population health approach, including risk profiling. Training and development needs to ensure that staff can work as part of a team made up of different health and care professionals.

Systems

Training, workforce planning, payment systems and contracts all need to be considered, to ensure that they are encouraging and not creating barriers to creating new models of care. Contracts will need to allow for more flexibility, enabling different professionals, particularly specialists and generalists, to work together to meet the needs of patients with complex conditions.

Culture, behaviours and attitudes

More multi-disciplinary working will require the cultural and behavioural barriers across sectors and professions to be broken down. Patients will need to be viewed more as partners in managing their own care.

Leadership

GPs and others in the wider primary care workforce need to be able to lead teams and make decisions in the new, more integrated, team-based environment.

If you have any comments on the thoughts and recommendations made in this paper, we are keen to hear from you.

Please contact **matthew.macnair-smith@nhsconfed.org**

Summary of recommendations

- Focus the approach to workforce planning, and the education and training strategy beyond, around achieving population health outcomes. This means understanding what matters most to the local population.
- Use the JSNA as a tool to determine the population health needs of a local area and better enable it to inform the effective defining of workforce needs locally, shaping who, what and how we train the workforce.
- Ensure that GPs and the wider primary care workforce know how to take a population health approach:
  - enable and support the primary care workforce to carry out risk stratification and segmentation
  - train more of the primary care workforce to coach patients to support them to identify and achieve the health and wellbeing outcomes they want for themselves
  - ensure that the health and social care workforce is trained in self-care and self-management.
- Focus on and support the development of alternative medical roles in general practice, such as physicians' assistants. These jobs can support integrated working, increase capacity and free-up GPs' time to treat patients with the most complex conditions.
- Enhance the GP curriculum so that it includes an understanding of population health, but also other skills, such as coaching for health and self-care/self-management approaches.
- Develop the GP training curriculum to include health economics so that GPs are able to understand and appreciate the quality and cost basis of their decisions.
- Ensure that GPs are trained and equipped to work as part of a team which may be made up of professionals from any part of the health or care system, as well as ensuring that many of them are able to take on leadership roles.
- Create more opportunities for inter-professional learning, so that GPs and other primary care professionals are aware of and value the skills of those working in the wider health and social care environment, breaking down cultural barriers and developing more integrated ways of working. This could be done through the expansion of high-quality placements and educational opportunities in local communities in community-based provider education networks.
- Keep medical generalism at the heart of GP training, but also support and encourage a generalist approach more widely amongst the primary care workforce and as a way to achieve population health outcomes.

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