Research – supplement

July 2016

Staffing matters; funding counts – Pressure point: GP recruitment and retention

Can the recruitment, retention and distribution of GPs be improved?

The Health Foundation

About this supplement

This supplement is produced to accompany the report *Staffing matters; funding counts: Workforce profile and trends in the English NHS.*

During the research to inform the report, six particular pressure points were identified for the workforce of the NHS in England. The pressure points were chosen based on feedback from a stakeholder roundtable, held in October 2015, and analysis of recent policy reports.

The pressure points are:

- the proposed changes to nurse bursaries
- international recruitment to fill vacancies
- the recruitment and retention of GPs
- the potential of physician associates
- the potential of nursing associates
- the use of temporary and agency workers.

These pressure points need to be addressed if the health service is to have access to the staff it needs to deliver high quality care.

In addition to the discussion in *Staffing matters; funding counts*, more detailed information and analysis about each of these pressure points is available as part of a series of supplements, from www.health.org.uk/publication/staffing-matters-funding-counts.

Please note: While the focus of this supplement is on England, some of the national/international data sets are at UK level. Where UK data is reported, it should be remembered that the NHS in England is by far the largest component, employing approximately four in every five NHS staff in the UK.

Staffing matters; funding counts – Pressure point: GP recruitment and retention
is published by the Health Foundation,
90 Long Acre, London WC2E 9RA

Can the recruitment, retention and distribution of GPs be improved?

Recruitment, retention and distribution of GPs: The issue

The shortage of GPs has been identified as one of the current critical workforce constraints in England. The population is increasing, and people are living longer with multiple medical conditions. This is likely to increase not only the level of demand in general practice but also the complexity. For example, the number of patients aged 75 or over, who use general practice most often, is predicted to grow by 38% in the next 10 years.[1] Demand for general practice is increasing, but the National Audit Office (NAO) reported recently that the Department of Health (DH) and NHS England do not have up-to-date data to estimate the number of consultations.[1]

Workload and job satisfaction concerns have also been cited. A review of the GP workforce by the Centre for Workforce Intelligence in 2014 reported that the existing workforce was under considerable strain and lacked the capacity to meet either current or future expected patient needs.[2] The most recent National GP Worklife Survey, in 2015, found that the level of job satisfaction reported by GPs was lower than in all surveys undertaken since 2001. Other surveys also indicate dissatisfaction with the workload in general practice.[1]

Improving access to general practice is a priority for the government. It has committed to recruiting 5,000 extra doctors to work in general practice, and to extending access to general practice from 8am to 8pm, 7 days per week, by 2020. The DH and NHS England have a range of initiatives to improve access. These include a workforce action plan and the Prime Minister's GP Access Fund, which has been piloting different approaches, including extended opening hours.[1] The DH and Health Education England (HEE) increased the number of training places for general practice by 199 in 2014/15. However, they were able to fill only 88% of these places, down from 96% in the previous year.[1]

Expanding the GP workforce is part of the mandate of HEE,[3] which received a taskforce report in 2014.[4] This highlighted that: 54% of GPs over the age of 50 were intending to quit direct patient care within five years; that a disproportionate number of older GPs nearing retirement were located in the more densely populated urban areas; and that the GP workforce demographic profile was changing. Almost two-thirds (65%) of GPs currently in training were women, and 40% of women who leave practice each year were under the age of 40, with no data on how many of them then rejoin the workforce. There was also a reported increased trend for both male and female GPs to work part time. As such, increases in headcount do not translate into similar increases in full-time equivalent (FTE) GPs.

The main recommendations from the taskforce report included: establishing a marketing strategy to promote general practice as an attractive and positive career choice; making improvements in workforce data in order to underpin workforce planning; setting short- and long-term targets of increases in GP training numbers (and corresponding reductions

in hospital specialty training numbers); shifting the geographic allocation of trainees to a weighted population capitation basis; and introducing a returner scheme targeted at under-resourced areas.[4]

The situation of GPs in the English NHS was put into international context by a multi-country study conducted by the Commonwealth Fund and co-funded by the Health Foundation.[5] The Fund surveyed 12,049 primary care physicians across 11 countries in 2015, including 1,001 GPs from the UK. The survey findings showed that there were certain aspects of care where the UK performed strongly, such as the use of electronic medical records. However, the survey also highlighted a number of areas of concern, in particular that UK GPs find their job more stressful than any of their international counterparts. The survey reported that 29% of GPs in the UK wanted to leave the profession within five years.

Another international study, published by the Organisation for Economic Co-operation and Development (OECD) in April 2016, highlighted that the trend towards a reduced proportion of GPs in the overall medical workforce across the last 20 years is apparent in the UK and five out of six other high income OECD countries that were examined; only in the Netherlands did the data suggests that GPs had increased as a proportion of the total medical workforce in recent years.[6]

In April 2016 NHS England published the *General practice forward view*, which states the aim is to add 'a further 5,000 net' GPs in the next five years, along with 3,000 new fully funded practice-based mental health therapists, an extra 1,500 co-funded practice clinical pharmacists, and nationally funded support for practice nurses, physician assistants, practice managers and receptionists.[7]

The most recent data available show that here were only 11 FTE physician associates working in English GP practices in September 2015, 168 FTE pharmacists and only 19 physiotherapists and 17 therapists working across GP practices. Overall it also showed an estimated 1.4% drop in FTE direct clinical care staff in GP practices in England between 2014 and 2015, and that the number of FTE GPs dropped by an estimated 1.9% over the last year.[8]

In May 2016, The King's Fund reviewed GP care in England.[9] On the basis of a large-scale survey it reported that consultations grew by more than 15 % between 2010/11 and 2014/15. Over the same period, the GP workforce grew by 4.75% and the practice nurse workforce by 2.85%. Only 11% of GP trainees surveyed intend to do full-time clinical work five years after qualification. Funding for primary care as a share of the NHS overall budget fell every year in the five-year study period from 2010/11 to 2014/15, from 8.3% to just over 7.9%. The King's Fund concluded that 'Increase in workload has not been matched by a transfer in the proportion of funding or staff.'

Recruitment, retention and distribution of GPs: The evidence

Practices are independent contractors, typically companies owned by an individual GP or group of GPs that provide care to a registered list of patients at one or more surgery sites. In 2014/15, NHS England spent £7.7bn on general practice.[1] In 2014, there were around 37,000 FTE GPs (including trainee GPs) working in 7,875 practices across England.

Some practices have only one fully qualified permanent GP (often called single-handed practices). At large practices there may be 10 or more GPs working together. GPs can have different roles in a practice – some are full or part practice owners; others are salaried GPs employed by the practice. In addition to these 37,000 GPs, there are also locum (temporary) GPs who work across practices as required. The NAO reports that complete data are not available on the use of locums within general practice, but there is anecdotal evidence that they account for an increasing proportion of the workforce.[1]

However, the NAO also notes that GPs make up only 29% of the general practice workforce,[1] which totals about 125,000 (FTE), with practice nurses, other health professionals, administrative and managerial staff accounting for the majority. Data on the general practice workforce and working practices are not complete, which the NAO reports 'makes it harder to identify where pressures are greatest and where more capacity is needed. Gaps include data on the use of locum GPs and the recruitment and retention of practice nurses. NHS England does not understand how different practices prioritise and manage the demand for appointments and cannot assess which systems provide better access for patients.'[1]

The workforce in general practice has an older age profile than staff in acute services. In 2014, 22% of FTE fully trained GPs were aged 55 or over, compared with 20% of fully trained hospital doctors. Also, an estimated 28% of FTE nurses working in general practice were aged 55 or over, compared with 13% working in hospital, community and mental health services. There is also a higher proportion of older GPs located in urban and deprived areas.[1]

The number of GPs rose by an average of 1.8% each year between 2004 and 2014, but problems in recruiting and retaining GPs are increasing, which will make it more difficult to meet demand. The NAO reported that 12% of training places in 2014/15 remained unfilled, and higher proportions of GPs are leaving the profession. In particular, the proportion of GPs aged 55 to 64 leaving approximately doubled between 2005 and 2014.

There is also variability in the levels of access to GP-led services. The NAO found that the distribution of general practice staff across England did not reflect need, with the combined number of GPs and nurses in each local area ranging from 63 to 114 per 100,000 weighted population. Patients living in more deprived areas had, on average, a lower ratio of general practice staff to patients.[1] The NAO also reported that GP practices' working arrangements affected the proportion of patients who could get appointments: the proportion of patients reporting they were unable to get an appointment ranged from 0% to 52% in 2014/15. Much of this variation could not be explained by demographic factors, practice characteristics or supply of general practice staff, which as the NAO noted 'suggests that the way practices work is an important factor'.

One necessary response to better management of demand, increasing provision of services and improving access, is to change the staff and skill mix. This has already been happening to some extent. The NAO noted that the proportion of consultations handled by nurses or other general practice staff increased from 25% in 1995/96 to 38% in 2008/09. The limited data collected since then suggest that this trend has continued, supported by a significant increase in the numbers of other staff providing patient care over the past 10 years.

The NAO referred to recent research which found that 27% of GP appointments were potentially avoidable – including patients who could have been seen by another member of practice staff – and that different practices vary significantly in their staffing mix. Another recent report highlighted scope for additional skill mix change – one in three practice nurses were independent prescribers.[10]

However, the skill mix option is also constrained because there are growing concerns about retention and future supply of other members of the GP practice team. A national survey of practice nurses conducted in 2015 reported that one in three (33.4%) practice nurses were due to retire by 2020.[10] The same survey highlighted that only 27% of practices offered placements for student nurses, compared to 61.5% offering placements for medical students.[10]

As noted above, the government has committed to providing an additional 5,000 doctors working in general practice by 2020 to improve access, but the NAO noted in 2015 that the lack of reliable data on the number of consultations means that the DH and NHS England do not know how many more GPs are required to meet demand, nor do they have detailed data on the number or use of locum GPs, or on staff vacancies in general practice.[1]

In trying to address the challenges of improving the recruitment, retention and distribution of the GP workforce, policymakers in England should give greater consideration to experiences in other OECD countries. England is not alone in having to attempt to encourage more doctors to work in general practice, and to be based in underserved rural and inner city areas. In all OECD countries, the number of physicians per capita is greater in urban regions than in rural areas, reflecting the preference of doctors to practise in urban settings, where there is greater scope to specialise, and access career opportunities and higher-earning private practice. OECD has recently reviewed the policy approaches in high income countries to achieving more effective geographic and speciality distribution of doctors,[11] focusing on three main areas of intervention: policies targeting the selection of medical students or the location of medical schools; providing financial incentives for doctors to practice in underserved areas or implementing regulations to restrict the choice of practice location; and promoting innovations in health service delivery and telemedicine.

- **Policies focusing on student selection** are based on evidence that students coming from rural backgrounds have a greater likelihood to practice in rural areas once they have completed their training than those coming from urban areas. Australia and Japan have fixed a minimum quota of medical places reserved for students with a rural background. These are sometimes accompanied by financial support provided to students in exchange for a return-of-service obligation to practice for a number of years in underserved areas once they have completed their training. Norway, Japan and Canada have established medical schools in rural or remote regions, with the expectation that more students graduating from these schools would remain in these regions afterwards. There is evidence from these countries that a high proportion of students stay in these rural/remote regions, with additional financial incentives also sometimes provided.

- **Providing financial incentives for doctors to practice in underserved areas or implementing regulations to restrict the choice of practice location** is another relatively common approach across OECD countries. The most common policy approach provides some type of financial incentive to attract doctors to practice in underserved areas and to retain them, for example through one-off payments to facilitate their installation and/or recurrent supplementary payments or bonuses. In Germany, most states offer financial incentives for GPs who are opening their practice for the first time, with GPs eligible to a higher payment if they choose to locate in underserved areas. This is combined with regulations which restrict the freedom of doctors to set up a new practice in areas that are deemed to be adequately supplied. Australia steers international medical graduates and foreign trained physicians into underserved areas, using regulations to impose practice in designated areas for a number of years (up to 10), before they become free to practice in any location.
- **Promoting innovations in health service delivery and telemedicine**, stems from the understanding that just focusing on trying to shift doctors' career choice and practice location will not in itself be fully effective in improving access. Other policies, which focus on other members of the primary care team, and on redesigning services and making greater use of technology, also need to be part of the package of solutions. Many OECD countries have also promoted various types of innovations in health service delivery to achieve the goal of providing adequate access to services with fewer doctors on site. These innovations include encouraging the introduction of new roles for other health professionals, changes in skill mix, most notably in the use of nurses in advanced practice roles, often with prescribing powers for which OECD note there is a growing evidence base (eg nurse practitioners),[12] and the development of telemedicine to remotely connect patients and doctors. OECD notes that there are growing numbers of initiatives underway to exploit the use of telemedicine to improve access to health services, notably in Canada, Australia and Finland.

An examination of this international experience highlights a broader range of potential policy options to address GP recruitment, retention and distribution issues than are evident currently in England, where much of the current policy effort is on trying to increase training numbers without a more comprehensive and coordinated package that includes looking at encouraging or regulating geographic re-balancing, removing barriers to greater use of nurse practitioners and other staff, and looking at service redesign and technical solutions to improving access.

Given that there is also an identified problem in England with current data and workforce planning for GP services, it also makes sense to review how other countries address these issues. The OECD's assessment of how different countries approach national health workforce planning and projections gives an entry point for comparative analysis.[13]

One example is the Netherlands, where there is a well-established approach to national planning for GP staffing that has received positive evaluation.[14] The national model includes the use of a range of scenarios to cover different demographic changes, and is independently managed, with stakeholders (including government departments) being

involved both in deciding which scenarios to focus on, and then in examining the results. This modelling approach is now developing the use of scenarios of 'vertical substitution' – the shift of activities between health professionals of different professional/educational levels, for example shifts between GPs and nurse practitioners. Informed by a review which concluded that 30%–70% of the tasks of physicians can be taken over by nurse practitioners and physicians assistants (and eg that approximately 75%–83% of the tasks of GPs in out-of-hours primary care could be taken over by nurse practitioners), the model has used a metric of a substitution ratio of 0.60 (1 FTE nurse practitioner can substitute 0.60 FTE physicians).[15]

Recruitment, retention and distribution of GPs: Conclusions

Primary care can only be delivered effectively by multi-skilled teams. There are significant gaps in the data available on GP services, including staffing, workload, and activity which undermines analysis and the identification of best policies. Better routine data would help with workforce planning and with proactively managing demand. The most recent survey-based data does highlight that workload is growing more rapidly than staffing. It also reveals that the NHS is struggling to attract sufficient medical students into the GP career option, and then to retain sufficient GPs in the workforce, with many looking to work less than full time or retire early.

While 'more' GPs (or, more accurately, more GP hours) is part of the solution to the current problems with recruitment, retention and distribution, there is a need for a broad and comprehensive policy focus, where the real driver is improved access to primary care and productivity, and where the staffing element of the 'solution' takes account of the need to enable effective team-working.

In part, this requires a policy response that gives greater consideration to how to achieve a more equitable distribution of current GP services. International experience on this issue suggests that this requires looking at skill mix changes, service redesign and better use of technology, as well as trying to increase initial supply.

Improvements in national-level workforce planning for GP-led services in England need to take account of the broader workforce, assess the implications of the ageing of the current practice nursing workforce, build in scenarios which have a more explicit focus on the scope for greater use of nurse practitioners and other staff, and factor in service redesign.

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Registered charity number: 286967
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