PRIMARY CARE WORKFORCE COMMISSION

Submission of evidence by the Royal College of General Practitioners

Thursday 2nd April 2015
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Executive summary

Introduction and background

1. The Royal College of General Practitioners (RCGP, or ‘the College’) welcomes the opportunity to respond to the Primary Care Workforce Commission. The RCGP is the largest membership organisation in the United Kingdom solely for general practitioners (GPs). We gratefully acknowledge the contributions of our members in formulating this response.

2. Primary care, and specifically general practice, faces numerous challenges in delivering care. These challenges cover changes in population demographics, complexity of care, workforce demographics and funding constraints. In order to sustain the delivery of care to primary care, new models of care need to be invested in and implemented. A selection of novel approaches is presented below. For ease of examination, a distinction between ‘new models of care’ has been made. New ‘clinical’ models of care pertain to changes in the approaches and ways of working by the primary care workforce in delivering patient contacts. New ‘structural’ models of care relate to changes in the organisational design of primary care and their potential relationship to financial and contractual arrangements which may underpin different models. The RCGP strongly believes that knowing the number of GPs and other health care professionals required to provide an effective workforce is essential to delivering new models of care. Therefore we have submitted some evidence regarding this as part of this submission.

New clinical models of care

3. New clinical models of care can be viewed according to four dimensions: access; continuity of care; care planning and coordination of care; and, comprehensiveness of care. These are expected to achieve the composite goal of good quality care.

4. ‘Access’ is both an objective and subjective term – whether it is satisfactory depends on both experience and on an individual patient’s priorities, which vary from proximity and availability of care to timeliness of care. Absolute appointment availability, both in clinic and at home, can be increased by additional workforce, and not all clinical contacts need a GP. New approaches to achieve proximity and availability of care use technology in the form of telephone, Skype and email consultations. The modernisation of home visits by use of technology and new clinical professionals has been key in providing care to isolated patients. Increased access to diagnostic testing in the community, to allow earlier diagnosis and routine monitoring, can also assist new ways of working.

5. Continuity is operationalised as relational, informational, and managerial. In the context of a multidisciplinary primary care team, who have to offset acute access against planned care, and use skills appropriately, continuity can be lost, and the challenge is to retain continuity where it is needed. This is often when a patient has complex diagnostic and management needs, or a serious illness. One of the measures to ensure continuity of care is to make sure that patients have a named GP and practice nurse for ‘usual’ contact; this can be extended to a ‘usual team’ model, which allows the practice some flexibility in allowing a patient to see a health professional with whom they have a prior relationship. Effective outcomes from continuity are of course also dependent on having sufficient time and skills.
6. Care planning and co-ordination of care is increasingly important as the proportion of the nation suffering from long-term conditions increases. A wide range of health professionals have been piloted as having a role in the co-ordination of care, for example, practice nurses and community matrons. This also involves the time, ability, and technology to link and co-ordinate with other services and professionals, where necessary. Care planning is a current approach that is being proposed to allow informational continuity and personalised care. It is important to note that the inclusion of ‘non-health’ professional carers in the design of any care plan is vital. The use of patient data can also be a very useful tool in the co-ordination of care for various patient cohorts. The co-ordination of care can also require significant alteration to non-clinical organisational processes – for example, records access and appointment allocation. In addition, significant investment may be required before any benefits are realised.

7. Comprehensive care is a core feature of expert medical generalism – seeing a GP who can tackle all aspects of health need. There is an important role for general practice to act as a hub, signposting patients to other services available across the health and social care system and the third sector. Comprehensiveness of care at this level can only be achieved through joint working. Development and evaluation of networked and collaborative models of care is required.

**New structural models of care**

8. Structural models of care can be viewed in terms of their governance and management structure; economic conditions; workforce personnel; and, infrastructure, technology and data.

9. Federated structures enable 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. To reflect the growing multidisciplinary nature of the primary care workforce, there should be opportunities for non-GPs to co-lead these structures via boards or partnerships.

10. The modern primary care workforce already offers a range of skills in the community, and this needs both consolidation and further development. GP federations can co-ordinate extended opening hours, with larger federations of practices combining to deliver extended clinical and integrated out of hours (OOH) services. Different approaches to practice staff mix would be required in different areas and training of all primary care workforce personnel will have to be expanded and altered.

11. To fully integrate services and to prevent fragmentation of healthcare in the community, patients should be able to access a range of multidisciplinary services via the general practice surgery. However, significant investment in general practice surgeries will be required to ensure that the infrastructure of the practices is able to support multidisciplinary services. A large challenge in multidisciplinary working is ensuring that patient records can be shared effectively between different members of the extended team. Another challenge for this is Information Technology (IT) infrastructure and ensuring that different systems are able to interact. The collection of effective medical data can drive improvements in the quality and use of patient data.
Quantitative workforce planning

12. To deliver any of the above models of care, it is of utmost importance that Health Education England (HEE) addresses the current shortfall in GPs and ensures that there is sufficient supply of GPs in the future. It is vital that HEE or an independent body works with interested parties to conduct detailed quantitative analysis. There are numerous methods to estimate if there is a shortage of GPs in England.

13. The College estimates current GP shortage using extrapolations of GP vacancy rate data. The College uses the Centre for Workforce Intelligence (CFWI) estimate of a 3,000 GP shortfall by 2020. However, the CFWI also model the impact of two probable supply shocks: decrease in median GP retirement age and increased emigration from the UK workforce. All of these estimates suggest a shortage of GPs in England of approximately 7,700. It is also important to note that the CFWI report itself states that its forecast baseline most likely underestimates future patient demand for GP services. Investment in the recruitment of GPs is needed to ensure delivery of new models of care and to address significant workforce issues including workload, patient safety and recruitment.

Recommendations

14. Key recommendations that the College believes are essential to design a primary care workforce that is able to deliver the new models of care and ways of working include:

a) Workforce planning
   i. Increased collection of workforce data
   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 UK 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 Allied Health Practitioners, Health Care and ‘Medical’ 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

e) Innovation
   i. Funding for research at frontline practices
Introduction

1. The Royal College of General Practitioners (RCGP, or ‘the College’) welcomes the opportunity to respond to the Primary Care Workforce Commission. The recommendations from the Commission will form a key part of NHS England (NHSE) and Health Education England (HEE)’s responses to the challenges faced by primary care in responding to changing patient demand. The RCGP is the largest membership organisation in the United Kingdom (UK) solely for general practitioners (GPs). Founded in 1952, it has over 50,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. We maintain close links with other professionals working in primary care, such as practice managers, nurses and physician assistants. We gratefully acknowledge the contributions of our members in formulating this response.

2. In responding to the terms of reference, this document will outline the key themes of evidence and recommendations for the Commission to consider. However, in the appendix of the College’s next submission, further supplementary and supporting evidence may be supplied. It is important to note that presented throughout the document are a wide range of approaches that have been proposed by our stakeholder group. Some of these new ways of working may be conflicting and others may not have undergone sufficiently rigorous evaluations for cost and effectiveness. However, for completeness, many of the models submitted from our stakeholders are included. Given the different options of models of care, it is the College’s belief that locally led decisions regarding the best model of care for a particular locality must be made. As the RCGP strongly believes that knowing the number of GPs and other health care professionals required to provide an effective workforce is essential, we have submitted some evidence regarding this as part of this submission.

Background

3. Primary care, and specifically general practice, faces numerous challenges in delivering care. These challenges cover changes in population demographics, complexity of care, workforce demographics and funding constraints.

4. The UK population is projected to grow by approximately seven per cent between 2012 and 2022. The greatest relative expansion in the UK population is the growth of patients aged over 80 years old. Patients aged over 80 consult four times more often than the average patient and have more complex needs. There is also strong evidence that the overall care general practice is required to deliver is becoming more complex. The number of people living with more than one long term condition is expected to rise from 1.9 million in 2008 to 2.9 million by 2018. There is evidence that around 65 per cent of those over 65 are living with multiple morbidity.

5. The general practice workforce is also ageing. Deloitte’s Centre for Health Solutions argued that the greatest supply challenge facing primary care is the average age profile

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The proportion of GPs aged 55 and over rose from 17.5 per cent in 2000 to 21.9 per cent in 2014. It is also concerning that 54 per cent of GPs over the age of 50 are intending to leave direct patient care within five years. Additionally, the practice nurse workforce is also ageing. A review in 2009 found that a disproportionate number of primary care nurses are expected to retire within five to ten years.

Table 1: Proportion of GPs aged 55 years or over, 2014

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of GPs aged 55 or over</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>21.9</td>
</tr>
<tr>
<td>Scotland</td>
<td>19.6</td>
</tr>
<tr>
<td>Wales</td>
<td>23.0</td>
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<tr>
<td>Northern Ireland</td>
<td>24.0</td>
</tr>
</tbody>
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The proportion of GP posts filled is also an area of concern: ‘the Health and Social Care Information Centre (HSCIC) GP vacancy survey was suspended in 2010. In the absence of centrally collected data the most useful proxy is a snapshot survey conducted in February 2013 of 220 practices, covering around 950 full-time positions. It suggested that the number of unfilled GP posts has gone up fourfold in the last two years: The results showed vacancy rates of 7.9 per cent of all GP posts in January 2013 – almost double the 4.2 per cent figure from the previous year’s survey in January 2012, which itself was twice the Department of Health baseline figure of 2.1 per cent from the last survey in 2010.’ This is reflected in qualitative evidence from GPs and providers of GP services.

These challenges to workload and ageing workforce have also correlated with a decline of investment in general practice. Research undertaken by Deloitte shows that funding to general practice in England as a share of total NHS funding has decreased from 11.0 per cent in 2004/05 to 8.5 per cent in 2011/12. Applying the same methodology as Deloitte, the College has estimated that funding for general practice has fallen further to 8.4 per cent in 2012/13.

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8. It is important to note that there are significant health inequality challenges in primary care. It is well-documented that the prevalence of multi-morbidity increases with deprivation, with people in deprived areas having the same prevalence of multi-morbidity as more affluent patients who are 10 to 15 years older. In particular, physical and mental health comorbidity has been shown to be almost twice as common in the most deprived compared with the most affluent areas.⁸

9. However, there is significant disparity in the provision of primary care workforce across the country. The Centre for Workforce Intelligence (CfWI) notes that ‘health inequalities caused by the imbalance in the local and regional distribution of GPs and other primary care workers has been an enduring policy issue since the founding of the NHS.

‘Prosperous rural and suburban areas may find it easier to recruit GPs than deprived urban or isolated, poorer rural areas. Poor local amenities, smaller practices and a higher workload generated by a disadvantaged population act as disincentives for GPs to work in such areas. Likewise, a National Audit Office report on health inequalities found: The number of GPs in areas with the greatest health needs has increased in recent years but GP levels, weighted for age and need, are still lower in deprived areas.’⁹

10. In order to sustain the delivery of primary care, new models of care need to be invested in and implemented. The modern primary care workforce already offers a range of skills in the community, and this needs both consolidation and further development. A selection of possible approaches is presented below. For ease of examination, a distinction between ‘new models of care’ has been made. New ‘clinical’ models of care pertain to changes in the approaches and ways of working by the primary care workforce in delivering patient contacts. Alongside these, new ‘structural’ models of care relate to changes in the organisational design of primary care. To assist the analysis of these two distinct types of change, a modified version of the framework developed by Kringos has been used.¹⁰ New clinical models of care are analysed according to four dimensions: access; continuity of care; coordination of care; and, comprehensiveness of care. Similarly, structural models of care are categorised in terms of governance and management structure; economic conditions; workforce personnel; and, infrastructure, technology and data.

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New clinical models of care

Access

11. There is no single definition of good ‘access’ to general practice, nor a universal solution that all practices should implement. Access is a subjective term and is highly dependent on an individual patient’s priorities. Absolute appointment availability, both in clinic and at home, can be increased by additional workforce, and not all clinical contacts need a GP. Within this section we analyse models that assist with two aspects of care:

a) **Availability and proximity of care.** Some patients would prioritise being able to access general practice in the right location to suit their needs. For example, people with reduced mobility need their local practice to be physically accessible.

b) **Timeliness of care.** Some patients would prefer to prioritise accessing GP services quickly or at a time most convenient to them, and would prioritise this over (for example) seeing a particular GP.  

Alternative use of technology

12. To assist the availability and proximity of care, a significant number of practices have introduced telephone triages. GP-led telephone triage is an example of demand management that is becoming increasingly used, including through a number of specific models such as ‘Doctor First’ and ‘Patient Access’. In these models, typically a GP calls back all patients in the first instance, and then either offers a face-to-face appointment with a GP or nurse (usually on the same-day), gives advice over the phone, or issues a prescription for the patient to pick up. There is an ongoing debate (hampered by lack of sufficient evidence) about whether such systems do reduce workload. Evidence recently published from the ESTEEM study (which focuses specifically on telephone triage of patients requesting same day consultations in general practice) found that the number of overall patient contacts increased, but noted a reduction in face-to-face GP contacts.

13. Additionally, alternative forms of consultations have also been used such as web consultations. Compared to telephone consultations, web consultations can permit a richer interaction between a patient and their GP, as non-verbal communication can also be analysed. Also, some of these technologies could grant certain isolated groups a new means of accessing primary care services e.g. carers. However, there are limitations of the use of such technologies including information security, evidence base for reduction in workload and / or financial savings, and challenges in establishing and maintaining IT infrastructure. Furthermore, as the nature of consultations change, training methods must reflect the different skillset required for alternative forms of consultations.

14. Another alternative form of patient contact can be with a specialist from secondary care. Tower Hamlets Clinical Commissioning Group designated community specialists as part

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of their diabetes ‘Year of Care’ pilot. These community specialists were accessible to patients with complex diabetes via email for rapid advice regarding controlling their condition. Comparably rapid telephone advice with a designated specialist, generalist physician has also been piloted. This rapid access allows the control of complex problems without attendance to the health care system. However, provision of direct access to secondary care specialists coverall could potentially fragment overall medical care if it occurs on an ongoing basis, and requires co-ordination between the sectors that could have new implications for funding models.

Home visits

15. Home visits are an important aspect of access, as they allow patients to receive care in the convenience of their own homes. Working with district nurses and health visitors, home visits have been used by general practice to ensure that immobile patient groups are able to receive general practice care. Paramedic assessment of acutely unwell patients can provide speedy evaluation and avoid GPs having to leave surgery at short notice. For less urgent care situations, use of advanced nurse practitioners for home visits could prove useful. One solution to this challenge is closer joint working between district nurses and GP practices – for example through the use of technology to ensure that district nurses can remotely access and share information about patients with their practice. Models of direct patient to specialist services are emerging, however, these will need further analysis of cost and effectiveness.

Intermediate care

16. The provision of intermediate care is essential in our health care system to prevent unnecessary admissions and readmissions into hospital. This is of great importance to patients with long term conditions who prefer to be treated at home, as well as being economically significant. Home visits also have an important role in assisting intermediate care. There are some instances where GPs are being piloted in assisting ambulance services to make decisions regarding whether a patient can be left to stay at home or not. Additionally, step down care, provided by a multidisciplinary team, can be arranged to prevent readmissions in a variety of ways:
   a. Home-based intermediate care with nurses and other input for rehabilitation
   b. Home-based six week reablement care plans

17. One specific example of home-based intermediate care is ‘Hospital@Home’, a service designed to provide an alternative to hospital admission for patients who are acutely ill. Delivered by a team of GPs experienced in acute care, advanced nurse practitioners and staff nurses, this 24/7 service has resulted in almost 2,000 patients receiving their treatment in their own home, including care homes, rather than hospital. The main provider of Hospital@Home is Partners4Health, a GP-run organisation and NHS body. The name was chosen as it is fundamental to the culture of Partners4Health that effective services and support can only be delivered by providers working together and utilising the skills and resources of all providers in an integrated systematic way in order to improve care for patients.

18. Hospital@Home is a partnership between Partners4Health and:
   a. the local acute trust for diagnostics and consultant advice, enabling the development of condition specific care pathways,
   b. community providers for district nursing and therapies,
   c. the Local Authority for equipment and rapid response for personal care.

The service has been independently reviewed and has been shown to be safe, effective and significantly less expensive than hospital care. Patient and carer feedback appears to be very positive with 793 out of 794 responders to the post discharge survey requesting Hospital@Home rather than admitted care in the future.\(^\text{17}\)

19. Beyond home visits, general practice can also have a role in the organisation of standard intermediate care beds and transitional care. Historically, community hospitals (often run by GPs) provided this opportunity, but these have become less common in recent NHS investment. There are challenges in providing effective intermediate care, including working with Local Authorities who face budgetary challenges.

**Diagnostics**

20. Historically, the NHS has been good at reactive care i.e. responding to serious ill-health, rather than proactive care i.e. identifying and addressing conditions earlier. The delay in diagnostics has both financial and clinical consequences.\(^\text{18}\) One of the barriers in diagnostics is both access to clinician time and access to diagnostic tests in the community. The introduction of physician associates for acute diagnostics of particular conditions could assist early confirmation of diagnosis. This coupled with point of care testing e.g. Hgba1c, d-dimer, C reactive protein and calcitonin precursors, would allow greater certainty in earlier diagnosis of conditions.

21. However, in order to deliver earlier diagnostics, significant investment in infrastructure to host point of care testing will be required. ‘Scaling up’ of such services to a larger population may be needed to justify the investment. Furthermore, training of staff so that they are able to make independent diagnostic decisions would also be required. There are also numerous other challenges in making earlier diagnostics a reality.\(^\text{19}\)

**Co-location of primary and secondary care services**

22. An additional approach is to have both primary and secondary care services located in the same physical area. In particular there is an opportunity to provide secondary care services on-site at a GP practice. This has been piloted specifically for glaucoma where mobile units are able to temporarily provide screening and post-surgery follow-up services in order to reduce hospital visits.\(^\text{20}\) This approach could also work for

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\(^\text{18}\) Deloitte Centre for Health Solutions (2014) *Working differently to provide early diagnosis: Improving access to diagnostics*.

\(^\text{19}\) Ibid.

outpatients by the transferring of acute generalists and geriatricians into the community. It is important that specialists use practice Information Technology (IT) systems to avoid confusion and the redundancy of practice medical records. Similarly, outreach clinics by secondary care clinicians could provide referral opinions and advice in GP settings (by remote technology or by direct attendance), and this has the added advantage of strengthening collegial relationships and mutual understanding of clinical needs and best referral practice.

23. Furthermore, there are a number of examples of GPs providing expertise and value to the health care system by being attached to hospital emergency departments, particularly during the out of hours (OOH) period. This approach may reduce demand on accident and emergency (A&E) departments as it is estimated that between 15 and 26.5 per cent of A&E attendances could be treated by primary care physicians. However, an issue with this approach is that patients could begin to treat A&E as a universal treatment centre perpetuating the NHS culture of reactive (and therefore more costly) care. For both co-location approaches there are cultural and organisational challenges in getting primary and secondary care professionals to work together in teams.

24. Beyond co-location, another model is multidisciplinary teams based at community hospital sites. One such example is the Emergency Multidisciplinary Unit (EMU) based in Oxford. Adult patients with acute illness can be referred by paramedics, GPs (in and OOH) and community nursing teams to the two EMU units. The units are open seven days a week and aim to provide an ambulatory treatment path for acutely ill patients, but are also able to undertake procedures that usually require day patient hospital attendance (e.g. blood transfusion). The EMUs use point of care blood tests, electrocardiograms and on site x-rays in order to determine underlying diagnosis or impact of acute illness. The EMU physiotherapists and occupational therapists can make same day assessment of the patients’ mobility and safety, while the EMU social worker can access urgent crisis care packages, or respite care home placements if appropriate. EMU have very close links with the Hospital@Home service, the Integrated Locality Team, and community nurse specialists such as those for Neurology (Parkinson’s Disease), Diabetes, Heart Failure, & Chronic Obstructive Pulmonary Disorder. The EMU approach emphasises the importance of transferable skills, development of advanced practice and novel GP training, the latter including GP trainee rotation in the multidisciplinary team training and a GP ST4 quality improvement fellow.

Seven day services

25. Whilst there is political interest for seven day services by general practitioners, it is also important to note that there could be increased demand for other non-GP services at the weekend, for example chronic disease management clinics by nurses, physiotherapy, and phlebotomy. However, to provide this level of access additional clinical and administrative resource would be required. If these services are to be delivered by practices, there could be some challenges to align workforce timetables, IT infrastructure, appointments and patient records across different providers. Maintaining

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fairness in the allocation of appointments is also an important factor to consider. There are further considerations to be made with the formation of seven day services, for example, the potential of creating supply-induced demand and an undesirable distribution of patient contacts. It is important that the availability of seven day services should be aligned to local demand and supply.

Continuity of care

26. For the purposes of this submission, ‘continuity of care’ concerns the ability to see a preferred GP or nurse (relational continuity), as well as the transitions between traditional primary and secondary care services. For some patients, being able to see a GP or nurse of their choice takes priority over fast access; this may apply in particular to those with long term conditions, and within an episode of care, where continuity of care is an important factor.

27. Continuity is operationalised as relational, informational, and managerial. In the context of a multidisciplinary primary care team, who have to offset acute access against planned care, and use skills appropriately, continuity can be lost, and the challenge is to retain it where it is needed. This is often when a patient has complex diagnostic and management needs, or a serious illness - including psychological vulnerability, where interpersonal dynamics over a period of time act as crucial enabler for engagement and therapeutic change. One of the measures to ensure continuity of care is to make sure that patients have a named GP and practice nurse for ‘usual’ contact; this can be extended to a ‘usual team’ model, which allow the practice some flexibility in allowing a patient to see a health professional with whom they have a prior relationship. Effective outcomes from continuity are of course also dependent on having sufficient time and skills to use the interpersonal relationship and diagnostic abilities to full effect – seeing the same doctor is an important building block, but if the patient and doctor do not have adequate time together to do the job it is not effective.

Care planning and co-ordination of care

28. Co-ordination of care is increasingly important as the proportion of the nation suffering from long-term conditions increases. Furthermore, as the prevalence of multi-morbidity rises, a more holistic approach to patient care is required. One approach to this focusses on person-centred assessments every six months, as opposed to separate reviews for individual diseases. This prevents multiple visits from patients, which can be beneficial for the patient and the practice. A wide range of health professionals have been piloted as having a role in the co-ordination of care, for example, practice nurses and community matrons. This also involves the telephone co-ordination of secondary care, where necessary. It is important to note that the inclusion of non-health professional carers in the design of any care plan is vital.

29. The use of data can also be a very useful tool in the co-ordination of care for various patient cohorts. Segmenting heterogeneous patient populations into clinically meaningful subgroups using data allows operational and core decision-making to be performed in advance. Multidisciplinary design of packages of care for these segmented patient

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groups has both clinical and financial benefits. The defined packages of care reduce health inequalities and the use of the most cost effective competent member of staff optimises spend. Furthermore, establishing particular warning signs or data levels for individual patients can assist the management of conditions e.g. use of red flags in motor neurone disease.\textsuperscript{24} In order to sustain effectiveness, case management practices must undergo monthly, multidisciplinary team review and challenge with relevant professionals from across the patient’s treatment pathways.

30. The co-ordination of care requires significant alteration to non-clinical organisational processes. In addition, significant investment may be required before any benefits are realised. The modification of training of different health care professionals to undertake a care co-ordination role is important to ensure that it is conducted correctly. There can also be legal and financial challenges in co-ordinating care as people age and / or conditions deteriorate.

31. A specific example of continuity of care and care-planning is the 3D project run by the University of Bristol, supported by the College. The 3Ds are Dimensions of health, Drugs and Depression, which are the focus of the intervention. The intervention is designed to address the problems of illness burden (poor quality of life, depression), treatment burden (multiple uncoordinated appointments, polypharmacy, poor primary/secondary care co-ordination) and lack of patient-centred care (low continuity, disregard of patients’ priorities) experienced by patients with multimorbidity. The intervention involves:

a. Identification and prioritisation of patients with multimorbidity

b. Improving continuity of care by having a named usual GP and practice nurse and longer appointment times

c. Comprehensive ‘person centred’ assessments every six months as opposed to separate reviews for each condition. A 3D review will involve two appointments approximately a week apart. The first will be with their named practice nurse and the second with their named GP. These will follow the 3D assessment structure and bespoke computerised template.

d. Integration with a designated general physician to provide telephone advice about complex problems and help co-ordinate hospital care

The trial is still ongoing however its intended outcomes include: an economic evaluation to assess the cost effectiveness of the intervention; A mixed methods process evaluation to explore how and to what extent the intervention was implemented; the advantages and disadvantages of different models of care for patients with multimorbidity; and, how and why the intervention was or was not beneficial.\textsuperscript{25}

32. In addition, effort must be made to generate patient and community activation. The promotion of self-care by patients and their communities was noted as crucial to overall

\textsuperscript{24} Royal College of General Practitioners. Accessed at: \url{http://www.rcgp.org.uk/clinical-and-research/circ-clinicians.aspx}. Downloaded on 11/02/15.

\textsuperscript{25} University of Bristol 3D project (2014). \url{http://www.bristol.ac.uk/social-community-medicine/projects/3d-study/research/}. Downloaded 11/02/15
better patient outcomes. Public health professionals could have an important role within the primary care workforce to use their expertise to help increase patient and community activation.

Comprehensiveness of care

33. Comprehensive care is a core feature of expert medical generalism – seeing a GP who can tackle all aspects of health need. This dimension also denotes having a comprehensive service for first contact at one location (in the UK the local general practice). The ‘third level’ is having a full range of services available for referral and patient support. There is an important role for general practice to act as a hub, signposting patients to other services available across the health and social care system and the third sector. The co-ordination of services from secondary care and social care at primary care level is fundamental to deliver holistic care in the community – if different parts of the service are not confident of the roles and actions of others, there could be duplication and missed opportunity. Both informational continuity and health professional attitudes can be relevant here: professional training is often conducted in isolation, and one way to improve this is to ensure that training includes development of the skills and attitudes essential for collaborative working across organisational boundaries. Protected learning times for practice staff are essential for continuing professional development. There is literature on this topic and it shows that the outcomes depend, in part, on role models and work culture.

34. Intermediate care focusses on two major patient flows: out of the acute bed services into community beds; and, the entry point from primary care and other health professionals to community services. One example of this model of care creates a single point of access (SPA) for primary care professionals to refer on their patient’s needs. A GP can make one phone call for a needs assessment from a range of health professionals including social care, nurses, therapists, end of life care, reablement and care home support. There is no need for a GP to complete a referral form and call handling is performed by an experienced administrator or clinician. Following the call, the SPA then pass the information to the relevant team who pick up the work. This system has not replaced the GP’s ability to directly refer to a team they know but it assists the GP’s role as a navigator. The SPA has led to significant admission avoidance due to easier access to appropriate community services.

35. The King’s Fund conducted a review of case studies where specialists worked in out of hospital settings. Four key interfaces for consultants working in the community it highlighted were:
   a. Consultant-run email and telephone helplines that provide advice for GPs, nurses and other health professionals

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b. Consultant participation in multidisciplinary team meetings  
c. Consultant-run education sessions  
d. Consultants supporting staff to work in extended roles  

**New structural models of care**  

**Governance and management structure**  

36. 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, extended opening hours and to co-operate in developing a local general practice workforce through shared investment and shared use of existing training capacity. However, practices should maintain their individuality and clinical autonomy in order to retain workforce satisfaction, value for patients and to drive synergies that can result from being embedded in the community. There are also some calls for the average practice size to increase.  

37. Federations could allow the maintenance of partnership structures. To reflect the growing multidisciplinary nature of the primary care workforce, there should be opportunities for non-GPs to co-lead these structures. Non-GP members could be granted the opportunities for partnerships, or where federations occur, integrated boards could be established. These boards could include a range of healthcare professionals ranging from the following stakeholders: practice representatives; patient representatives; community nurses; mental health specialists; community geriatricians; community paediatricians; social care managers; public health specialists; financial directors; and, general managers. The optimal size of federation could range from 25,000 to 100,000 patients.  

**Economic conditions**  

38. For federated practices there could be one core contract that covers the delivery of services that are currently funded through global sum, Quality Outcome Framework and Direct Enhanced Services. In addition, the owner(s) of the practice would receive additional rental payments and funding for their involvement in training. There could be a single prescribing budget, which would exclude high cost specialised drugs.  

39. An additional delegated budget for community and secondary care budgets could be provided. Potentially, the federation should focus on the needs of the local population and should not compete with other organisations or providers to win contracts for the provision of services outside of their area.  

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Workforce development

Organisation of workforce

40. In order to develop the primary care workforce a range of skills in the community will be needed. The modern practice could have a range of skills that are currently reflected in the roles of GPs (medical generalists); nurse practitioners and practice nurses; health care assistant roles; phlebotomists; pharmacists; and, a full range of administrative staff and a high calibre practice manager. Innovative models also include care planning leads and community outreach workers. A GP federation would co-ordinate extended hours services, with larger federations of practices combining to deliver OOH services that are integrated with other urgent care services in the region.

41. Community and specialist services would be commissioned by each practice. In some instances, the individuals delivering community and specialist services could be shared between different practices. Examples of commissioned services include district nurses, community connectors, social workers, complex case managers, community matrons, health visitors, midwives, maternal and child health clinics, lifestyle coaching, speech and language therapists, community practice nurse with a mental health specialism, drug and alcohol workers, advice workers and physiotherapists. The community and specialism service provider would retain responsibility for the employment, HR and backfill of staff on leave.

42. A specific example of general practices delivering community services from general practice surgeries is the ‘GPs at the Deep End’ work with general practices serving Scotland’s 100 most socio-economically deprived populations. This programme aims to assist GPs to find ways of tackling the inverse care law. The project has identified a range of measures to improve the care of, and outreach to, the most vulnerable and marginalised groups within GP practices’ local communities. These include:
   a. targeted appointments for patients with most complex needs, combined with additional consultation time
   b. practice-attached community link workers, connecting practices and patients to community resources for health
   c. attached alcohol and mental health workers

These ideas have been tested out through pilots such as the Glasgow Links Project, which explored opportunities to connect local citizens, primary care teams, the voluntary sector and other providers of support. Under this, 18 per cent of patients were identified as having a need for support, and in 50 per cent of cases this was for mental health or addiction services. Of those patients with an identified need, 75 per cent were signposted to a resource, and 70 per cent of those who made initial contact were still using the resource four to six weeks later.32

43. Given the increased complexity of federations and the opportunity to achieve efficiency savings, certain administrative and back office functions could be shared. New roles

such as IT specialists and data analysts have emerged within federations in order to pool resources to drive new ways of working.

*Practice skill mix*

44. To resolve workforce staffing issues, there are many different models of staff mixes that have emerged. In the absence of medical professionals many practices have adapted and trained less qualified health professionals. Whilst there is a proportion of traditional GP work that can be done competently by other members of the practice team, there are questions regarding what is the ideal level of service and practice staff mix. There can be reasonable concerns about safety issues and substitution borne out of financial and recruitment constraints rather than clinically-led decisions. There is a lack of evidence regarding what the clinical outcomes of GP substitution are or will be in the future.

45. There can be no single, universal workforce solution regarding staff mix. Each locality will face different challenges due to variations in patient need, availability of health care professionals and infrastructure. 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 could face significant challenges that will demand more radical workforce transformation and a complete redesign of primary care clinical pathways. However, whilst workforce pressures may be a stimulus for new thinking, we should be recruiting the workforce we need to deliver new models of care that are optimal for patients, not tailoring new models of care to current constrained workforce numbers. As presented in Figure 1, the practice skill mix contribution to direct patient care has changed significantly. Further evaluation of the impact this has had on clinical outcomes needs to be conducted.
Figure 1: Percentage of consultations conducted by practice staff type 1995/96 to 2008/09

46. Over the next few months, the College is conducting a workshop and developing a position paper about practice skill mix. The aim of this process is to articulate the challenges faced in this area and outline the range of potential solutions. The College is willing to submit the outcomes of this process to the Commission, if requested.

Training of workforce

47. There needs to be a multi-professional approach to training and workforce delivery. 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 one. Clearly defined roles and standards of training for all working within primary care are essential to ensure high quality and safe care is provided to patients when they are often at their most vulnerable in locations best suited to them, though this could be used flexibly to meet the needs of the population.

48. Training capacity within general practice needs to be increased, with multidisciplinary training occurring within general practice. Nurse training capacity is an area that needs particular attention. Primary care workforce training at undergraduate and postgraduate levels can be limited by the poor availability of nurse supervisors. The process for becoming a nurse supervisor is fairly straightforward and funding is provided via the Learning Beyond Registration funding. However, the accreditation process doesn’t limit the supply of nurse supervisors. A reported barrier to supply of nurse supervisors is that practices are reluctant to release nurses from patient contact time. Smaller practices in particular are less likely to release nurses. Locally practices can establish primary care
development centres to co-ordinate the facilitation of nurse training within primary care.\footnote{Primary Care Development Centre. Accessed at: http://www.pcdc.org.uk/about-us/standing-advisory-groups. Downloaded 11/02/15}

There needs to be enabling of training in general practice otherwise the volume and speed of training will not match demand.

**Infrastructure, technology and data**

49. To fully integrate services and to prevent fragmentation of healthcare in the community, patients should be able to access multidisciplinary teams via the general practice surgery. However, significant investment in general practice surgeries would be required to ensure that the infrastructure of the practices is able to support multidisciplinary services, and some of this may best be done at a 'community hub' level, linking with the local practices. Whilst the GP premises funding announced in the 2014 Autumn Statement is welcome, there should be co-ordination between this review and NHS England’s new models of care programme to ensure that public finances are not wasted on infrastructure projects designed for traditional ways of working.

50. A large challenge in multidisciplinary working is ensuring that patient records can be shared effectively between different team members. A key challenge for this is IT infrastructure and ensuring that different systems are able to interact. It is essential that every practice within a federation uses a common IT system or systems that are compatible. Capability with the IT systems of other services e.g. community health, is also vital.

51. The collection of effective medical data can drive improvements in the quality of patient data. By using coding from EMIS, performance dashboards for the management of patient cohorts with long term diseases can be created. It is also vital that patient registration data is maintained up to date especially email and mobile telephone contact details as patients move away from postal communications.

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\footnote{Primary Care Development Centre. Accessed at: http://www.pcdc.org.uk/about-us/standing-advisory-groups. Downloaded 11/02/15}
Quantitative workforce planning

52. To deliver any of the above models of care, it is of utmost importance that the current shortfall of GPs is addressed and that there is a commitment to sufficient supply of GPs in the future. It is vital that HEE or an independent body works with interested parties to conduct detailed quantitative analysis, to allow the development of a consensus on the number of GPs needed to work within and deliver these new models of care. This section will outline the College’s initial work in estimating what the shortfall in the number of GPs in England is and how many will be needed by 2020.

53. There are numerous methods to estimate if there is a shortage of GPs in England. To date, the College has segmented this approach into two time frames i.e. estimating the current GP shortage and estimating the long-term number of GPs required.

54. Short term estimates are generated using two key approaches:

   a. **Approach A**: The current shortage in GPs is mainly driven by supply-side factors of attrition, unfilled posts and lack of trainee doctors
   b. **Approach B**: The current shortage in GPs can be attributed by benchmarking against different coverage levels e.g. vs. England, UK and Europe

55. To estimate the current shortage of GPs four methodologies have been used:
   a. Increasing England’s coverage to the upper quartile of EU coverage
   b. Increasing England’s coverage to the average and upper quartile of England coverage
   c. Estimating the current shortfall using estimates of vacancy data i.e. unfilled posts
   d. Increasing England’s coverage to the average of UK coverage

56. The preferred estimate of current shortfall is using estimates of vacancy rate data because the other methodologies are normative and subject to change. Furthermore, comparisons against other European countries can be difficult due to the differences in primary care systems. HEE’s GP Taskforce report states that vacancy rates have grown fourfold in the last three years – ‘The results showed vacancy rates of 7.9 per cent of all GP posts in January 2013 – almost double the 4.2 per cent figure from the previous year’s survey in January 2012, which itself was twice the Department of Health baseline figure of 2.1 per cent from the last survey in 2010.’

   The College uses a reasonable estimate of 9.0 per cent vacancy rates in 2014, which results in a shortfall of circa 3,200 GPs.

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To estimate the long-term shortfall is a complex question with the analysis of numerous supply and demand factors required. The College suggests using the Scenario 4 estimate by the CfWI to estimate the long-term need. The College believes that this is the best reflection of the current situation in general practice i.e. ‘professionally driven workforce development and perceived decrease in the status and attractiveness of the GP profession’. The scenario forecasts a shortfall in 2020 of approximately 3,000. This is the same estimate used in the HEE Workforce plan.

However, in the discussion the CfWI also model the impact of two probable supply shocks; decrease in GP retirement age and increased emigration from the UK workforce. Reduction in GP median retirement age from 59 to 58 creates an additional shortage of approximately 430 FTE in 2018. Whereas, increased emigration could create a further reduction of supply to about 1,000 by 2020. The evidence base for these supply shocks occurring is widely documented. Therefore if you add these estimates to the Scenario 4 total, the long term undersupply by 2020 could be in the region of 4,500. This long term estimate coupled with the short term estimate suggests a GP shortage of 7,700 in England shortage.

The inclusion of these supply shocks are supported by numerous sources of evidence:

- The reduction in retirement age is supported by a British Medical Association (BMA) survey, which ‘found that that in the past year around 57 per cent of GPs responding said they had considered retiring early, 28 per cent had considered leaving the profession entirely, and 24 per cent had considered working overseas.’ It is also supported by evidence quoted by HEE’s GP Taskforce, which states ‘that the proportion of GPs expecting to quit direct patient care in the

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next five years had increased from 6.4 per cent in 2010 to 8.9 per cent in 2012 amongst GPs under 50 years-old and from 41.7 per cent in 2010 to 54.1 per cent in 2012 amongst GPs aged 50 years and over.\(^{37,38}\)

b. The State of Medical Education and Practice report found that emigration is one of the two most common reasons for doctors leaving the workforce. It also highlights that proxy indicators suggest that the number of UK graduates leaving to work abroad is increasing. A key indicator for doctor emigration is the number of applications for Certificates of Good Standing. Applications for certificates have risen by 22 per cent since 2008, with doctors aged between 24 and 27 years old forming the majority of the applicants. In 2013, destinations were predominately to two countries – Australia and New Zealand (51 per cent). A further 9.7 per cent went to Canada, 8 per cent went to three countries in east Asia (Hong Kong, Malaysia and Singapore), 6.7 per cent went to Ireland and 4.9 per cent went to the United Arab Emirates.\(^{39}\) Further research should be conducted.

60. It is important to note that the CIWI report itself states that its forecast baseline is probably underestimated: ‘baseline demand for GP services is projected to increase by 10.75 per cent (or 0.6 per cent per annum) on a FTE basis between 2013 and 2030, based on two drivers: population growth and the changing age and gender composition of the population, particularly the increase in older people. However, as the baseline does not include changes in patient expectations, the rise of multiple morbidities and case complexity, or the potential impact of greater prevalence of non-age-related long-term conditions, such as obesity or diabetes, it most likely underestimates future patient demand for GP services.’\(^{40}\)

61. There has also been a historical imbalance between consultant and GP recruitment. In 2014, there were 32,628 GPs (excluding retainers and registrars, full time equivalent) and 40,443 Consultants (including Directors of Public Health, full time equivalent) recruited. Compared to 2004, this represents an annual average growth of 1.7 per cent and 3.7 per cent respectively.\(^{41}\) In addition to this, ‘there were 2,814 level one entry posts for GP training compared to 4,143 level one entry posts for a Consultant medical career (i.e. other specialty training). The ratio of level one entry points to CCT holders suggest that we are replacing 7.9 per cent of the GP workforce annually compared to 10.3 per cent of the Consultant workforce replaced annually.’\(^{42}\)

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62. Analysis to date is also limited because it has looked at general practice in isolation from staff mix. There could be shortages in other members of the primary care workforce team but data availability is poor. For example, there has been an overall downward trend in the number of nurse training places since 2010/11.\textsuperscript{43} The CfWI’s baseline projection for supply and demand demonstrates a possible shortfall of registered nurse headcount by 2016.\textsuperscript{44} There is evidence to suggest that varying staff mix and roles of other professionals (clinical and other) could have a significant impact on the demand for GP services and therefore on the number of GPs required in the short and long-term. However, whilst different skill mixes have arisen, these should not necessarily be considered as ideals as in some localities they are consequences of a failure to have sufficient workforce planning and investment. Regardless, investment in the recruitment of GPs is needed to ensure delivery of new models of care and to address significant workforce issues including workload, patient safety and recruitment.

63. It is noted that HSCIC has made improvements to the collection of workforce data on other members of the practice team. Analysis on the number of full time equivalent practice nurses between 2013 and 2014 has shown a growth of 8.6 per cent in the number of advanced nurse practitioners and a reduction in the number of overall practice nurses of 2.1 per cent. Whilst growth in the number of advanced nurse practitioners is welcome the overall increase of 0.8 per cent in the number of nurses could be insufficient given the rise in general practice demand.\textsuperscript{45} Furthermore, there is no consensus or clarity on the definitions between ‘extended’, ‘advanced’ or ‘practice’ nurses. Further work must be done to ensure clarity around definitions (potentially including career frameworks), with analysis of the impact this has on workforce planning. There is also a need to increase nurse training capacity with increased mentors and trainers and to standardise nurse training.

Key recommendations

64. This section outlines the key recommendations that the College believes are essential to design a primary care workforce that is able to deliver the new models of care and ways of working outlined above. These recommendations are organised into the following categories: workforce planning; recruitment; training; and, retention.

Workforce planning

a) **Increased collection of workforce data.** HSCIC are undertaking a review of primary care workforce data collection and the College looks forward to the results of this process. The outcome of this consultation is intended to be published in February 2015. We welcome the intention of the consultation, however, further comment cannot be made until it is published. There is an urgent need for better primary care data to underpin better understanding of workforce numbers and activity. To highlight the poor collection of primary care data, the last official collection of GP consultation rates in England was in 2008/09 and the last vacancy rate data was collected in 2010. This is in stark contrast to the weekly publication of secondary care activity data. The use of EMIS and other practice software as a source of accurate workforce and activity data should be explored and potentially funded. In addition, there needs to be analysis of the overall competencies for professional roles and any provisions that may be needed for innovation.

b) **Quantitative forecasting of workforce numbers.** Given the length of time it takes to train a GP and other healthcare professionals, quantitative analysis of workforce requirements in the future must be undertaken, based on new models rather than old.

c) **Evaluation of the relevant competencies for different health and care roles.** There is a lack of clarity regarding the distinctions between certain professional roles and evaluation of the relevant competencies and accreditations required would assist in workforce planning.

Recruitment

d) **Cultural change to encourage recruitment to general practice.** There is a body of evidence that highlights that some of the perceived deterrents to choosing general practice as a career were its portrayal, by some hospital-based teachers, as a second class career compared to hospital medicine.46

e) **Stabilisation of GP careers** – NHS England’s Five Year Forward View set out a clear vision that put general practice at the centre of the health care system and outlined a new deal for general practice and primary care. Decisive action to implement the joint Action Plan by NHS England, HEE, BMA and the College is required to inspire confidence in training medics to choose general practice. In addition, building on HEE’s work with the Royal College of Nursing and

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universities, we would welcome a programme that provides ready and easy access to conversation courses for GPs and other professionals who wish to switch from the acute sector to the community.\textsuperscript{47} There also needs to be further clarity regarding the funding of training for non-GP health professionals.

f) \textbf{Greater exposure to general practice at undergraduate and foundation school level.} For example, in 2014, zero per cent of F1 doctors rotated through general practice in their training and 43.3 per cent of F2 doctors experienced general practice.\textsuperscript{48} This is despite the findings that including general practice throughout medical education is the most effective way of making general practice more attractive.\textsuperscript{49}

g) \textbf{Review of incentives to attract locum doctors.} There is a lack of data available on locum doctor usage and availability. However, usage is reported to have increased.\textsuperscript{50} Further research should be done to evaluate the scale and cost of locum usage and also what incentives can be designed to encourage locum doctors to join the general practice workforce.

h) \textbf{Review of underlying reasons why UK graduates emigrate to other countries.} There is a urgent need to understand why UK graduates do not wish to practice in the UK and also what differences in work conditions keep them abroad. An anecdotal survey performed by an expatriate GP highlighted favourable comparisons for autonomy, stress and consultation length in comparing general practice in the UK and Australia.\textsuperscript{51}

i) \textbf{Incentivising practices to recruit / commission a wider variety of health care professionals in new roles.} Incentives should be designed to promote practices to integrate different healthcare professionals into their practice teams. Examples of different staff members include district nurses, social workers, community matrons, health visitors etc.

\textit{Training}

j) \textbf{Increased GP training capacity, especially in our underserved areas.} Delivering the number of GPs and/or primary care professionals will need significant expansion to training capacity. This may require increased incentive packages to potential GP trainers and a review of GP training models. The


\textsuperscript{49} The characteristics of general practice and the attractiveness of working as a GP: medical students’ views 2014 Mar http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4207180/


geographical distribution of GPs is linked to regional training capacity and programmes, with most GPs taking their first job in their region of training.\textsuperscript{52}

k) **Increased nurse training capacity with co-ordinated structure and funding.**

Primary care workforce training at undergraduate and postgraduate levels can be limited by the poor availability of nurse supervisors. Central funding and co-ordination should enable sufficient training capacity.

l) **Funded education and advanced training provision for current and new Allied Health Practitioners, Health Care and ‘Medical’ Assistants.**

Apprenticeships for health care assistant and business administration apprenticeship roles should also be included.

m) **Funded education and training provision for administrative and practice manager roles.** As the complexity of general practice care and organisation changes, it is vital that the back office functions are led by highly competent staff.

n) **Review of funding for GP training.** Whilst it is ‘cheaper’ to train a GP than to train a consultant, in terms of the cost per output; the annual cost of GP training is greater than the annual costs of training a trainee in a secondary care specialty. Training costs for secondary care are contained within service level agreements and it requires greater notice to vary the value of contracts than it does to extract savings from GP training. A review of the incentives and financial reimbursement (especially service level increment for training, ‘SIFT’) for becoming a training practice should be conducted to ensure that practices aren’t financially discouraged from doing so.

o) **Review of training content for health professionals who will have a more active role within the future delivery of primary care.** Changes to ways of working will mean that health care professionals will work in non-traditional roles, which will require non-traditional skills. A review of the standards and content of training courses should be conducted to ensure that training is still fit for purpose.

**Retention**

p) **Invest in occupational health and GP morale.** There needs to be a dedicated programme to understand the drivers of GP attrition. In addition, access to greater occupational health programmes should be funded to assist doctors in managing their occupational health needs. Potentially, there should be encouragement and financial support for structured sabbaticals for at-risk doctors to prevent long-term attrition. The charity Royal Medical Benevolent Fund provides some funding towards financial support in addition to the central funding provided by NHS England. Better GP morale could also boost recruitment, the perception of low morale amongst current GPs was a key deterrent for graduates.
to choose general practice as a career. Despite common perceptions, financial remuneration was low on the motivations for people to select general practice.

q) Establish clearer workload management guidelines. This will prevent GP burnout and assist in the positive perception of general practice as a career. One of the most popular reasons people choose general practice as a career was its perceived compatibility with a work-life balance.

r) Career structures for non-GP primary care workforce members. Professional practice management skills and flexible career structure. The Calderdale framework can help in identifying an appropriate skill mix and improved career structures.

Innovation

s) Funding for research at practice paid from other funds. Novel models of care are continually created by frontline workers, however, additional funds should be provided for practices to have dedicated primary care based researchers that look at research across all of the professions.