

**LMC Position Paper on the Implications of the Shrinking GP Workforce in Somerset**

**Summary**

**The number of Whole Time Equivalent GPs in Somerset is falling, whilst demand for their skills is rising. The Sustainability & Transformation Partnership needs to take urgent action to ensure that its resource of skilled family physicians is used to best advantage. Failure to do so will make the STPs broader strategies, including reaching its savings targets, unachievable.**

**Background**

Although primary care is acknowledged by STP planners to be an essential component of the Somerset health economy, the structure of general practice has made it hard for STP groups, composed primarily of managers from large organisations, to engage with primary care providers. This has inevitably meant that STP attention has been mainly directed at the most obviously pressing problems, notably the system financial deficit. However, it is becoming clear that an even more urgent threat is the capacity of general practice not only to manage change and take on work that has traditionally been done in hospitals, but also to continue to provide existing primary care services.

**Current Workforce**

Although there is no completely definitive source for GP workforce information, the best national figures probably come from NHS Digital who provisionally reported a fall of 445 (1.3%) in English WTE GPs in the last quarter of 2016. In recent years in Somerset the position has been significantly worse, with a drop of 48 WTE GPs during the twelve months to June 2016 , a decline of 17%.

The shortage of GPs in the county is evident across the board with some practices unable to recruit partners, salaried doctors or locums. Other general practice work is also persistently understaffed : in the last week of May the Somerset GP Locum Agency was unable to provide locum GPs for 41 daytime practice sessions, ten shifts for GPs in the Emergency Department at Musgrove Park were unfilled and although Vocare prefer not to give details for commercial reasons, we are aware that a significant number of GP Out of Hours shifts were unfilled during the same week. The LMC estimates that the county needs more than thirty more WTE GPs to either maintain the current service configuration or safely support transition to a new model.

**Unrealistic Expectations**

Meanwhile, It appears to the LMC that national politicians and central health service planners still do not appreciate the critical state of the whole primary care workforce. Despite a small but encouraging increase in recruitment to GP training schemes for August 2017 and welcome improvements to GP Returner and Retainer programmes, there is little prospect in England that GP recruitment in the short term can do more than maintain current GP WTE headline number, but the political drive to increase routine access to general practice services and to use GP capacity to absorb demand for A&E services continues unabated.

Whilst the requirement for “Improved Access” to routine primary care consultations across the county every evening from 18.30 to 20.00 and at weekends can partly be met by reconfiguration of existing services and the use of other professional staff, all primary care clinicians are in short supply and the default provision of primary care during these hours will inevitably fall to practice based GPs.

At the same time, in August the “Integrated Front Door” in the Taunton Emergency Department expects to recruit to another two GP shifts from Friday to Monday, and the Vocare OOH service hopes to attract more GPs into triage sessions during this year. In the medium term the national Urgent & Emergency Care strategy also expects GP-led Urgent Treatment Centres to be established everywhere by April 2019 , though fortunately the county is not in the first wave for this provision.

**Limitations on Recruitment and Retention**

Somerset CCG and the LMC have had some success in attracting recruits through the “GP in Somerset” attraction strategy, but the challenges the county faces in this regard are well known. Retention of GPs is a national problem for equally familiar reasons, but Somerset has a high proportion of older GPs who are likely to retire and leave the profession shortly. NHSE funding for a “GP Plus” retention scheme in Somerset is welcome but the anticipated benefit in WTE GP numbers will be small compared to the size of the problem.

GPs are often accused of endlessly complaining about their working hours even though other professionals work as hard or harder, but there are some important distinctions. All acute services that deal with undifferentiated demand ( Acute Medicine, Accident & Emergency, General Practice) are undersubscribed as their work is felt to be more intense, more risky and less controlled than that in more protected specialties. Of the acute specialties only general practice is not protected by some kind of shift system – in the current system a GP just has to continue working until all the patients who require attention that day have been dealt with. Furthermore, GP work is particularly intense and covers the whole gamut of healthcare: sudden life threatening critical illness, child abuse, suicidal depression, death, desperation and decline as well as coughs, colds and rashes.

Decision making in general practice is often complex and based on incomplete information, yet GPs often have several workstreams running at once, and consultations are conducted under great time pressure. At the same time, family doctors are particularly vulnerable to complaints and litigation to which they must personally respond without the support of a trust PALS or complaints handling service. The consequence of all this is that GPs are increasingly aware that their working conditions are safe for neither their patients nor themselves and this is the strongest single reason why GPs reduce their practice commitment, withdraw from more risky work or retire from practice.

The STP must not assume that incentives, threats or appeals to GPs social consciences will reverse the current trend. Until the principles of a safe working day have been agreed and implemented it must be assumed that the workforce is functioning at capacity.

**GP Numbers and Clinical Quality**

The accepted solution to GP shortages is for primary care to adopt a wider skill mix so that all professionals are “working at the top of their licences” whilst routine tasks are protocolised and delegated to less qualified support staff. Whilst this approach has merit, it is not a complete solution. No other health profession offers the rapid assessment generalist risk management skills of general practice, and whilst other clinicians can provide part of that skill set, if their clinical load strays too far outside their training and experience the risk of both under and over treatment increases, which carries significant cost and medicolegal consequences.

The effects of working under constant pressure are well known, and in general practice that means not only that more errors are be made, but also that non-urgent work is deferred and then forgotten, and more referrals are made into secondary care.

Skill mixing is most definitely not a matter of “one for one” replacement. As other professional and support staff deal with simpler conditions and questions, the complexity of those left for the GP increases. Consultations take longer, become more exhausting, and are often less satisfying to deliver. Less qualified staff need their decisions ratified and often have a slower consultation rate so the job weight for GPs can become unsustainable if the process is not carefully managed. For the present at least there is therefore an irreducible minimum number of GPs required to maintain acceptable clinical quality.

An analysis by *GPOnline*  magazine showed a clear link between the medical staffing of practices and their CQC rating with “outstanding” practices having on average 50% more doctors than “inadequate” ones.

**Capacity of General Practice to Meet STP Objectives**

There is general agreement that the only possible route to a sustainable health system is to encourage communities and individuals to become healthier and more self-reliant, and for care to be provided at the lowest safe intervention level. Although the LMC accepts that there is much work currently undertaken in secondary care that could be moved to primary care, and that GP referrals and admissions could both be reduced, both of these will require more resources, particularly skilled clinicians, to be moved into primary care. Secondary care providers sometimes perceive that the answer to their own capacity problems is simply to push everything that does not require the resources of hospital into primary care, and the lack of specifics in the GP core contract can make this hard for GPs to resist transferred work, and there is an urgent need for a whole system approach to deciding what should be done where and by whom rather than letting individual organisations make these decision. Practices are caught between increased patient demand for primary care and the growing volume of work moving down from secondary care and this is not sustainable.

**Long Term Solutions**

Early evidence suggests that the Enhanced Primary Care model already adopted in parts of the county has an immediate and direct impact on GP workload as well as improving patient care and reducing avoidable admissions and interventions. This is the most promising route to ensuring that GPs have a safe working day and time to use their skills where they are most needed. However, it does not directly allow a substantial reduction in the GP workforce. Collaborative working amongst GP practices to provide, for example, same day urgent care may ease some of the current pressure but it is unlikely to release enough GP capacity to staff all the non-practice based services that are currently seeking medical time. There will still be a need for a coherent plan that considers how the whole system need for generalist medical time can best be met.

**Conclusions**

1. Whatever grand plan for service redesign the STP may propose, if the primary care base of service provision is not secured none of the rest is achievable. Most of the 3 million or so primary care consultations in Somerset are invisible to the rest of the system, yet the ability of independent contractor general practice to flex to meet demand peaks whilst maintaining an efficient service at low cost is essential to the stability of the service.
2. General Practice in Somerset is under considerable and growing pressure due to rising demand from patients, politicians and other health care providers for primary care services.
3. The GP workforce in the county is currently still shrinking , and whilst other clinical professionals can supplement it there comes a point at which this is neither safe nor effective.
4. If expectations of what general practice can do are not controlled, losses from the GP workforce will continue and may increase.
5. Current short term recruitment strategies are effective, but with only a small national pool of available GPs to draw from their effect will be limited.
6. There are not enough GPs available in the county to staff all the current schemes that require primary care input, let alone those that are proposed . The STP needs to develop a workforce plan that prioritises those that make most effective use of the limited resource. Others should be merged or abandoned.

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