NHS
Executive

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Guidelines

HSG(97)9
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WORKFORCE PLANNING FOR GENERAL MEDICAL SERVICES: FURTHER GUIDANCE

Executive summary

EL(96)69 highlighted the need for Health Authorities to undertake workforce planning for General Medical Services. It asked them to form a view on GMS medical and non-medical staffing requirements, and related education and development needs, for a five year period from April 1997. The role it outlined for HAs is rooted in the effective performance of their existing functions in:

* making reports to the Medical Practices Committee (MPC) on the adequacy of the local GP workforce; and

* making decisions on the use of GMS cash-limited funds to support the employment of practice staff.

* relation to arrangements made under section 63(1) of the Health Services and Public Health Act 1968 and in particular where this function is exercised jointly with one or more other Health Authorities, Special Health Authorities or NHS Trusts through, for example, consortia.

The purpose of this HSG is to:

* provide further guidance for Health Authorities on medium-term GMS workforce planning activity (**Annex A**);

* expand on the short-term action which Health Authorities are asked to take on GMS workforce planning, and explain how this links with plans for Personal Medical Services (PMS) pilots under the provisions of the NHS (Primary Care) Act (**Annex B**).

This is consistent with the development of a more integrated approach, co-ordinated at education consortia level, to workforce planning covering all professional groups in the NHS. It also underlines the key role of HAs in supporting GMS interests within consortia, and in taking an overview of GMS and HCHS workforce requirements.

Action

In line with EL(96)69, Health Authorities are asked:

* by April 1997, to have formulated initial views on current and future GMS workforce needs. The results of this work should be used to inform their recommendations on any proposals for PMS pilots under the Primary Care Act 1997;

* by April 1998, to have formed and begun to implement a fully considered view on likely GMS workforce needs, including non-medical and medical staffing projections. Projections should cover five years, though less detail will be possible for years four and five.

Background

See Annex A and B

Addressees

For action:

Health Authorities

For information:

Consortia Chairs
Regional Postgraduate Deans
Directors of Post-graduate General Practice Education
Regional Office Education Leads
Medical Practices Committee

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ANNEX A

WORKFORCE PLANNING FOR GENERAL MEDICAL SERVICES

GUIDANCE FOR HEALTH AUTHORITIES

BACKGROUND AND INTRODUCTION

1. EL(96)69 *Workforce Planning for General Medical Services*, issued on 30 July 1996, set out the role for Health Authorities (HAs) in workforce planning for General Medical Services (GMS). The letter asked HAs to arrive at a clear view of:

* how GMS will be provided and developed over each of the next five years; and

* the consequent workforce needs.

Workforce plans will will enable HAs better to perform their existing functions in making reports to the MPC on adequacy of the local GP workforce, and in making decisions about the use of GMS cash-limited funds to support the employment of practice staff.

2. It is recognised that there is a need for more local flexibility in the provision of family doctor services. In this context it will be increasingly important that Health Authorities in understanding the health needs of its population, understand the actual and expected demands for General Medical Services and the consequent implications for the workforce. In particular, HAs will need to consider the appropriate balance of services between secondary and primary care, and the spread of provision - including GPs - required to achieve an equitable distribution of services.

3. This guidance has been informed by the work of a Reference Group comprising General Practitioners, representatives of Health Authorities and NHS Executive officials. It aims to provide HAs with ideas and information to assist with:

* drawing up a "baseline" picture of the current workforce;

* quantifying workforce requirements arising out of developments to general medical services over the next five years consistent with HAs strategic plan;

* working with the MPC and consulting locally on GP distribution issues;

* integrating GMS workforce planning with that for the secondary care sector, in the context of local education purchasing consortia;

* responding to ad hoc national requests for views on demand to assist with national resource planning;

It also suggests key data items on which HAs may wish to draw to underpin the planning process.

DEVELOPING A WORKFORCE PLAN FOR GENERAL MEDICAL SERVICES

Forming a view on services required (demand)

4. Health Authorities are already required to make reports to the MPC at least every three years and when vacancies occur, to enable the MPC to judge the adequacy of the number of general medical practitioners to provide services in the area and to advise about the need to fill vacancies. This work should provide HAs with a clear view of current service provision and the workforce providing those services to arrive at a baseline position. They can then assess plans

for service developments against this baseline and available resources, and quantify additional workforce requirements. Such information will in particular provide the HA, in collaboration with the MPC, with a clear view on adequacy of the number of general medical practitioners and any unmet needs. Factors which will impact on the established baseline include:

i) any service changes planned in relation to the balance of services between primary/community/secondary and social care. This might include:

* impact of continuing care policies;
* service reconfiguration;
* extent of any increase in day surgery/local plans for more minor surgery in practices;
* closer working in primary and community nursing teams;
* integration of child services/organisation of child protection;
* developments of diagnostic/maintenance services in surgery instead of outpatient (e.g. sigmoidoscopy/ anticoagulation);
* public health initiatives and policy.

ii) the characteristics of the local population, including:

* list sizes;
* demography (including ethnicity) and geography, and any associated special local needs.

iii) locally agreed policy on General Medical Services, including:

* practice configuration (support for branch surgeries etc);
* allocation of GMS resources among practices to achieve a better balance and encourage good practice;
* support for shared practice services;
* investments in IT and LINKS and the effects this might have on staffing numbers and development and educational needs;
* public health initiatives and policy.

Forming a view on the workforce needed to deliver these services (supply)

5. The workforce plan will need to cover the three main staff groups:

* general practitioners (including non-principals);
* nurses and other professional staff including PAMs; and
* practice managers, ancillary and administrative and clerical staff.

Information for GMS workforce planning

6. In order to plan effectively, HAs may need to gather information from practices in their area to inform the decision-making process. Detailed information about current staffing (for example known recruitment/ retirements or significant changes in contractual commitment) will be important to obtaining a clear **supply** picture. Of equal importance will be information about factors which are likely to affect **demand** for services, such as an increase in the local population due to housing developments.

7. Health Authorities' own population needs assessments should help them piece together a picture of likely overall demand for GMS and other services, which will in turn inform HAs' assessment of service requirements. There are also a number of potential sources of practice based information on both supply and demand. These may vary from one HA to another and depend upon the extent to which a systematic planning process exists for both practice and service development.

8. A list of information which HAs might find it useful to consider is at Appendix 1(a). HAs should be able to rely on information which they already collect; some likely information sources are set out at Appendix 1(b).

Format of the Workforce Plan

9. It will be for HAs themselves to determine the precise format of the workforce plan. However the following can be usefully considered in this context:

- the need to work collaboratively with the Medical Practices Committee (MPC), and provide the MPC with the information it needs to help HAs implement their service plans;

- how such information might be usefully used within consortia, to provide a better understanding of the balance of requirements between the primary and secondary care sectors and to take forward ideas on the educational and development needs of practice staff.

10. A good GMS workforce plan can be of use to a HA in several respects by:

* helping HAs take a holistic view of local workforce needs (for example in relation to PMS pilots - see annex B);

* assisting with local financial planning, particularly in the context of greater flexibility for HAs to use their own resources to address GMS needs;

* providing a useful basis for discussions within consortia about the GMS implications of their work;

* informing HAs' dialogue with the MPC.

11. Education consortia will have considerable experience in workforce planning, and may be able to help their member HAs by suggesting approaches and methodologies.

CONSULTATION

12. In addition to close working within consortia, to achieve robust workforce plans HAs are advised to work closely with:

i) **General Medical Practitioners**

HAs should seek to build on the good working relationships which currently exist in many areas. Actively involving and supporting those working in general medical practice in the planning process will be a key component in achieving successful outcomes. In particular, GPs' plans for service developments and any consequent need for training/development of their staff could inform regional training and development strategies and form a useful basis for discussion with consortia and Regional Education and Development Groups (REDGs).

ii) **Local Medical Committees (LMCs)**

As discussed in paragraph 4, HAs are required to make reports to the MPC to enable it to judge the adequacy of the number of general medical practitioners providing services in the area and to advise on vacancies. Before such reports are made, a HA must consult the LMC [1]. Workforce plans, dealing with medical and non-medical staff, should therefore reflect the agreed need for general practitioners providing general medical services. Consultation with LMCs on workforce plans, particularly where these show how services are to be developed, should therefore take full account of this statutory process as it affects the need for, and distribution of, general practitioners.

Health Authorities are also advised to consult with:

iii) **Education and Training advisers and providers**

Workforce plans will need to be developed in a way which takes full account of the availability of education and training and the timescales within which it is provided. The aim would be to understand what is or could be available, to whom and when. This is particularly important in relation to practice staff so that workforce plans can fully address related educational and development needs and assess when and how such needs might be met.

iv) **Community Health Councils**

Consultation with CHCs will help to ensure that HAs' GMS workforce plans adequately address the needs of local people.

INTEGRATED WORKFORCE PLANNING

13. Workforce planning for GMS cannot, of course, be carried out in isolation. Health Authorities need to consider both GMS and HCHS workforce planning to ensure an integrated approach across all NHS services rather than one which compartmentalises different service sectors. Recent NHS Executive guidance (ELs 96(46), 96(68) and, for GMS, 96(69)) describes how workforce planning should develop. Further guidance is being prepared on the roles and responsibilities of consortia and REDGs, and this will be issued shortly.

14. All the interested parties (including HAs, providers, consortia, REDGs, and the NHS Executive) need to work together to develop integrated workforce planning. HAs are uniquely placed to take an overview of GMS and HCHS workforce requirements and ensure that a balance is struck which best meets the healthcare needs of the population and the education and training needs of NHS professional staff:

HAs have a key role (along with GP members) in representing GMS workforce needs in consortia; for example by ensuring that GMS needs are fully recognised when consortia are developing plans for commissioning HCHS education and training . They also need

to agree what information consortia require to commission appropriately for GMS needs;

Helping to ensure that GMS workforce requirements are adequately recognised in the work of **REDGs**.

WORKING WITH THE MEDICAL PRACTICES COMMITTEE

15. As already set out, the MPC is entitled, under statute, to certain information which will assist it in deciding whether an area is "adequately doctored" or not. In making that decision they take account of a number of factors, which are set out in "Guidance to HAs" issued in January 1991. Using the information the MPC classifies areas either as restricted, intermediate, open and designated. There are some 1400 MPC areas, which may match with HAs' localities. The MPC is currently looking at how it classifies areas and intends to review its guidance to HAs.

16. HAs will need to work closely with the MPC to ensure that its workforce plan properly reflects the view which the MPC is likely to form on adequacy. Similarly, in reaching a view, the MPC needs to be clear of HAs' strategic plans and understand how any planned service development fits into this overall strategy. It will also need to understand how HAs have estimated workforce needs in relation to planned services. Exact arrangements for such liaison is for HAs themselves to decide, but involvement of the MPC at an early stage of the workforce planning process should be considered. Some HAs have found it helpful to set out their aims for the local GMS workforce in a short document and share this with the MPC.

17. Although the MPC is governed by statute and has limited discretion within which it can operate, it is able to be flexible in a number of ways which may be of help to HAs. In particular it may change the boundaries of the areas which it classifies for the purpose of judging the distribution of GPs to match those of HA localities were this would help HAs in developing their plans.

18. Further information on how HAs should work with the MPC in relation to potential Personal Medical Services pilot schemes is at annex B.

TIMESCALE FOR ACTION

19. Health Authorities are asked to produce and begin to implement, by April 1998, a five year plan for the development of the local GMS workforce. Plans should be subject to ongoing development, and will need to be increasingly robust to complement the developing role of primary care in the NHS.

FURTHER INFORMATION

20. If you have any queries about this guidance, in the first instance please contact the appropriate NHS Executive Regional Office contact listed at Appendix 2

1. *The National Health Service (General Medical Services) Regulations 1992, regulation 11.*

APPENDIX 1

(a) Information for GMS workforce planning

Information on supply:

* All staff:
  - timing of any known retirements or departures;
  - known or likely reductions or increases in commitment (hours worked);
  - number of trainees/expected local supply of trained staff;
  - skill mix (between professional and non-professional staff);

  - the planned/potential role of other professional staff, for example pharmacists or optometrists within primary care.
  - sharing of staff for example Practice Managers.

* For GPs:
  - requests for a partner/additional partner and the reason for this change eg. because of clinical/commissioning or non-GMS reasons.

Information on demand:

- changes in the size or demography of the patient population;
- changes in the health status of the patient population, which could have staffing implications;
- epidemiological information.

(b) Sources of information

i) Census Data (supply)

A good source of information on which HAs can draw is information they themselves collect for the annual and half-yearly national census. Local information can be accessed to help draw up a comprehensive picture of the current workforce in a HA's area. For comparative purposes and to better understand trends, information from the national census is available in "Statistics - England and Wales: National and FHSA Tables". Single copies can be obtained from Code A Room 8E44, Quarry House, Leeds LS2 7UE.

ii) Health Plans produced by GP Fundholders (supply and demand)

In areas where there are high levels of fundholding, GPFH plans probably represent the best single source of information about general practice for HAs. Such plans will give a good indication of the demand for services in the areas served by GPFH and should also give information about the current and expected levels of staff required to provide services (supply).

iii) Data on Practice Staff (supply)

Information held by HAs on staff employed by GPs for reimbursement purposes. This information usually includes sufficient detail (grade, hours of work) to establish current supply levels.

iv) Audit (supply and demand)

Audit information can highlight areas were resources are being used particularly effectively and also where there are service problems. For example, an audit of

complaints may indicate areas where staff are under pressure or where there is a gap between service levels and the expectations of patients. Audit information can be used to assess priorities for service development and assist in quantifying the consequential workforce requirements.

v) **Practice Reviews (supply)**

Annual review meetings with general practices can provide a useful source of information, both hard and "soft" or anecdotal. Such occasions might be useful opportunities to help practices map out their areas by means of postcodes. This will help HAs to assess the level of services available in a given area. Similarly practice leaflets should provide some information on services offered by individual practices.

APPENDIX 2

REGIONAL OFFICE CONTACTS

Anglia & Oxford	**Code A**	(01908) 844 400
North Thames		(0171) 725 5300
North West		(01925) 704 000
Northern & Yorks.		(0191) 301 1300
South Thames		(0171) 725 5300
South and West		(0117) 984 1750
Trent		(0114) 263 0300
West Midlands		(0121) 224 4600

ANNEX B

WORKFORCE REQUIREMENTS FOR GMS - LINKS WITH POTENTIAL PMS PILOTS

Background

1. The NHS (Primary Care) Act, sets out proposals to allow piloting of different models for Personal Medical Services (PMS) to complement current GMS services. Subject to commencement of the relevant parts of the Act, GPs and NHS Trusts will be able to explore more flexible ways of providing services. This will provide greater employment opportunities for GPs and other health professionals in meeting local needs for services. Health Authorities will be responsible for submitting applications for pilots to the Secretary of State for approval.

2. Consequent upon early enactment of the Act, it is expected that the first pilot projects will begin on 1 April 1998. Those who wish to put forward applications to pilot new arrangements from April 1998 will need time to prepare their proposals and to ensure satisfactory arrangements are in place before the pilots begin. EL(97)27 'Personal Medical Services Pilots and The NHS (Primary Care) Act 1997' and the accompanying guide issued on 7 April 1997 sets out the preliminary informtion Health Authorities and others need to know in order to make an expression of interest to undertake a Personal Medical Services Pilot.

Links with GMS workforce planning

3. When considering pilot proposals, Health Authorities are advised to assess whether and how they relate to overall local GMS workforce needs and any plans they have for addressing these as set out in Annex A.

4. It is important that Health Authorities' views on pilots are consistent with their assessment of GMS workforce needs. HAs are in a unique position to view Personal Medical Services pilots as part of an authority-wide strategy for securing the primary care workforce to best meet local needs. Accordingly, to help them consider and make recommendations on PMS pilot proposals with potential workforce implications, Health Authorities are asked to to consider at least the following basic questions:

* in what ways should local primary care services be developed over the next 3-5 years?

* are these developments likely to require more staff, and if so of what kind(s)?

* how will any proposed developments affect the viability of existing GP practices? HAs will need to discuss this locally.

* taking account of expected turnover, how many staff of what kind are likely to be needed to maintain a "steady state"?

5. The answers to these basic questions will influence both Health Authorities'views on PMS pilot proposals and their ongoing dealings with the Medical Practices Committee regarding the approval of GP Principal vacancies. Subject to directions being made, Health Authorties will be expected to demonstrate that these issues have been fully taken into account in preparing PMS pilot proposals for approval by the Secretary of State. In their recommendations on PMS pilot proposals, Health Authorities should be able to demonstrate that they have taken account of these issues.

6. When considering proposals for pilots, the Secretary of State must consult the MPC if the scheme changes the number of GPs in the relevant area. It will be important, so that consistency of approach can be achieved, for HAs to have full regard to the views of the LMC and MPC on the number and distribution of doctors currently providing general medical services.

The workforce plan, as discussed in Annex A, can usefully be a single point of reference in this respect, providing an agreed picture of general medical services as they are likely to develop and HAs views on how pilot schemes are to be used to further develop services.

7. Further details of the application process for PMS pilots will be available shortly. In the meantime if you have any queries about the proposed pilots, please contact Code A (GMS Branch, NHS Executive) on (0113) 254 5191.