Greater Manchester Workforce Project (Primary Care)

Work package 1: Mapping of primary care roles across Greater Manchester

Final summary report

WORKING IN COLLABORATION WITH

Greater
Manchester
Health and
**Social Care**
Partnership

NHS
England

AND THE
10 CLINICAL COMMISSIONING GROUPS
ACROSS GREATER MANCHESTER

This work was conducted by the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care Greater Manchester (NIHR CLAHRC GM), which is one of thirteen CLAHRCs in England. NIHR CLAHRC GM is a collaborative partnership between NHS organisations, the third sector and the University of Manchester focused on improving the health of people in Greater Manchester and beyond through the conduct and application of high quality applied health research.

This work is part of NIHR CLAHRC GM's Organising Healthcare Programme. There is currently a drive to 'transform' the NHS to address the growing, and increasingly unsustainable, pressures faced by the system. This drive includes initiatives to transform the health and care workforce, to integrate health and care to better meet the needs of the population and to expand and improve patient access to healthcare. The Organising Healthcare Programme aims to inform and support this by:

- Conducting rigorous and research-informed evaluations which shed light on the implementation and impact of change initiatives across health and social care;
- Supporting partner organisations to generate and evaluate innovative projects seeking to better integrate primary care with other parts of the health and social care system;
- Providing commissioners and providers with evidence to support decision making to deliver effective and sustainable future service design and configuration.
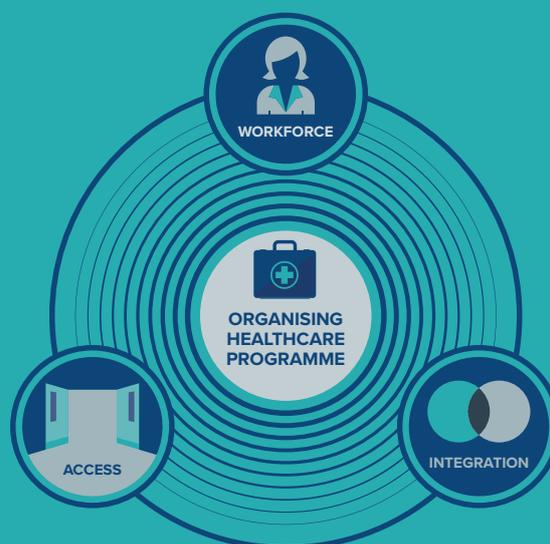
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This summary report was created as an appendix to the Greater Manchester Primary Care Workforce Strategy, further details may be found here:

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1.0

BACKGROUND AND CONTEXT

This report forms part of the Greater Manchester Primary Care Workforce Study being carried out by NIHR CLAHRC Greater Manchester (GM) in collaboration with the Greater Manchester Health and Social Care Partnership. The report presents findings from Work Package 1 of the study, aiming to conduct a baseline audit of the total staff employed in general practice in GM to enable a better understanding of current workforce capacity.

2.0

DATA AND METHODOLOGY

We used the General and Personal Medical Services, England data to answer the following questions:

1. What is the current general practice workforce in GM and does this vary across CCGs?
2. How has the general practice workforce in GM changed over time?
3. Is the available data representative of all practices across GM?

The report analyses data for GPs (excluding retainers, registrars and locums), nurses, Direct Patient Care (DPC) and administrative staff in GM. We present figures for the average workforce across GM and its CCGs per 10,000 registered patients. Findings are based on practices with complete data for all roles. We restrict the analyses to practices with complete submissions because our primary target was to obtain a picture of the workforce in its entirety; if practices with incomplete data had different configurations of workforce this would skew our picture of the GM baseline.

Baseline assessments were made using the September 2018 extract of the data. Longitudinal assessments were conducted to assess completion rates over time and data consistency using extracts from September 2016 to September 2018.

3.0

SUMMARY OF KEY FINDINGS

Whilst practice workforce returns for GPs **(93.86%)**, nurses **(94.92%)**, DPC **(93.64%)** and admin **(93.43%)** staff were high, approximately 21% of practices in GM had incomplete returns for at least one role. Complete return rates varied across CCGs, with the highest in NHS Trafford CCG **(87.50%)** and lowest in NHS Oldham CCG **(70.45%)**, with an average of **78.60%**. Incomplete data was associated with practices whose patients were less satisfied

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with overall experience of their practice, but not associated with measures of deprivation and population need.

In September 2018, based on 371 practices with complete data across all staff roles, there were: **4.11** full time equivalent (FTE) GP, **2.34** FTE nurses, **1.22** FTE DPC and **11.23** FTE administrative staff per 10,000 registered patients in GM (Figure 1).

AVERAGE WORKFORCE ACROSS GREATER MANCHESTER PRACTICES
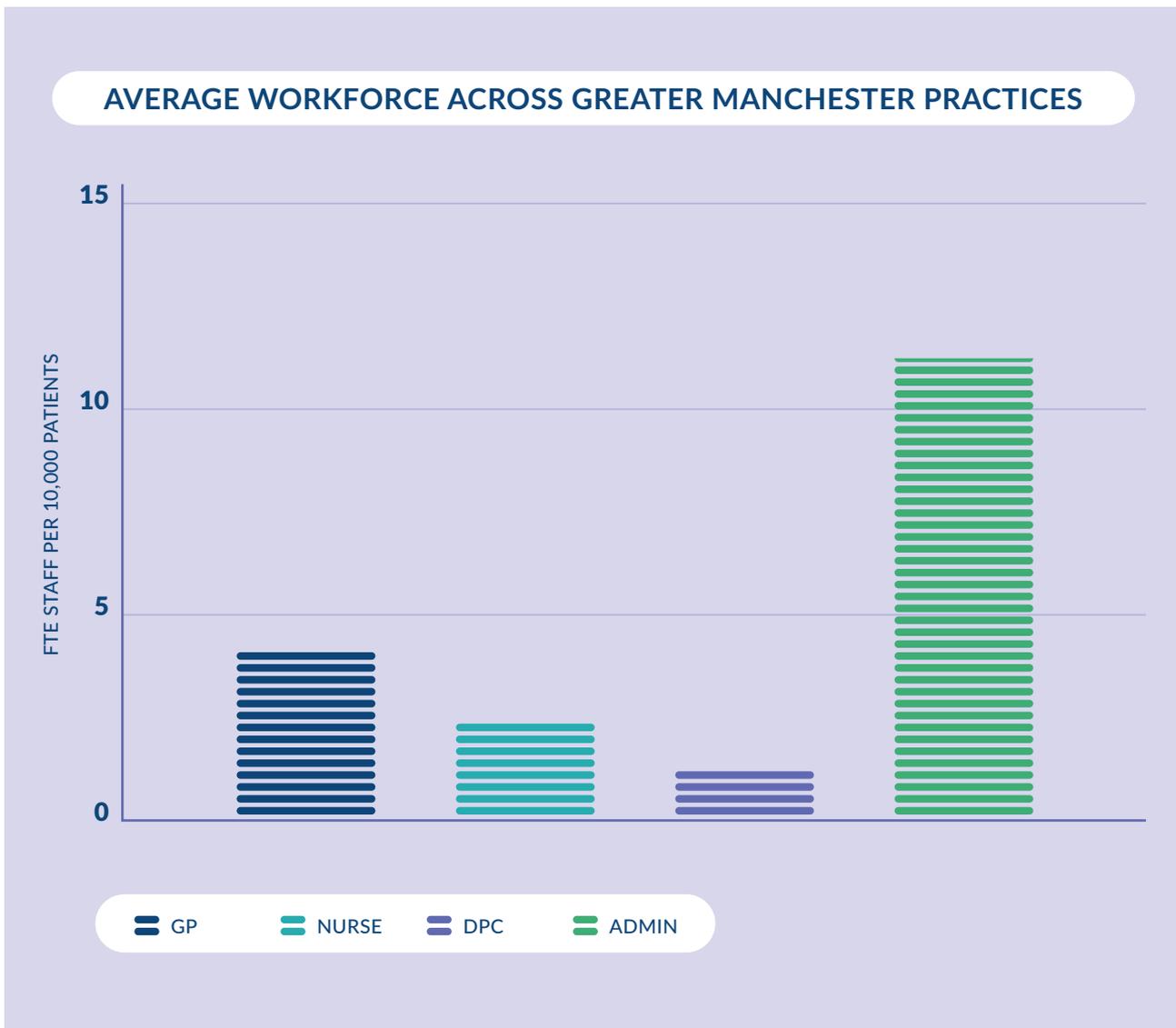
Figure 1 Baseline analysis (September 2018 data) showing the average workforce by role per 10,000 patients of 371 practices with complete data on all staff roles in general practice

These figures vary across and within CCGs:

• NHS Stockport CCG had the most FTE GPs per 10,000 **(4.79)** and NHS Oldham CCG the fewest **(3.64)**.

• NHS Salford CCG had the most FTE nurses per 10,000 **(2.92)** and NHS Manchester CCG the fewest **(1.82)**.

• NHS Tameside and Glossop CCG had the most FTE DPC per 10,000 **(1.84)** and NHS Trafford CCG the fewest **(0.67)**.

• NHS Salford CCG had the most FTE admin per 10,000 **(13.24)** and NHS Manchester CCG the fewest **(9.46)**.

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Differences in practice FTE GP staff numbers were not associated with CCG-specific factors or practice or population differences, implying that variations here may reflect local challenges in recruitment and retention. This may identify practices in relative greater need of support with recruitment and retention. Differences in FTE nurse, FTE DPC and FTE administrative staff were associated with measures of population need (age, deprivation) and also CCG-level factors. Future evaluations may wish to explore why CCG differences are evident for these roles.

Longitudinal assessment of practices with complete data (46.19%, 218 practices) in the September 2016 through to September 2018 data extracts suggests a decline in numbers of FTE GP and FTE administrative staff but little change in FTE nurse and FTE DPC staff numbers (Figure 2). This suggests any assessment of the impacts of expanding nurse or DPC staff in general practice in GM is not feasible at present.


AVERAGE WORKFORCE ACROSS GREATER MANCHESTER PRACTICES

Legend: GP, NURSE, DPC, ADMIN
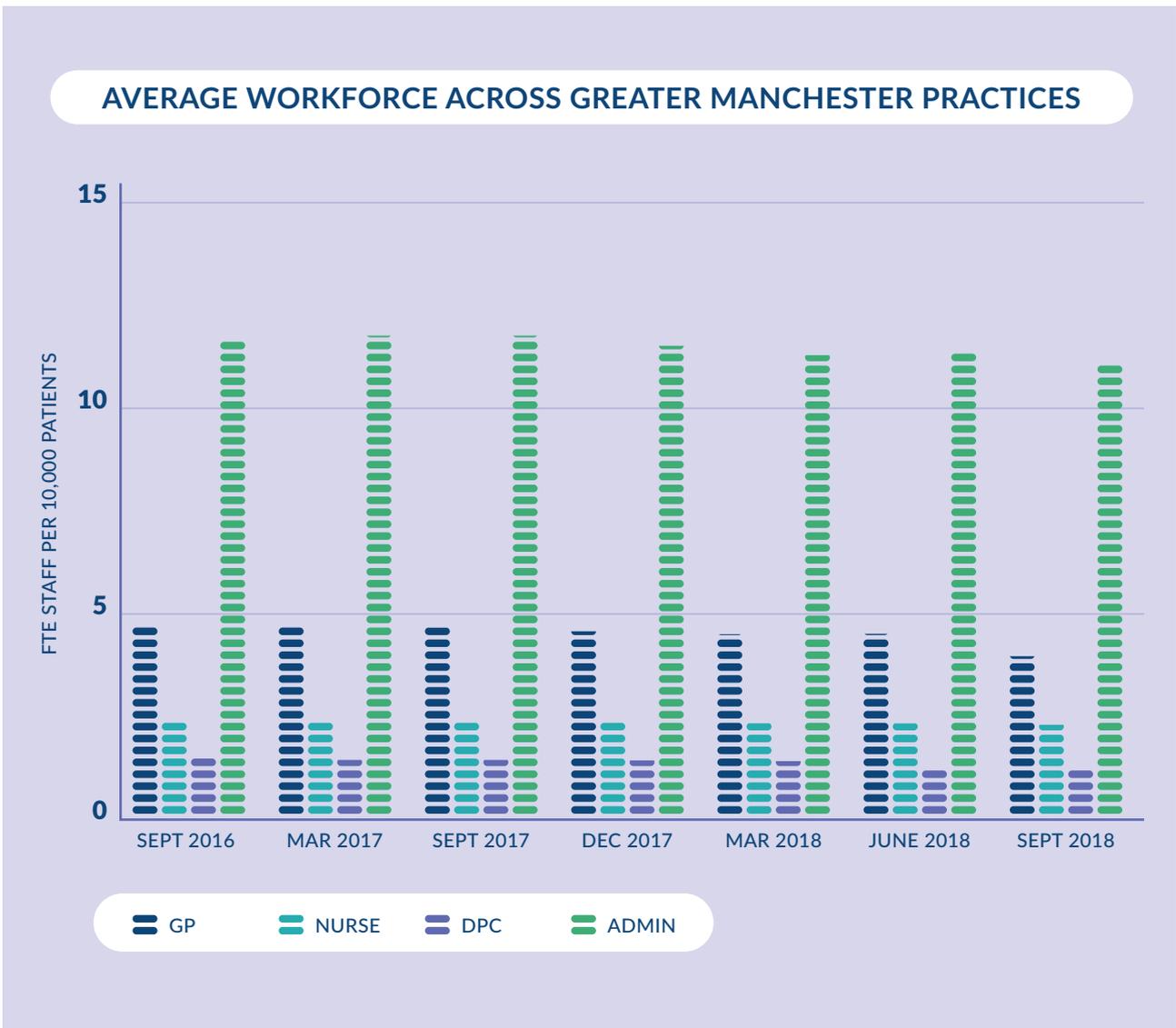
Figure 2 Longitudinal assessment of the general practice workforce over time (September 2016 – September 2018) of 318 practices with complete data on all staff roles in general practice over the period

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There are representativeness issues with any longitudinal assessment using the current data. From June 2018 onwards, the data was presented in such a way that it was now possible to distinguish between a zero headcount for submissions for a staff role and non-disclosure of data. This change is likely to explain some proportion of the increase in completion rate, which rose from approximately 60% of practices in GM in March 2018 to 75% in June 2018. Therefore any longitudinal analysis in the future may need to begin with the June 2018 extract.

Furthermore, the longitudinal assessment was found to be not representative. Some CCGs are underrepresented in the analyses due to missing data. The data may under-represent those practices with patients reporting positive overall experience with their practice, and under-represent practices with greater population need (identified from NHS England primary care weighted populations data).

4.0

IMPLICATIONS

This report has highlighted the following:

1. General and Personal Medical Services, England data gives the most complete picture available of staff employed in general practice in GM, however the data is hampered by incompleteness, and therefore the generalisability of findings is limited. This could lead to misrepresentation of the current workforce in GM and should be considered if the data are used to inform future workforce strategies.

2. There is variation in data completeness across CCGs in GM; this variation is not associated with practice characteristics or CCG-specific factors but is associated with lower patient-reported feedback on overall experience with their practice (which may in turn be associated with practice pressures/capacity). Additional support/input may be required for these practices with incomplete data in order to improve the completion rate.

3. GP FTE appears to not reflect CCG-specific factors, or practice or population differences implying that the variations here may reflect local challenges in recruitment and retention. This may identify practices of relative greater need for recruitment and retention support.

4. We find some evidence that the variations in nurse, DPC and administrative roles are associated with measures of population need (age, deprivation) and also CCG-level factors. Future evaluations may wish to investigate why CCG differences are evident for these roles.

5. Assessment of the impacts of expanding nurse or DPC staff in general practice in GM is not feasible at present, due to the limited variation in staffing numbers over time.

6. There are representativeness issues with any longitudinal assessment using the current data, suggesting any longitudinal analysis in the future may need to begin with the June 2018 extract.

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