Rutland County Council

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Ladies and Gentlemen,

A meeting of the **RUTLAND HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on **Tuesday, 5th December, 2017** commencing at 2.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs
Chief Executive

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6) SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP AND GENERAL PRACTICE FIVE YEAR FORWARD VIEW

LLR – General Practice Workforce Plan

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Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

General Practice Forward View

LLR – General Practice Workforce Plan

Leicester, Leicestershire and Rutland

Sustainability and Transformation Partnership

31st October 2017

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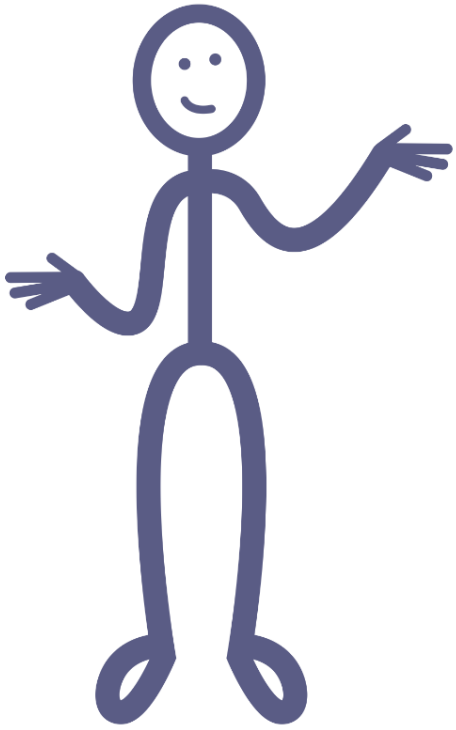

Better care together
Leicester, Leicestershire & Rutland health and social care

LLR General Practice Workforce Plan

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LLR General Practice Workforce Plan

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Chapter 1 - Introduction

General Practice is the foundation of a high performing health care system and as such is critical to the successful implementation of the Leicester, Leicestershire and Rutland (LLR) Sustainability and Transformation Partnership. Ensuring the development and resilience of Primary Care will assist in bringing about the system-wide transformation required to meet current and future patient needs and demographic growth.

In line with the publication of LLR's General Practice 5 Year Forward view strategy in February 2017, we have a clear direction for the future of primary care in which General Practice is the foundation of a strong, vibrant, joined up health and social care system. This system is patient centred, engaging local people who use services, acting as equal partners in planning and commissioning which results in the provision of accessible high quality, safe, needs-based care. This is achieved through expanded but integrated primary and community health care teams, offering a wider range of services with increased access to rapid diagnostic assessment and, crucially, patients taking increased responsibility for their own health.

This development is in a climate of years of relative under-investment in primary medical care. There are significant workforce issues with a 15% drop nationally in the numbers coming into GP training, over 50% of GPs under 50 years of age considering leaving the profession in the next five years, and the move away from partnerships to salaried or locum positions. The recruitment and retention issues affecting GPs are mirrored in the practice nursing workforce, nationally 64% of practice nurses are over 50 with only 35% under 40. Between 2001 and 2011 the number of community nurses fell by 38%, whilst the nursing workforce expanded by 4% in the acute sector and there is a growing reliance on agency staff.

Workforce is recognised as one of the biggest challenges in delivery of on-going operational stability. During 2016 and 2017, the General Practice workforce work stream have undertaken work to develop intelligence about the local challenges for LLR and form a clearer baseline position for the size and shape of the current available workforce. Workforce has been allocated additional programme support by HEEM to support the development and delivery of the key workforce objectives.

The aim of the LLR General Practice Workforce Strategy is to support the recruitment across staff groups where historically the system has struggled, manage the existing workforce flexibly across the system and develop staff to fit into new accredited roles based on a competency and skills framework.

This plan outlines the joint working taking place across LLR, the scale of the issues being faced and some of the solutions to delivering a resilient General Practices workforce. This is a system wide response to a problem facing all 138 of our practices.

This is not going to be an easy task, there are many challenges facing General Practice, including adequate workforce, funding and rising demand. In LLR we will work together to develop and co-design a resilient and sustainable model in which General Practice can thrive.

Chapter 2 - General Practice Workforce - National and Local Context

What will this chapter tell you?

- Overview of the current workforce challenges
- Outline NHS England Strategy for the General Practice workforce
- Understanding of the General Practice landscape within LLR
- An overview of where staff are sourced and local training opportunities
- How the system is working together to find a solution

2.1 National Context

The current national workforce challenges within the NHS and social care are well known. It is anticipated that over two million new workers will need to be recruited and trained into the health and social care sector as the sector grows and current staff retire. This is the equivalent to over half of the existing workforce and presents some key challenges for training and staff retention. (UKES – Sector insights: skills and performance challenges in the health and social care sector. May 2015)

- By 2021 there will be a national shortfall of between 40,000 and 100,000 nurses and there could be 16,000 fewer GPs than are needed
- In 2012, GPs reported lower job satisfaction than at any point in the previous 10 years
- An increasing number of UK-trained doctors, nurses and allied health professionals choose to move abroad
- The ageing population means that by 2025 the national social care workforce will need to increase from 1.6 million to 2.6 million
- The nature of work undertaken by staff is changing. As the population ages, our staff will need to care for more people with complex needs and multiple co-morbidities
- National commitments to better out-of-hospital care (including primary care) have not translated into a combined commissioning and workforce strategy designed to increase the proportion of NHS resources (and staff) going into primary care. The share of NHS resources going into General Practice has, in fact, been declining.
- The significance of long-term conditions - Over 80 per cent of additional demand is driven by increasing healthcare and support needs which are associated with long-term conditions. This relates both to the ageing population and a projected increase in prevalence across age groups.

All of these factors will impact on the demand and supply of the workforce necessary to deliver modern and fit for purpose General Practice

2.1.1 NHS England Strategy for General Practice Workforce.

Across the country, the NHS is facing significant challenges. As life expectancy continues to increase, so does the number of people who will live with one or more long term health conditions that limits their lifestyle. The Department of Health estimates that by 2018, there

will be 2.9 million people with three long-term conditions (from 1.8 million in 2012), and their health care will require £5 billion additional expenditure (Department of Health, 2012). With an estimated 90% of all patient contacts with the NHS occurring in General Practice, these challenges are inevitably being encountered within our practices in Leicester, Leicestershire and Rutland.

In April 2016 NHS England published the General Practice Forward View (GPFV), which commits to an extra £2.4 billion to support General Practice services by 2020/21. NHS England believe that it will improve patient care and access, and by investing in new ways of providing primary care, and is committed to strengthening the General Practice workforce.

NHS England acknowledges that to achieve the vision in the GPFV they need to recruit and retain a strong workforce.

Working with Health Education England (HEE), the Royal College of General Practitioners (RCGP), the British Medical Association (BMA), The Royal College of Nursing (RCN) and Public Health England (PHE) the Government have made the following commitments over the next 5 years;

- Increase the number of doctors in General Practice by a minimum of 5,000 of which 2,000 will be overseas doctors
- Increase the number of other health professionals by at least 5,000:
- 3,000 more mental health therapists including co-location
- 1,000 physician associates in to General Practice
- 1,500 clinical pharmacists
- Increase uptake and promote nursing in General Practice; introduction of a 10point action plan
- 3,250 GP training places
- 250 post-certificate of completion of training (CCT) fellowships
- A range of ways to retain our GPs
- Supporting GPs to return to practice
- General Practice Development Programme
- International GP Recruitment Programme.

By doing this, NHS England believe it will free up GP time to focus on patients with complex needs, as there will be a bigger team of staff providing a wider range of care.

NHS England has allocated £336m and £429m in 2017/18 and 2018/19 respectively to support transformation of the GP Five Year Forward View. In addition to the central programme budget and transformation fund, they also hold separately a Sustainability Fund of £1.8bn to support the financial position of providers. The deployment of this fund is agreed jointly between NHS Improvement, NHS England, the Department of Health and the Treasury. NHS England also holds £260m in capital resource for both 2017/18 and 2018/19 to deliver agreed capital schemes, such as supporting information technology infrastructure and transformation in General Practice. CCGs will receive this funding either directly on a registered population share basis, or for some schemes, such as International Recruitment, they will be required to submit an application supported by a detailed business case.

The regional Director of Commissioning Operations (DCO) offices have appointed dedicated key contacts that lead on the various work streams within the workforce programme.

For the Central Midlands, the GPFV Steering Group has introduced review meetings that will be held with each STP twice a year in October and February, with the purpose of these meetings to monitor progress against the GPFV programme.

2.1.2 Summary – So what does this mean?

The CCGs, together with our partners from across the STP footprint, are working on a number of initiatives from the Five Year Forward View pledge made by NHS England.

By using collaborative approaches such as joint applications for funding, sharing of lessons learnt from colleagues in Central Midlands region, the CCGs have identified a number of schemes that form part of our workforce plan. These are identified in the table below;

Table 1: NHS England Five Year Forward View Initiatives

	Clinical Pharmacists	International Recruitment (IRGP)	Targeted Enhanced Recruitment Scheme (TERS)	National GP Induction and Refresher Scheme	GP Retention Scheme	GP Return to Practice	GP Career Plus	Switching to GP Training	General Practice Nursing	Physician Associates	Mental Health Therapists	General Practice Development Programme
Funding Available	✓	✓	✓	✓	✓	✖	✖	✓	✓	✓	✖	✓
LLR Partaking in scheme	✓	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓	✓

2.2 - Local Context

2.2.1 What we know about our population

It is important to recognise that the starting points and the needs of the population that each CCG serves will require differing approaches which recognises the environment and the local needs and demands. Across the Leicester, Leicestershire and Rutland STP area we have a total population of 1,114,316 with a forecast increase over the next five years of 3.6% for children and young people, 1.7% for adults and 11.1% for older people. The age structure of the area is on par with the national average but there is a variation with Leicester City having a higher population of young people and East Leicestershire and Rutland has more people aged over 50.

Leicester City (LCCCG) has significantly greater levels of deprivation, scoring 18/209 most deprived CCG in England and the added pressure of working with diverse populations with high numbers of people from minority ethnic communities who face both language and cultural barriers in accessing care. In both East Leicestershire and Rutland (ELR CCG) and West Leicestershire (WL CCG), the number of patients over the age of 65, (21% and 19% respectively against a national average of 17%), —where demand significantly increases coupled with the challenge of rurality—creates demand for home visiting.

Analysis of our health data identified the following areas that we need to address

- **Reducing the variation in life expectancy**—in Leicester the average life expectancy is 77.3 years for males and 81.9 years for females and in Rutland it is 81 years for men and 84.7 for women. More variation can be found across the STP footprint, for example in Leicester City the gap between the best and worst life expectancy is 8 years. The difference in life expectancy is complex and is impacted on by deprivation, lifestyle and the wider determinants of health.
- **Reducing the variation in health outcomes**—there is a considerable difference in health outcomes across the STP footprint. For example 43.8% of diabetes patients in Leicester city meet all three of the NICE recommended treatment targets compared to 41.9% of patients in East Leicestershire and Rutland. 66.4% of people with long term conditions in West Leicestershire and 58.5% in Leicester City feel supported to manage their condition.
- **Reducing premature mortality**—premature mortality across the STP footprint is caused by cardiovascular disease, respiratory diseases, cancer and liver disease, the level of premature mortality varies across LLR. More than 50% of the burden of strokes; 65% of CHD; 70% of COPD and 80% of lung cancer are due to behavioural risk and we will tackle this through early detection programmes and preventative public health strategies and programmes. Infant mortality has improved in Leicester with the city now comparable to England as a whole. However the still- birth rate at 6.5 days per 1,000 total births in 2012/14 is higher than the national average of 4.7. A strategy is in place which focuses on targeted work on predisposing factors including prematurity and small-for-date babies.
- **Improving the early detection of cancers and cancer performance—** one year survival rates from all cancers varies across the STP footprint. In Leicester city the rate is 65.9% compared to East Leicestershire and Rutland which is 70.2%. Cancer is also one of the major causes of premature mortality across the STP footprint. Detecting cancers early improves survival rates for example 5 year survival rates for colon cancer.
- **Improving mental health outcomes**—across the STP footprint there is a difference in mental health need. East Leicestershire & Rutland and West Leicestershire CCG areas have high levels of dementia, where Leicester City has high levels of psychosis. All have high levels of depression.
- **Moving from chronic disease management to prevention**—much of the above health outcomes are caused by lifestyle and are preventable; late detection leads to costly chronic disease management.

2.2.2 The Local Landscape – General Practice in LLR

The national picture is mirrored locally with recruitment, retention and workload cited as the key issues affecting the local sustainability of General Practice. As such our plans need both to support our practices in the day to day delivery of core services, and to bring about transformational change.

Across LLR there are 138 GP practices, ranging from single handed practitioners to registered lists of over 38,000 patients.

Table 2: LLR Population and General Medical Services

CCG	Population (As of Sep 17, NHS E)	Number of Practices	Average List size	Contract Split
ELR CCG	329,012	31	10610	GMS 31
WL CCG	387,251	48	8068	GMS 47
				APMS 1
LC CCG	398,053	59	6747	APMS 13
				PMS 1
				GMS 45
Totals	1,114,316	138	8,074	

Significant work has taken place across all three CCGs to support and develop General Practice, but as a system we acknowledge that each of our three CCGs is at different stages which pose challenges to achieve a broadly consistent approach.

LC CCG

A draft primary care strategy in 2016/17 set out the main challenges faced by primary care in the city and the approach to addressing the needs. City practices have come together to form two federations which are fully constituted and CQC registered. These federations cover 32 practices with the remaining practices opting to refrain from federation membership.

One of federations, Millennium Health foundation currently holds the contract for provision of extended primary care access.

Across Leicester federation has secured funding from NHS England to pilot clinical pharmacists.

The city federations continue to work towards identifying opportunities for collaborative working supported by the CCG.

ELR CCG

Within ELR CCG, GP localities have a long standing history of collaborative working and the CCGs Primary Care Strategy entitled “General Practice Operational Framework” was released in 2014 and was co designed with member practices and aligned with the overall LLR model.

During 2015/16 there was recognition across the member practices for the opportunity of an ELR wide GP federation. The federation covers all 31 member practices and is a constituted organisation. The CCG has provided development funding to support the federation and assist in the establishment.

ELR Federation is already providing support to various initiatives including:-

- Supporting development of Integrated Locality teams.

- Supporting joint working amongst practices.
- Supporting the pilot of a Primary Care Home within Rutland.
- ELR Federation is also an active member of the GP Programme Board and taking on delivery of the GP Five Year Forward View.

WL CCG

Since the development of the Primary Medical Care Plan in 2014 which outlined the ambition to develop resilient General Practice, West Leicestershire has been working with member practices and federations to achieve this aim. The primary care team works closely with practices to support with issues of sustainability and has developed a comprehensive offer to practices seeking support. The four localities across WL CCG have a strong and positive history of collaborative working and recognise the local and national challenges facing them and the impact on the viability of General Practice in its current form. All practices are members of one of the federations which are now well established and are providing leadership for integrated care which is central to the CCG's strategy. In addition, the federations are offering support to their member practice to aid continual development of core General Practice and additional services.

To test collaborative arrangements in 2016/17 the four WLCCG federations:

- Led a number of test beds to develop an integrated approach to care homes, Urgent care and inter-practice referrals.
- Actively participated in the development of Integrated Locality leadership teams across the CCG area.
- Successfully won contracts to provide services at scale.

2.2.3 General Practice Workforce

To fully understand the complexity of the General Practice workforce, it is first necessary to understand the roles each member of the team takes in delivery of health care services;

General Practitioners treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care. GPs can have different contractual working relationships. They can be a Partner in the business, Salaried (employed by the practice) or a Locum

General Practice Nurses work in GP surgeries as part of the primary healthcare team. In larger practices, they might be one of several practice nurses sharing duties and responsibilities. In others, they might be working on their own, taking on many roles.

Advanced Nurse Practitioners (ANPs) are nurses who have gained suitable and sound experience in the field of General Practice. Development to become an ANP in General Practice should be supported by appropriate mentorship, supervision, annual appraisal and ongoing appropriate continual clinical practice in this area. This includes relevant audit, reflective practice and research where possible.

Healthcare Assistants (HCAs) work in hospital or community settings, such as GP surgeries, under the guidance of a qualified healthcare professional, usually a Practice Nurse.

Practice Managers work in primary care, where they manage the overall running of General Practices (GP surgeries).The Practice Managers are responsible for the smooth running of a centre that could have a team of ten GPs and other clinical staff, with as many as 20,000 registered patients.

Administrative and Reception a Receptionist is the first person that a patient meets when they go to their GP Practice. Patients and their relatives can often be nervous or upset when they visit the Practice so a Receptionist needs to have excellent customer service skills. As well as dealing with patients face-to-face the reception team combine their role with other administrative duties, e.g. processing repeat prescriptions, dealing with requests from the GPs and scanning hospital correspondence into the patient's electronic records. Care Navigators are part of this team and their duties include sign posting patients internally to the most appropriate member of the Practice team, and externally via the local Directory of Services.

Over last couple of years there has been a number of new roles introduced in General Practice workforce across LLR, these include:

- **Clinical pharmacists** - in GP surgeries resolve day-to-day medicine issues and consult with and treat patients directly. This includes providing help to manage long-term conditions, advising those taking multiple medicines (polypharmacy) and delivering clinical advice about treatments. They will assist with communication across a patient's care pathway, manage medicines shortages by suggesting suitable alternatives where appropriate, and mentor newer pharmacists.
- **Emergency Care Practitioner (ECP)** - is a generic practitioner who combines extended nursing and paramedic skills. The "new" role emerged out of changing workforce initiatives intended to improve staff career opportunities in the National Health Service and ensure that patients' health needs are assessed appropriately.
- **Nursing Associate** - is currently being trialled to help build the capacity and capability of the nursing workforce in England. The role aims to bridge the gap between health and care support workers who have a care certificate, and graduate registered nurses.
- **Physician Associates** - support doctors in the diagnosis and management of patients and work under the supervision of a doctor. They are trained to perform a number of day-to-day tasks including:
- **Medical Assistants** - A member of staff that support doctors in the smooth running of their surgery by handling the routine administration and some basic clinical duties enabling the GP to focus on the patient.

HEE Midlands and East have produced a Primary Care Workforce Report based on information derived from the NHS Digital Primary Care Workforce Tool that collects data from individual practices. This provides a data set that has been used to develop an understanding of the current General Practice workforce and to highlight where the potential challenges and risks might occur. The baseline aims to provide a catalyst for discussions about the future and the actions that need to be taken to ensure a strong and sustainable primary care workforce for the future.

2.2.4 Establishing our current General Practice workforce numbers in LLR

Health Education England, Midlands and East region, have produced a Primary Care Workforce Report based on information derived from the NHS Digital Primary Care Workforce Tool that collects data from individual practices. This provides a data set that has been used to develop an understanding of the current General Practice workforce and to highlight where the potential challenges and risks might occur. The baseline aims to provide a catalyst for discussions about the future and the actions that need to be taken to ensure a strong and sustainable primary care workforce for the future.

LLR, like some other STP footprints in Midlands and East, have actively supplemented the information gathered by NHS Digital with a local collection. Practices have been asked to complete the local tool each quarter in place of the National Tool submission. This will allow changes in workforce numbers and skill-mix to be tracked across LLR on a quarterly basis and allows all stakeholders to view the changing picture across LLR

The data used in this workforce plan was obtained from the 86.2% (119/138) of Practices that completed the local tool (as of 1st October 2017). For the other 19 practices 18 of these submitted data in March 2017. This data has been used to give a 99% response rate.

This data, in line with HEE/ NHS England (NHSE) methodology, has been used to calculate the total number of Whole Time Equivalent (WTE) GPs that we have working within LLR. The NHSE definition of a Whole Time Equivalent (WTE) is 9 sessions. The GP data provided includes GP Partners, salaried GPs and locums. GP registrars have been excluded.

In line with the NHSE methodology, the data shown below does not include any GPs or other healthcare professionals that work in the following areas:

- Urgent Care Centres such as Loughborough
- The Out of Hours service
- Walk in Centres such as Oadby
- City Hubs
- Home Visiting Service (GPs and ECPs)

Table 3: Staffing Numbers and WTE in LLR

	Total GPs (excluding Registrars)	WTE GPs (excluding Registrars)	Total Nurses	WTE Nurses	Total Other Clinical	WTE Other Clinical	Total Admin/Non Clinical	WTE Admin/Non Clinical	Total Staff	Total WTEs
EAST LEICESTERSHIRE AND RUTLAND	255	176	135	92	154	107	690	505	1234	880
LEICESTER CITY	240	174	112	75	124	78	621	480	1097	807
WEST LEICESTERSHIRE	261	192	130	88	154	100	875	607	1420	987
LLR STP Total	756	542	377	256	432	284	2186	1,592	3751	2674

This workforce data is in the context of the national target for WTE GPs set by NHSE in September 2017 of 639 by September 2020 based on LLRs share of the nationally promised 5000 additional GPs.

Table 4: WTE GPs in LLR from Sept 2015 Baseline to Oct 2017 against the NHSE target by 2020

STP	Sep 15 WTE GPs	Mar 17 WTE GPs	Oct 17 WTE GPs	NHSE Target by 2020	Target (WTE per 1000 population)
LEICESTER, LEICESTERSHIRE AND RUTLAND	563	565	541	639	0.58

2.2.5 Extended Primary Care Access Model and Workforce

The workforce numbers and the target set by NHSE only include those staff working for one of the 138 GP Practices within LLR. This does not reflect the entire workforce providing primary care services to our patient population.

There are significant additional commissioned services that account for numerous staff and appointments available for patients to access. Details can be found in the following table:-

Table 5: Commissioned services for additional primary care service provision across LLR

CCG	Contract Type	Service Offer	Location	Access	Hours of Operation
ELR CCG	DES	Extended Access 29/31 practices = additional 165 hours per week	GP Surgery	Prebookable	Morning/Evening/ Weekend
	CBS	Minor Injuries Service 31/31 practices	GP Surgery and Harborough and Rutland hospitals	Walk in/ Prebookable	8.30-5 Mon-Fri
	NHS Contract	Home Visiting Service	Mobile Visiting	Referral via GP/ Care Home	Weekday 9-4
	NHS Contract	Urgent Care-Minor Injuries and Ailments	St Luke's Hospital at Market Harborough, Rutland Memorial Hospital in Oakham, Melton Mowbray Hospital, Oadby	Walk in and prebookable via NHS 111	Harborough/Rutland/Melton ser vice 5-9 pm Weekdays. Oadby 8 am - 9pm weekdays and 8am -8pm weekends and bank holidays.
CCG	**Contract Type**	**Service Offer**	**Location**	**Access**	**Hours of Operation**
LC CCG	CBS	Extended Hours 42/ 59 Practices 153 addi- tional hours	GP Surgery	Prebookable	Morning/Evening/ Weekend
	CBS	Quality Contract 29/59 practices offer 90 Clinical appointments per 100 population	GP Surgery	Prebookable	Core GP Hours
	CBS	PMC Fund—3x Primary Care Hubs offering core primary care 1481 additional appointments per week	3 Hubs across the City	Prebookable	1. 8–8 7 days . 2. Monday–Friday 6.30pm-10pm Weekend 12- 8pm
	CBS	Crisis Response Team	Mobile Visiting	Referral via GP/ Care Home	8am-8pm 7 /7
	NHS Contract	Walk In/ Urgent Care	Merlyn Vaz centre	Walk in	8am-8pm 7 /7
CCG	**Contract Type**	**Service Offer**	**Location**	**Access**	**Hours of Operation**
WL CCG	DES	Exteneded Hours 21/48 practices 112 Hours per week	GP Surgery	Prebookable	Morning/Evening/ Weekend
	CBS	Minor Injuries Service 48/48 practices	GP Surgery	Walk in	Core GP Hours
	CBS	Home Visiting Service	Mobile Visiting	Referral by GP/ care Home and patient "passport" at weekends	Weekdays 9-5 Weekends and bank holidays 8am-7pm
	NHS Contract	Urgent Care Centre	Loughborough Hospital	Walk in and prebookable via NHS111	24 hours 7 days
	NHS Contract	Out Of Hours Base visit	Hinckley and Bosworth District Hospital	Prebookable	Weekdays 7pm- 12am

This clearly illustrates that the system has a workforce delivering significant additional capacity for the patients of LLR. These numbers should be taken into consideration when analysing the LLR numbers. The only concern is that these are often the same clinical staff that provides the Core General Practice services

2.3 Sourcing and developing the workforce

There are a number of recruitment channels in to General Practice that range from the established routes such as local medical schools/undergraduate schemes, to more innovative routes such as work experience placements.

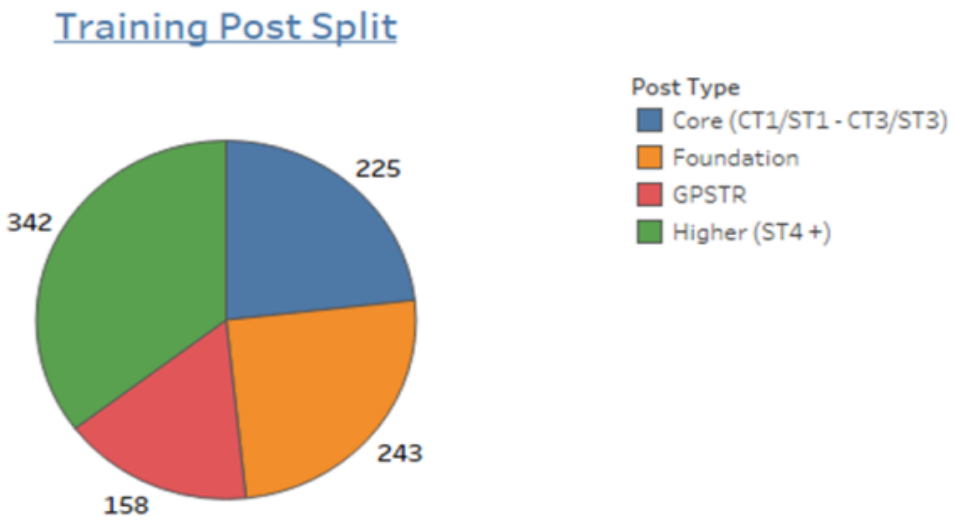
Traditionally practices have nurtured their reception staff in to roles such as Health Care Assistants and Practice Managers, however, in recent years there has been a move towards recruiting candidates from the private sector that bring with them skills and experience from a corporate setting.

In LLR we have excellent links with local universities as well as HEE Midlands and East, developing local initiatives such as the Physician Associate programme offered at De Montfort University. Locally our partners offer training routes for both under graduate and post graduate education.

General Practitioners

- University of Leicester Medical School – Undergraduate
- GP Speciality Training (GPST) HEE (East Midlands Post Graduate Medical Education)

Figure 1: LLR medical training posts split by head count at July 2017



Practice Nurses

- Leicester School of Nursing and Midwifery- De Montfort University
- Return to Practice (Nurses and AHPs) programme- University of Derby, University of Northampton and University of Lincoln that enables nurses who have left the profession to re-enter and gain their nursing registration". This is run in partnership with three universities across the East Midlands- University of Derby, University of Northampton, University of Lincoln

Table 6: Active number of nursing students in LLR at June 2017

Active Students By Year	Course End Date				
Course Title 2	**2017**	**2018**	**2019**	**2020**	**Grand Total**
Nursing Adult	789	1025	1167	30	3011
Nursing Child	79	120	122		321
Nursing Dual Reg	7	2	4	1	14
Nursing Learning Disabilities	49	48	41		138
Grand Total	924	1195	1334	31	3484

Pharmacists

- Leicester School of Pharmacy- De Montfort University

Other (Physician Associate / ECPs

- Physician Associate, University of Worcester and De Montfort University (as of Sept 17)
- Emergency Care Practitioners (ECPs) undergraduate paramedic course- University of Northampton

In the last few years we have seen an increase in apprenticeships in LLR. These are available for both clinical and non-clinical posts, and are offered by practices within each of the 3 CCGs.

We believe that there are two major factors for us to continue to source and develop the LLR workforce. These key dependencies are:

1. Maintaining, and increasing, the number of high quality initial training placements in primary care.
2. Through continuing to invest funding that will enable us to develop the central skills training hub.

We will need to invest and support our existing training practices, whilst pro-actively promoting new practices in becoming training practices in their own right, or by working with one of the training hubs. Working with HEE, we will pro-actively promote the opportunity of becoming a GP trainer with our GPs across LLR, either for their own practice or as part of one of the training academies.

2.3.1 What the local training offer looks like?

Although a significant proportion of the current training and development within LLR is provided through formal channels, there is a well-established local network of training and education that supports the LLR General Practice workforce

CEPNs and Training Hubs

Each of the CCGs in 2015 LLR set up a Training Hub, and we firmly believe that these are instrumental in helping to train the workforce of the future. With a joint vision to provide an educational environment that fosters inter-professional learning between students of different disciplines and deliver enhanced networks of personalised care, our 3 hubs in LLR are;

- The Academy East Leicestershire and Rutland CCG

- Fantastic Foxes Leicester City CCG
- The Hub West Leicestershire

In their first year the key area of focus has been on achieving Academy status with Leicester University Medical School, Kings College London, University College London and Nottingham University to teach undergraduate medical students. This has facilitated the rolling out Inter-professional Education and Training for both Medical (including Physician Associates) and Pharmacy student placements, as well as developing an infrastructure for nursing student placements in primary care.

Some of the key areas that the training hubs are working for 2017-2019 are;

- Second intake of Nottingham Medical Students
- Placements for Pharmacy students (these will take place in Feb 2018)
- Year 10 work experience placements via HEE
- 2nd cohort placement of Physician's Associates
- Agreement with the University of Derby for nursing student placements in LLR.
- Provide placements for student nurses focusing on Frailty and return to work schemes.

Nurse Training

Experienced nurses are increasingly scarce and there is a regular movement across the workforce, and factors such as financial pressures, changing priorities and an ageing GPN workforce dictate that consideration needs to be paid to how GPN education is managed in the future. NHS England's recently published 'A ten point action plan for General Practice Nursing' encourages non-reliance on traditional solutions when considering the challenges in recruiting and retaining a GPN workforce that is fit for the future.

Working with HEE we have established 5 part-funded, county based GPN Fellowship posts. They offer a route into General Practice nursing for nurses new to the field. They support employers by offering additional funding so a new nurse can be employed before an experienced nurse has left a vacant post. They also offer significant development opportunities within the nursing community amongst those who want to make the transition to General Practice nursing. In addition, GPN Fellows will impact their local areas by working on a HEE project for 1 day a week.

In addition, on 30 January 2017 our 2 year Nursing Associate Pilot commenced. This was developed by working in partnership with University Hospitals Leicester, Leicestershire Partnership Trust and LOROS and the CCGs. In LLR we have 4 Trainee Nursing Associates from Primary Care.

In addition to this, the Nurse Learning Beyond Registration (LBR) programme has been introduced, funding Practice Nurses within LLR, who are eligible to apply for modules that are part of the LBR contact which is funded by HEE regionally. The number of nurses that have accessed this training in 2016/17 was 11 and currently in 2017/18 we have assessed 5 further applications.

Primary Care Training

In addition to the training hubs, the CCGs commission through the LLR Primary Care Training department a bespoke local training and support service to practices across the STP footprint in LLR. The training package offered, and accessed by all 138 member practices in LLR, provides a training programme for all practice employed staff.

All courses are defined as either mandatory such as clinical updates or non-mandatory, and are designed to assist with an individuals' personal and professional development. Courses are offered in either a class room based environment or via an e-learning via an external provider called Bluestream, reducing the need for staff attending off-site training.

The Training department also organises annual conferences which are well attended for the following groups; Practice Nurses, Healthcare Assistants, Practice Managers and Assistant Practice Managers.

Practice Managers and Administration

We recognise that Practice managers play a key role in supporting the day to day delivery of primary medical care services and are important in system wide work to transform how care is delivered, and this is why we have establish a Practice Managers Academy. The initial focus on the academy has been to establish a practice manager induction programme, appraisal process and mentoring scheme.

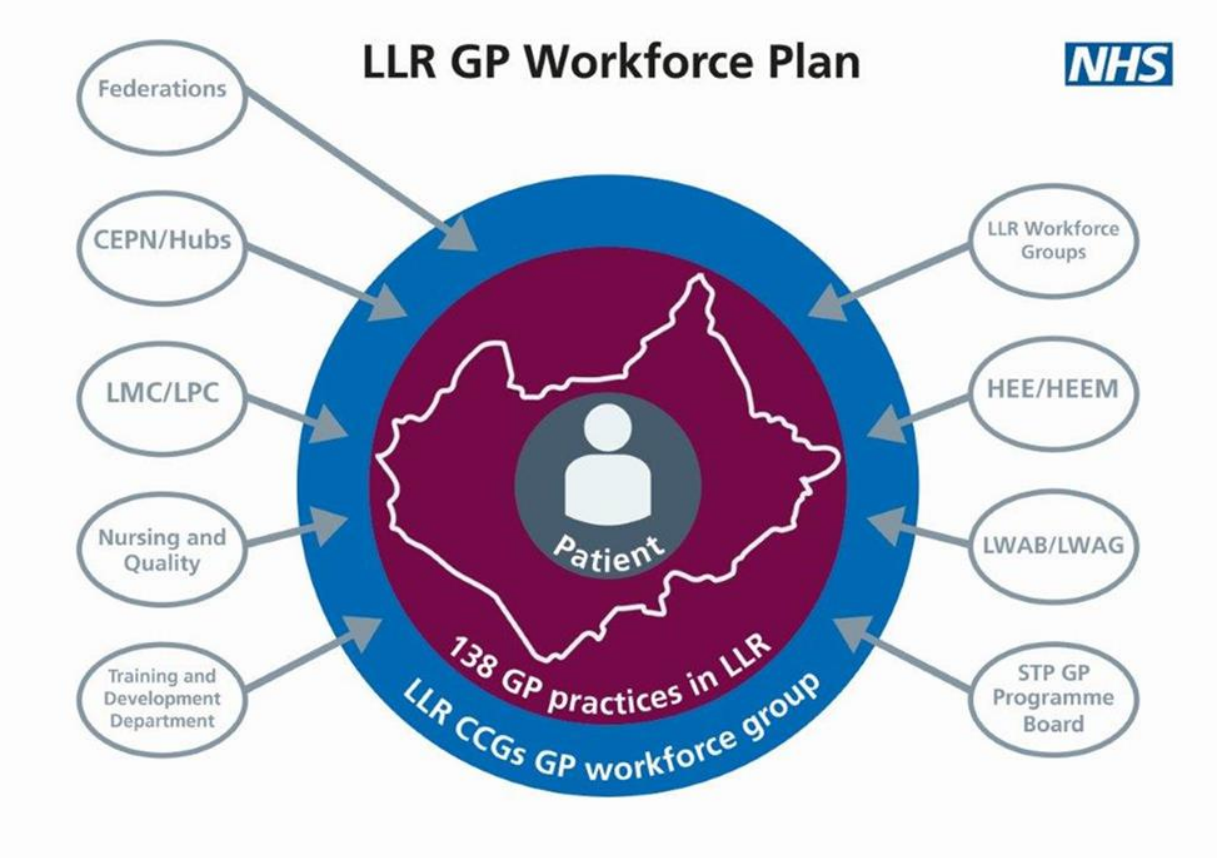
Working with local training and education providers there are two types of apprenticeships in place; new recruits 16 years to 24 years old and existing employees. These are for Administration, Healthcare Assistants, and Practice Managers.

2.4 Our Joint approach to workforce delivery

Whilst we are three separate CCGs we are committed to working collaboratively as a single STP footprint. We have jointly risen to the challenge of delivering the Five Year Forward View, and our LLR workforce plan is fundamental to the delivery of this strategy.

The General Practice Workforce group has been established for nearly two years and has a core membership, including GPs, Nurses, Practice Managers, HEEM, HEE, NHSE, Federations and the LMC. This group has a very clear focus to meet the workforce needs of the General Practice system in order to meet the current and future needs of our patients. This group does not sit in isolation; its specialised support comes from the key LLR workforce groups that together feed into the Local Workforce Actions Board (LWAB) and the STP Leadership group.

Figure 2: Stakeholders involved with the LLR GP Workforce Plan



2.5 System Workforce Challenges

The local picture mirrors the national evidence of significantly lower growth in GPs compared to hospital consultants in the last decade. This creates a shortage of GPs compounded by substantial difficulties with recruitment, both of qualified GPs and GP trainees, with local training places unfilled. In parallel to national research there are fewer GPs working full-time in patient- facing General Practice, some working full-time but taking on other responsibilities, including roles in Clinical Commissioning Groups (CCGs); management tasks in their own practice or in a wider federation.

The local data analysis shows that there are real pressures on workload and demand for services in each of the three CCGs within LLR, but often for very different reasons. Leicester City has significantly greater levels of deprivation, scoring 18/209 most deprived CCG in England and the added pressure of working with diverse populations with high numbers of people from minority ethnic communities who face both language and cultural barriers in accessing care. In both ELR and WL CCGs, the number of patients over the age of 65, (21% and 19% respectively against a national average of 17%),—where demand significantly increases coupled with the challenge of rurality—creates demand for home visiting.

There are also vast differences in numbers of GPs and other health professionals per 1000 registered patients. This is partly down to historical funding, but also the challenge of recruitment in inner city and more deprived areas. This is compounded by the age

demographic of both GPs and nurses, where a significant proportion will be retiring in the next 5-10 years, often in areas that are already under doctored.

Practices are finding it increasingly difficult to recruit and retain GPs. Some GPs reaching the end of their careers are choosing to retire early in response to workload pressures. There are also many older GPs who have been affected by changes to the tax treatment of pensions which create disincentives to work when the lifetime allowance for pensions has been reached. Fewer GPs are choosing to undertake full-time clinical work, with more opting for portfolio careers or working part-time. This is true for both male and female GPs. Trainee GPs are often planning to work on a salaried basis or as a locum. This continues a long term trend in which fewer doctors aspire to become partners.

There are challenges too with recruitment and retention of other members of the primary care team, particularly practice nurses and practice managers.

This makes it difficult for some of the work of GPs to be taken on by other staff and therefore support change of clinical delivery model.

It is clear from the workforce data available that there are current gaps in numbers of GPs required and both the number of and skill mix of other health professionals. To deliver new models of care will require additional recruitment, especially if groups of practices, federations or MCPs undertake extra services to support the left shift of work from secondary to primary care, which may also require the transfer of staff across settings.

There are specific challenges that are impacting on the system which will require mitigations. Many of these are nationwide, but a local plan will be necessary to support our providers of General Practice services.

- Recruitment: There are fewer trainees in the system who wish to become salaried GPs or partners. This move towards locum posts is driving market forces. Locum rates are rising disproportionately and the flexibility these roles offer are appealing to newly qualified GPs. There are fewer employees to take on the workload and therefore the spiral of more work to fewer people drives more to become locum doctors.
- Career Framework: For GPs there are few opportunities to have a diverse career, due to the way practices deliver care and demands from patients. The prospect of undertaking 8 or 9 clinical sessions every week, is less appealing and often GPs are reducing clinical sessions, leaving capacity gaps.
- For nurses a different issue arises, the lack of career progression and/or training opportunities as a practice nurse has made the profession less popular and has led to gaps in capacity.
- Workload: Demand from patients, either due to complex needs or expectations has meant that there is greater pressure than ever on General Practice capacity. This demand is also created by a system that passes work directly or indirectly to General Practice as a fall back. This can be seen through hand-offs from Community and Secondary Care and the pressures are leading to calls from GPs and the LMC that the service is becoming unsafe.
- Finance: Although the 2004 GMS contact added significant budgets to General Practice, since this point there has been little or no growth in funding and pressures

have increased due to need for more staff to meet demand, growth in indemnity costs and running costs. This has seen reduced incomes and lower numbers of partners managing the primary care business.

In response to these challenges being faced in LLR, there needs to be a concerted focus on creating a working environment where General Practice is considered as an attractive choice, due to the opportunities it gives for a varied and balanced career. This will only be possible, with investment, changes in workload and new models of delivery that meet both patients and staff needs.

What have we learnt?

- A clear understanding of the local workforce and patient demography
- Where the CCGs have developed local initiatives to support workforce recruitment and training
- The current system challenges and risks for LLR workforce

Chapter 3 - Vision for General Practice Workforce

What will this chapter tell you?

- Outlines a vision and proposed model for General Practice in LLR
- Outlines local examples of new models of care being delivered
- Runs through how workforce and skill mix could change based upon innovation delivery tool
- Shows the efficiencies from working collaboratively
- Illustrates the broader system change to delivere sustainability
- Outlines how staff will be sourced
- Highlights the O.D and leadership offer

3.1. Our Vision

Our proposed model keeps General Practice and the primary healthcare team as the core unit of care, with the individual practice patient lists retained as the foundation of care. However, while a large proportion of care will remain with a patient's own practice, an increasing proportion will be provided by practices coming together to collaborate in networks or federations using their expertise, sharing premises, staff and resources to deliver care for and on behalf of each other. In this way it will be possible to improve access and provide an extended range of service to our patients, as well as creating an environment that attracts doctors and other health professionals into a career in primary health care.

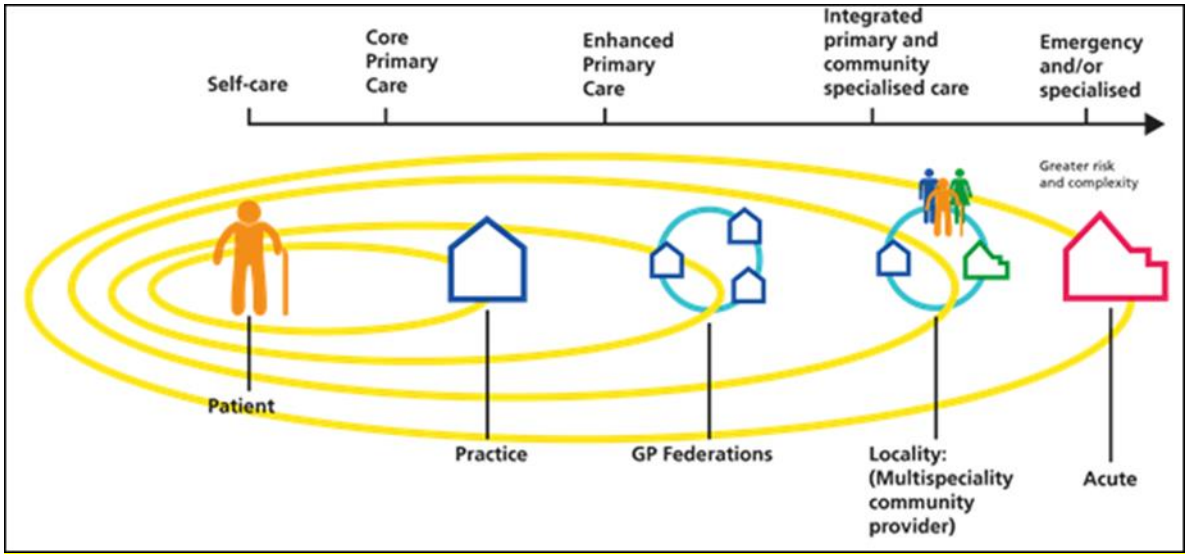
We believe that the vast majority of health problems— including mental health issues—could be dealt with by primary and community care. We have not yet fully realised the potential of General Practice, so too often patients receive care in hospital that could be safely provided in the community, coordinated through their General Practice, and supported by the wider health and social care teams.

3.2 The Future Model

Our model is based on the GP as expert clinical generalist working in the community, with General Practice being the locus of control, ensuring the effective co-ordination of care. The GP has a pivotal role in tackling co- morbidity and health inequalities but increasingly they will work with specialist co-located in primary and community settings, supported by Community providers and social care to create integrated out of hospital care.

Our model places the patient and their General Practice at the centre of provision, extending the care and support that can be delivered in community settings through multidisciplinary working. The aim is to reduce the amount delivered in acute settings, so that only care that should/must be delivered in the acute setting will take place there in the future. This is illustrated in the diagram below.

Figure 3: The LLR Model



To achieve this, the changes will mean that primary medical care will be more integrated and federated with patients co-designing services and taking increased responsibility for their own health. This new system will be patient-centered, providing accessible high quality needs-based care. This is achieved through expanded but integrated primary and community teams offering a wider range of services in the community with increased access to rapid diagnostics assessment and co-located specialists. This will require a shift of resources from the acute sector, investment in facilities and a greater role for nurses, pharmacists and health care assistants.

It is often hard for this message to be translated, as change is not always seen as improvement, but cuts or reductions. The proposed model does suggest change, but aims to improve integration and collaboration and ensure that patients are treated in the right place, first time. This could mean that practices deliver care in a different way or patients are treated in a different setting, but fundamental to this is that it has to be a joint approach and a shared vision

With any change, there is fear that it is top down and imposed, rather than holistic and incremental. The aim of any change is to make improvements in service quality and outcomes as well as ensuring a sustainable model for the future. For this to be successful there have to be benefits for practices, patients and the system.

Figure 4: Benefits of the new models of care

3.3 What this could mean for General Practice

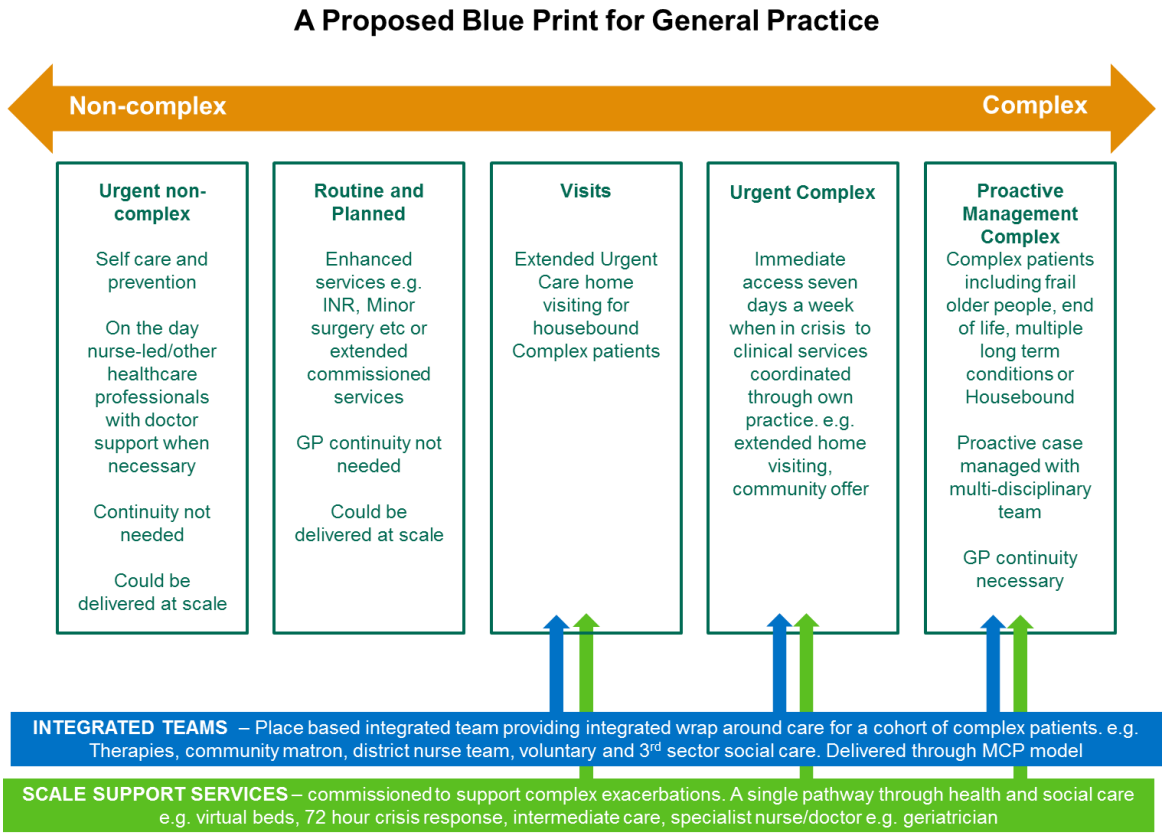
The evidence of demand, patient disease-profile, and expectation, shows that the reasonable needs of patients have changed since the contract was issued in 2004. All practices need to provide a level of urgent primary care access as well as planned services and should support patients in self- care management as well as accessing other appropriate health services, such as pharmacy or when really necessary, urgent or emergency care.

To meet the reasonable needs of patients, now and in the future, the model of delivery will need to adapt. This adaptation is based around patient need and seeing the right health care professional for their condition.

The evidence shows that patients with complex needs, whether this is LTC, mental health or frailty, require a coordinated package of care that will require care planning, regular pro-active interventions and support. This continuous care is best provided by a multi-disciplinary team with the GP acting as the designated accountable care coordinator for the most complex or vulnerable patients. This level of service utilises a GPs skills to best effect and patients will be streamed accordingly. All other patients will have access either on the day or pre-booked to another appropriate health professional with GP oversight.

The proposed blueprint below shows a model of how General Practice could manage patients according to need, supported by community services. Care is not necessarily delivered by a GP but by a nurse, pharmacist, nurse practitioner or emergency care practitioner according to need.

Figure 5: Proposed blue print for General Practice



3.3.1 Progress towards new models in LLR

The changes in models of care, the shortages of staff and momentum from the GPFV have prompted many practices, both nationally and locally, to think through how they might collaborate and work with others for the benefit of the localities they serve. Initially this has been about working with other practices but ultimately it will also be collaboration with others providing care in the community in order to deliver services through the new integrated care teams. It is clear that no one size will fit all and that practices need to develop these partnerships for themselves otherwise they will be destined to fail. It is also clear that there will remain four 'units' of collaboration - Practice, Joint Practices, Localities and Federations.

However, we have been providing guidance and support, highlighting those areas where 'place based' collaborative care is really beginning to make a difference. Below are examples of what we have been doing locally:

Rutland Primary Care Home Model

This model brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for the local community. Staff come together as a complete care community and are drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector, to focus on local population needs and provide care closer to patients' homes.

Primary care home shares some of the features of the multispecialty community provider (MCP) with its focus is on a smaller population enabling primary care transformation to happen at a fast pace, either on its own or as a foundation for larger models.

For Rutland, the Primary Care Home model covers 4 Practices with a total patient population of 36,000. Through true integration of a multi-disciplinary workforce there has been improved access to effective local health and social care, initially focusing on the frail elderly and those with chronic conditions. This has also led to improved opportunities for innovation both in clinical care and use of technology. Feedback from both patients and staff has been extremely positive.

West Leicester Federations
The federations have led on a number of test beds to develop an integrated approach to care homes, urgent care and inter-practice referrals. The largest initiative undertaken has been the federations working collaboratively together as one to create 'Four Fed'. As the unified 'Four Fed' and working in conjunction with Derbyshire Health United, this unity model is delivering urgent care services across West Leicestershire.

Individual Federations are working with their Integrated Locality Teams to support the establishment of the locality teams and implementation of the area test beds. These test beds include looking at multidisciplinary team (MDT) case reviews and new and efficient ways of holding an MDT by utilising new technology call solutions.

In addition, through federations, practices are working collaboratively to provide inter practice referrals such as joint injections and Coils and Implants. This new way of joint working enables practices to share access to their specialist services providing care closer to home in a timely manner for the local population.

Leicester City Health Care Hubs
Millennium Health Federation successfully bid for, and was awarded, £3.2million of funding under wave 2 of the Prime Minister's Access Fund. Under this the federation has delivered a number of healthcare hubs across multiple locations in the city. The healthcare hubs provide additional core services for patients, on top of the care GP practices can provide themselves. The three healthcare hubs in Leicester City have continued to have a positive impact on patients' ability to get a convenient GP appointment in 2016/17.

From the 1st October a fourth Healthcare Hub opened in Leicester City, to replace the walk-in centre at Merlyn Vaz Health and Social Care Centre. The service complements the three existing hubs in the city.

All hub appointments are available for the same day and up to 48 hours in advance, these can be booked by the patient directly with the hub via a dedicated healthcare hub phone number, via their GP practice or by calling NHS 111. The hubs provide an extra 2,350 appointments each week, on top of what is already available through GP practices locally.

3.3.2 General Practice workforce implications of the new models

Adapting to workforce shortages and finding alternative clinical pathways for patients is not a new phenomenon in LLR. There are multiple examples of how practices have trained ANPs, employed ECPs or Pharmacists to meet patient's needs when GPs have not been available. This use of alternative skills has often been welcomed by patients and has enabled practices to continue to deliver services. Building on this and the national initiatives for the development of role substitution, the LLR GP Workforce Group has decided to support three workforce explorer sites to undertake a detailed analysis of where the future skill mix and capacity could be managed through practices working at scale. This work is being facilitated

by Whole Systems Partnership (WSP), an organisation that nationally has been undertaking this type of modeling to define where skill mix needs to changes to deliver patient needs.

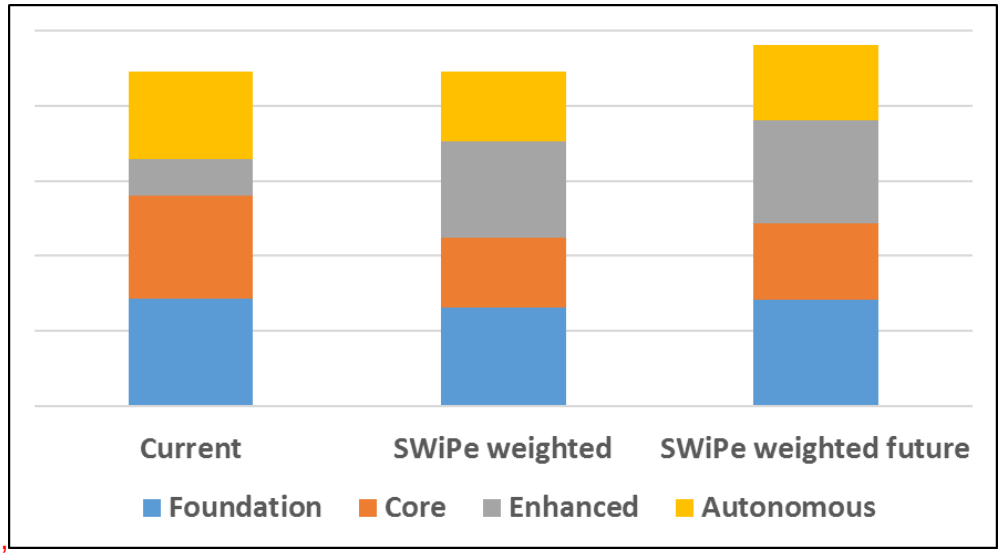
Using the ***SWiPe* framework (Strategic Workforce Integrated Planning and Evaluation),** which combines data sourcing with system dynamics modelling; The framework provides a vision of the future skill mix based on four broad skill levels which are not profession or pay band specific.

Table 7: Skills Definitions for GP Workforce

Group	Description
Autonomous	Knowledge across a range of work procedures underpinned by advanced theoretical knowledge acquired through extended formal education and training and practical experience. E.g. GPs, ANPs
Enhanced	Understanding of a range of work procedures and practices that require a higher level of theoretical knowledge and practical experience normally acquired through formal training or equivalent experience and applied in a specific area of need such as a single health condition. E.g. Specialist Nurses
Core	An understanding and knowledge of work procedures that requires a level of theoretical knowledge normally acquired through formal training or equivalent experience. E.g. Practice Nurses
Foundation	This level of skill requires staff to have an understanding and awareness of work procedures which staff would be expected to have after induction and on the job training. E.g. Receptions

This framework has been tried and tested in a range of environments and care pathways but of particular interest was its initial use in General Practice which arrived at a clear plan for developing the skills and competencies needed for the future. A local example of where this model has been used to model the future needs of patients is the Vanguard site of Lakeside surgery in Corby (Northamptonshire). The analysis showed that the future model did not need to be so GP-centric, but did require a significant programme of training to enable staff to take on greater responsibility. The output of this can be seen in the following Graph, whereby the initial bar is the skill mix they have at present, the second if the was a change to their optimum skill mix and finally the effect of demographic change over five years

Graph 1: Lakeside Surgery, Corby: staff modelling



The Workforce Explorer sites in LLR build on the work in Corby as they are all sites where one or more practices are working together and were chosen to illustrate the three different models of collaboration;

- Rutland – a collaboration of four practices working in a rural location with a widespread locality
- City – two practices working closely together within a City environment
- North West Leicester – a GP federation of 13 practices working together

All three sites have now completed their initial workshop where a cross section of staff has come together to examine:

- 'Who do we care for?'
- 'What care will be needed?'
- 'Who will provide care?'

This output will be combined with the activity and workforce data which is now being collected and then modelled.

The second workshops in each site will give an opportunity to confirm and challenge the future vision but more importantly to come 'down from the helicopter' and begin to plan how it might be achieved across the practices. This will gives the opportunity to consider the roles that would best deliver the care provision by each skill.

The outcome of this work will be shared across LLR and will support the continued and ongoing development of this workforce plan to influence the system to ensure that there are adequate training placements available and practices are able to evolve their models where necessary

3.3.3 Organisational Efficiencies/enablers for General Practice

A key way to addressing the workforce challenges is for practices to explore new ways of working together at scale to make best use of a broader range of health, social care and third sector professionals / multi-disciplinary team to meet patients' needs in the right place and at the right time and enable GPs to manage the most complex patients and co-ordinate the care for their patient population. By working together more effectively, practices will also be able to contribute to the provision of place-based integrated community and primary care.

New models, including streaming of patients and provision through federations and local integrated teams, will bring together groups of existing and new health professionals to meet the future needs of patients covering larger geographical areas. By working together practices will deliver improved organizational efficiency and make more effective use of existing resources to ensure that practices are sustainable in the long term. They will also be able to create more attractive, flexible and diverse career, training and employment options and greater flexibility in succession planning.

Clearly, there is not one model of joint working that fits all circumstances, so we have developed a toolkit to help practices determine the most effective ways of working at scale to address the sustainability and resilience challenges they face. Drawing on national and local best practice, the toolkit provides guidance, tools and templates to enable practices to come together, either formally or informally, to transform their working arrangements to meet patients' needs at scale.

The toolkit provides resilience assessment and option appraisal tools to help practices assess and prioritise which areas of their operation need focussing on and where joint working could assist, as well as a business plan template to enable the development of robust and effective plans.

Opportunities for joint working include;

- Hub and spoke working, e.g., joint provision of acute on the day access
- Inter-practice referrals; e.g. family planning, minor surgery.
- Provision of a joint home visiting service
- Shared specialist staff; e.g. diabetes and respiratory nurses
- Shared back-office functions such as stock ordering, centralised booking

The toolkit includes guidance, tools and templates that cover;

- Joint working between practices – either informally or through a contract mechanism
- Mergers between practices
- Opportunities for working with Federations
- Multispecialty Community Provider (MCP) new care model and contract issues
- Primary Care Home model

The Federations in LLR play a key role in enabling practices to identify opportunities and realising the benefits of at scale working. As such, with the assistance of the federations, the toolkit will be used to stimulate, enable and support joint working between practices to

improve organisational efficiency. The toolkit will be further developed as we work pro-actively with practices and identify areas where further guidance is required.

3.4 Joint Working Models in LLR

Having focussed on how General Practice will need to re-model or adapt to deliver the services that patients need, it needs to be recognised that this cannot be done in isolation. With General Practice at the centre of co-ordinating and delivering patient care, there needs to be a continued development of those services surrounding the patient delivered in the community.

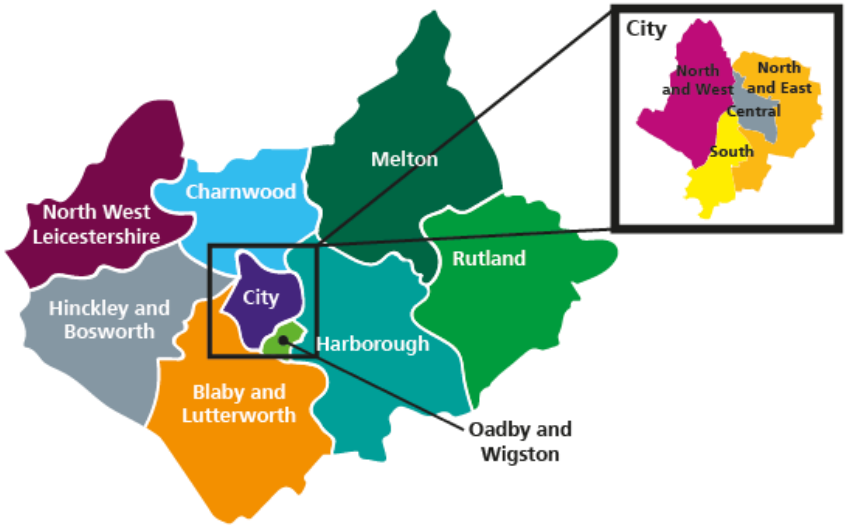
3.4.1 Integrated locality teams

Across our practices in LLR we have a strong sense of locality, promoting with our partners the concept of place-based care.

All our 138 practices are active members of 11 geographical localities which have existed for many years. These localities are headed up by GP clinical locality leads who sit on the governing bodies of the three CCGs.

Our localities are the unit at which we actively engage with General Practice co-designing pathways and services to improve patient outcomes and the quality of care delivered. They are increasingly the unit at which care is commissioned, coordinated and provided and are forming the basis on which our member practices collaborate with each other and the wider health and social care teams. These localities are often subdivided further into smaller geographical units bringing together practices and teams covering a population of 40-60,000.

Figure 6: Map of LLR localities



Cementing the localities as the key unit of primary care service provision and delivery has enabled the wider system to, wherever possible, build on this same footprint to deliver wider

community services. Both planned and urgent care provision across LLR is now centered around hubs aligned with our GP localities.

In taking our model forward we have reached consensus from our three CCGs on the direction of travel, and from our partners on the form and function of integrated locality teams. As part of the implementation structure of the Sustainability and Transformation Partnership, we have established two key programme boards that will drive implementation of our model.

Our LLR Integrated Teams Programme Board has built on the current locality structures aligning our community and social care teams on the same geographical footprint. We have established 11 locality leadership teams each of which is led by a Board GP and Commissioning Manager, with membership from our federations, adult social care and LPT community services. Their purpose is to:

- Develop a deep understanding of the needs of the initial cohorts identified across organisational boundaries, service users and datasets
- Identify how care and support varies, why it varies and how these differences can be addressed
- Define new ways of working and support staff to change their practice
- Undertake some initial test of new ways to deliver care
- Plan how the new ways of working can be rolled out across all eleven localities in 17/18.

This will enable the full integration of our practices with our community and social care teams to support out of hospital care. Through this we are shaping services with our practices, patients, partners and communities that are coordinated and integrated at a locality level to meet their needs. The locality leadership teams will work ‘as one’, being jointly accountable for the care of their identified population

3.4.2 Interdependencies with other transformational programmes in LLR

In order to develop our model, the General Practice Programme Board are working closely with other leaders and teams in the LLR health and care system who are responsible for related redesign work that builds both the generic and specialist offer in the community to support General Practice.

The approach in each of the related programmes is again centered on place- based pathways and systems of care which wrap around the patient and their General Practice, delivered through locally based health and care teams.

These are:

The LLR Prevention Programme—supporting patients to manage their own conditions and preventing illness through healthy living

The LLR Integrated Teams Programme—developing and implementing both the generic and specialist offer of integrated placed based teams supporting an identified group of General Practices.

The Home First Rehabilitation and Reablement Programme— seeking to develop a consistent offer at the point of discharge which enables patients to return to the community as quickly and safely as possible

The LLR Urgent Care Programme—leading the development of integrated urgent care across LLR, ensuring that access to 24 hour urgent care aligns with General Practice.

The LLR Planned Care Programme—leading the development of planned care in community settings, the diagnostic element of which will increase the number of ambulatory pathways improving direct access by GPs to locally based diagnostic hubs and services some of which will be provided in and by general practitioners working together.

This joint planning and development will lead to a place based model for health care to support delivery of our aims and vision.

Figure 7: Place based footprint model

Developing a 'Place Based' Plan for an STP Footprint

Baseline

Total 'Out of Hospital' workforce gathered and analysed from NHS Trust ESR and NHS Digital:

- ✓ Neighbourhood: General Practice and Integrated Teams;
- ✓ Area: Therapy services, mental Health services – Community Hospital, assertive in-reach, UCC, WIU and MIU workforce;
- ✓ System: further out-of-hospital services including specialist Nurses and therapists and single pathway workforce such as MSK and Stroke.

Future

The future of 'out-of-hospital' workforce in each Neighbourhood needs to be identified having taken into account the following:

- ✓ The balance of work stream activity that will take place out-of-hospital after the transformation envisaged in the STP;
- ✓ The number of people requiring ongoing support;
- ✓ The skill mix necessary to deliver this support;
- ✓ The impact of demographic change.

The workforce within a local **Neighbourhood Team** should be planned for in the context of the above and recognising:

- ✓ The nature of integration at a local level between General Practice, Neighbourhood teams and Social care;
- ✓ The contribution made to addressing need by area/ CCG teams and any system wide specialist teams.

The workforce within local **General Practice** provision should also be understood in the context of the above recognising:

- ✓ The nature of integration at a local level between General Practice, neighbourhood Teams and Social care;

The contribution made to addressing need by patients, carers and the voluntary sector

3.5 Where will clinicians and staff be sourced to deliver this model?

The GP workforce work stream cannot deliver this change in isolation and will need to work with all providers across LLR take an overall system view of workforce impact in order to manage future commissioning of training provision, and understand the capacity risks. Simultaneously, it will need to ready the system to make the changes required, and work with each of the programmes and clinical work streams in an iterative way to confirm and challenge workforce plans at a project level as models of care continue to develop. These can be summarised as follows:

The shift of activity – acute > community > primary > social – and the resultant need to change the capacity significantly across the system, increasing the capacity within primary, social and community care before capacity can be released in acute settings. *The projected increase in primary care workforce is around 10% by 2020/21 with a reduction in provider workforce of around 5% over the same period.* This in some cases necessitates a double running period which must be staffed. Ability to recruit within this timeframe will be a key risk, particularly given regional pressures. There is a need to move staff around the system to provide care in different settings, and some staff may change employer to undertake new roles. The system must enable the movement of staff to be as efficient and effective as possible.

Change of location – community hospitals, primary care hubs, home – staff will deliver care in different locations, with more care being provided in the patient's own home or in their locality. This may entail greater levels of autonomy and staff working with different levels of support and supervision, as well as a change in work location. Travel between settings will be a new consideration for some staff. In the longer term, the supply of staff will need to take account of the change in location, so training schemes must ensure exposure to these new environments.

Roles and skills mix – There is an opportunity to look at skills mix as the pathways are redesigned, and thereby potentially mitigate some of the existing recruitment challenges. Shifting care from secondary to community settings will require a review of both generalist and specialist skill balance. There will likely be the introduction of new emerging roles (such as Physician Associates) as well as joint roles for example across health and social care. The structure of some teams will change, particularly in primary care where the skills mix will need to account for the shortage of GPs.

Re-skilling - there will be significant levels of re-skilling of the current workforce required to support the roles and skills mix that is defined. This includes the consideration of new skills around the use of technology to support the digital roadmap and new skills in support of the prevention agenda and our own workforce wellbeing. The partner organisations and LETC/LWAB must work together to allocate resources effectively in support of clinical pathway and capacity changes.

Culture - Working across boundaries – levels of cross organisation working are already increasing and will continue to do so. There is a need for continuing development of the system, its leadership and culture (over and above organisational approaches) to successfully deliver change through closer working and service integration

3.6 Organisational Development and Leadership Development

Ensuring effective management of change and development of the 'system' culture requires a whole system change and the need for clear leadership. Working across LLR, the GP workforce group will link with the LWAB, LWAG and Leadership Academy to deliver the appropriate solutions. This will include;

Developing Culture

It is recognised that the differences in culture between respective partner organisations could be a barrier to successful delivery of the programme. Organisational Development (OD) leads from across the system will continue to develop approaches appropriate to the maturity of the overall partnership and system and will support the Clinical Leadership Group in driving culture change.

Setting Vision and direction

The aim of this work is to provide a clear vision / set of principles for the STP enabling engagement across the system. An induction package for new employees joining the LLR system will be developed and will be delivered in a way that engages people in a discussion of how they would see themselves as working as part of a system, enabling a greater understanding of system.

Staff engagement and change management

The OD group will support the Clinical Leadership Group (CLG) to identify clinical leaders in the system to enable effective support and engagement. Beyond the Clinical leads of STP work streams, we will reach out across the system using talent management approaches to identify clinical leaders. We will create an engagement framework that enables two way communications so that the champions have influence in shaping priorities within new model development and implementation.

System leadership capacity

Working with the East Midlands Leadership Academy (EMLA), we have produced a set of competencies around system leadership, together with a programme of support. There will be some elements bespoke to the LLR STP, and it is anticipated that this will include leadership development facilitation and work-based action learning for teams across the programme.

Learning together

The Organisational Development Leads are supporting cross-system learning opportunities in the development of new programmes. LWAB funding was prioritised for programmes which offered cross-system benefits, and the team have begun to map existing leadership development offers to explore opportunities to collaborate more effectively, with the aim to move toward an 'LLR Academy' concept.

Whilst our vision for General Practice workforce is ambitious, it is built on established foundations already in place across LLR. Our future vision, including new models of care, can only be achieved by working together as an STP footprint, we've already started this journey but there is still a considerable way to go.

What have we learnt?

- Our plans for new models of care are built on established foundations already in place across LLR
- That we need to continue to work together as an STP footprint to deliver the change in workforce
- The CCGs recognise the importance of OD and Leadership to implement and deliver the workforce plan

Chapter 4 - General Practice Workforce Data and Analysis

What will this chapter tell you?

- Detail the current LLR General Practice workforce
- Profiling of staff mix, age, gender and variation across LLR
- Analysis of the workforce data
- Highlights the much greater challenge for recruitment and retention in Leicester City
- Highlights future workforce risks

4.1 General Practice Workforce data and Analysis

We have already outlined in chapter 2 the work undertaken by HEE Midlands and East in collating data relating to our current General Practice workforce.

The aim of the local and national data collection is to gather intelligence on the demographic of the workforce in the STP footprint.

By using these data sets we are able to explore potential gaps in our current and future workforce and identify our staff skill mix profile as a collective STP as well as by individual CCGs.

The LLR General Practice Workforce plan has been populated using data from the HEE tool and in the coming months will utilise the newly released NHSE Midlands and East Primary Care Workforce Monitoring Tool (v0.4) to further enhance our depth of analysis and future workforce planning.

It must be recognised that the data collected from practices is down to their individual interpretation of the very complex spreadsheet requested of them by HEE. In LLR we have worked very closely with all of our practices to support the data being provided to be as accurate as possible.

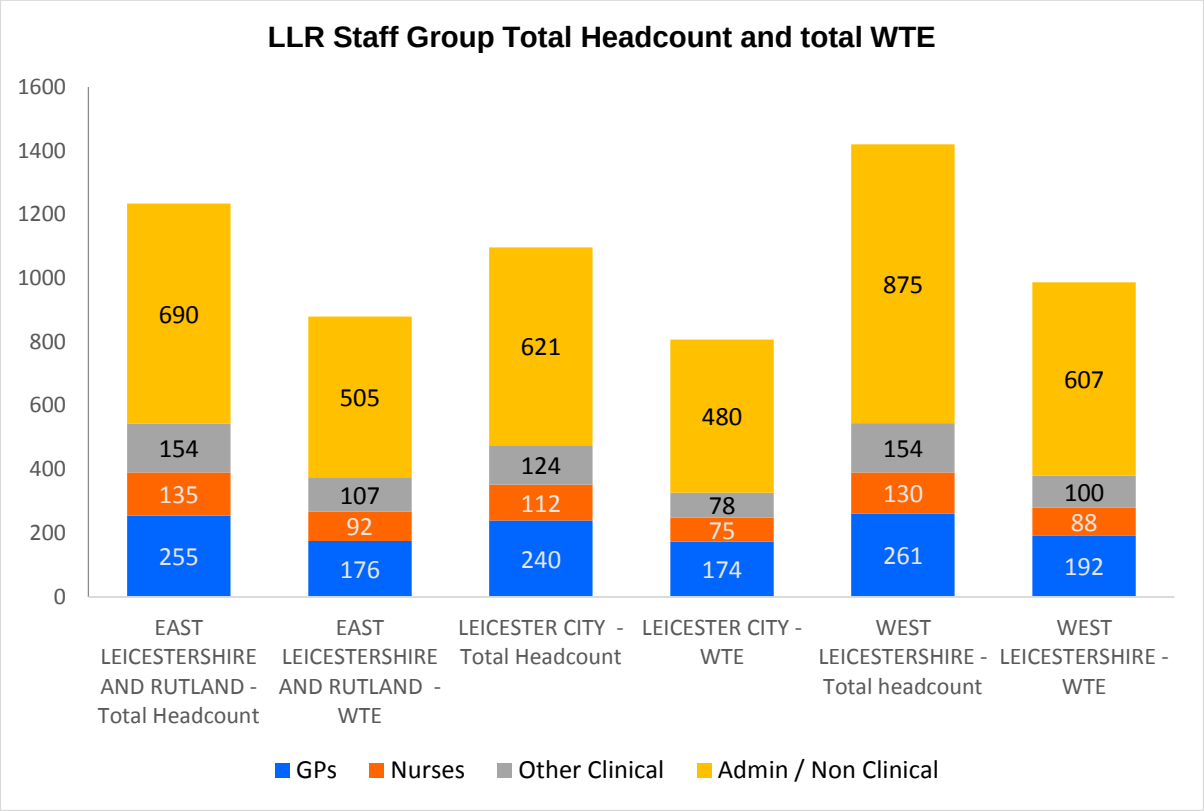
The data set provided by 137/138 practices (extrapolation for the last practice used for a complete analysis) provides a very clear picture on numbers, age, gender, reported vacancies and use of locums.

The following graphs show the data upon which all of the analysis has been based for workforce baseline, supply, and future trajectories and targets set out in Chapter 5

4.1.1 Numbers

The number of staff and WTE working within General Practice can be seen in Graph 2

Graph 2: Head count and WTE of all staff by grouping.



This is in the context of the NHSE target number of 639 WTE GPs required by September 2020, which has been based on a 12% increase in GPs from the September 2015 data submission of 563.

This initially showed a Gap against their target of 76 GPs. In the ensuing 2 years there has been a 5% reduction in the WTE number of GPs in LLR to 541, leaving a gap of 98. This has been due to more leavers, retiring early or reducing sessions. This is a very concerning trend, although is in line with the national analysis by the likes of the King's Fund, Nuffield Trust and BMA.

Table 4: WTE GPs in LLR from Sept 2015 Baseline to Oct 2017 against the NHSE target by 2020

STP	Sep 15 WTE GPs	Mar 17 WTE GPs	Oct 17 WTE GPs	NHSE Target by 2020	Target (WTE per 1000 population)
LEICESTER, LEICESTERSHIRE AND RUTLAND	563	565	541	639	0.58

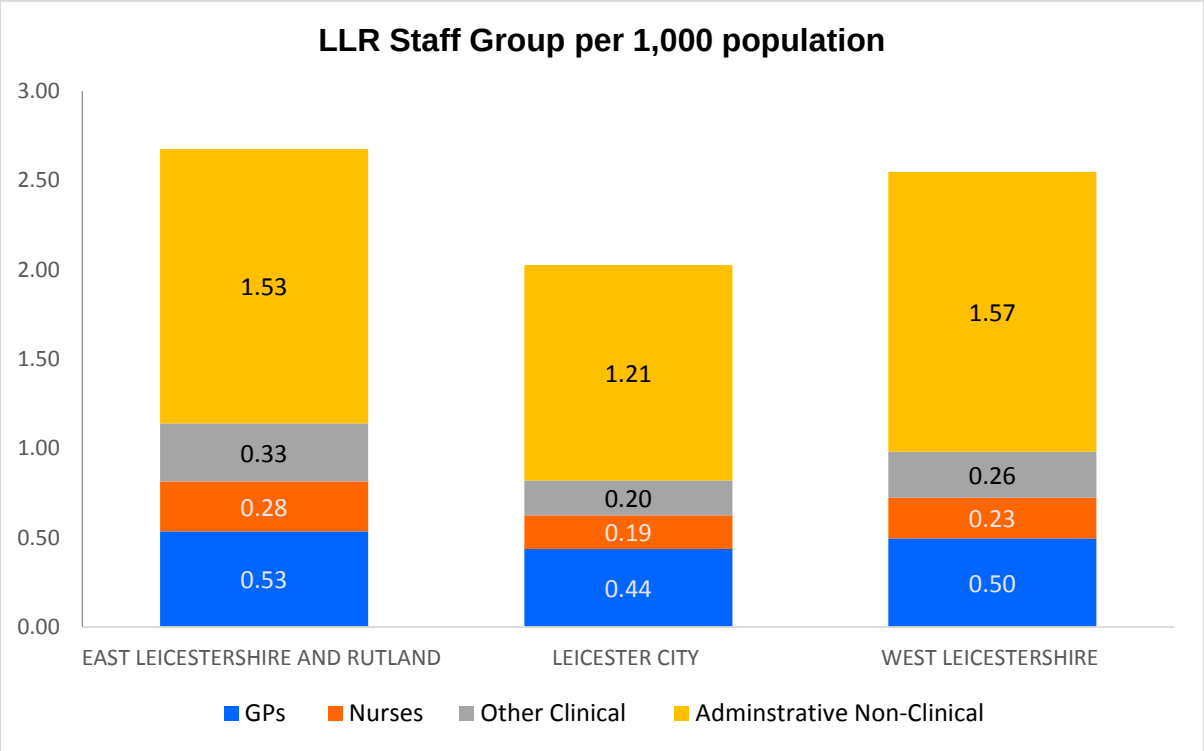
This makes the achievement of the target even harder, especially with the knowledge that fewer Doctors are becoming GPs and those that do are often working part time or as Locums.

The NHSE target is for 0.58 WTE GPs per 1000 patients, this figure becomes increasingly more challenging across the three CCGs in LLR, when compared to the current numbers seen in Table 8.

Table 8: General Practice Staff benchmarked per 1000 population

	Population	GPs		Nurses		Other Clinical		Adminstrative Non-Clinical		Total	
	Population as of Sep 17, NHS E	Actual	No: per 1000 Population	Actual	No: per 1000 Population	Actual	No: per 1000 Population	Actual	No: per 1000 Population	Actual	No: per 1000 Population
EAST LEICESTERSHIRE AND RUTLAND	329,012	176	0.53	92	0.28	107	0.33	505	1.53	880	2.67
LEICESTER CITY	398,053	174	0.44	75	0.19	78	0.20	480	1.21	810	2.03
WEST LEICESTERSHIRE	387,251	192	0.50	88	0.23	100	0.26	607	1.57	1007	2.60
LLR STP Total	1,114,316	541	0.49	256	0.23	284	0.25	1592	1.43	2720	2.44

Graph 3: WTE Staff employed within each CCG area per 1000 population

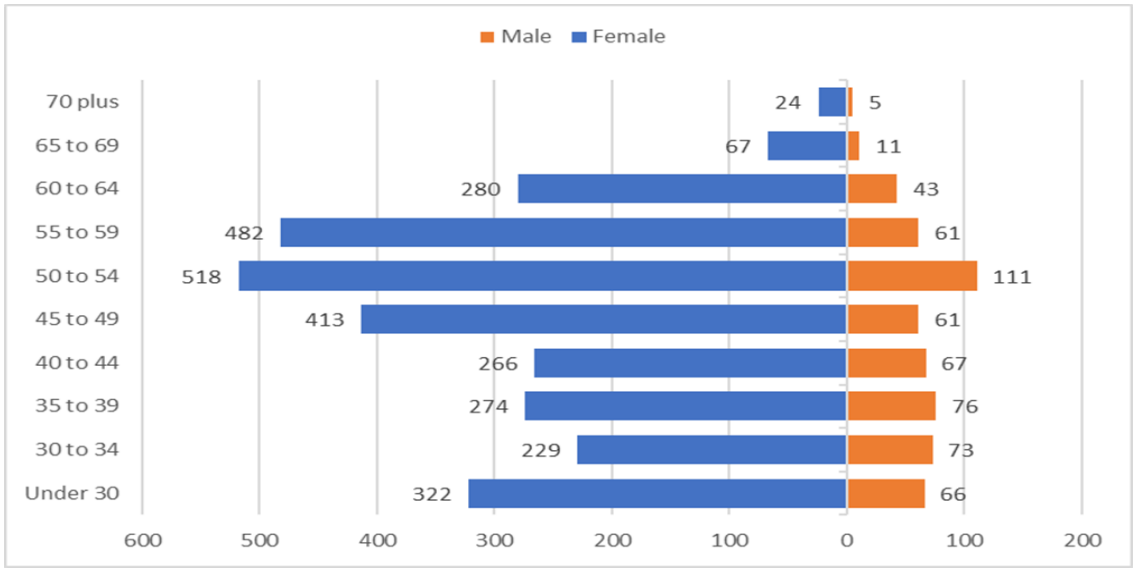


This clear inequity in numbers of GPs is mirrored with both nurses and other clinical staff. None of the CCGs meets the nationally expected number and there will be challenges throughout LLR to meet the staffing requirements of the General Practice Sector. However, the City with low numbers of staff and with its high health needs is a clear outlier. Any strategies we adopt needs to recognise this as well as identifying areas of difficulty in some County urban and rural localities that might require specific action.

4.1.2 Age Profile

The age profiles seen in Graphs 3 and 4 and Table 10 paint a clear picture of an ageing workforce. This is no different from the national profile, but of most concern in LLR is that the registered nursing workforce has a figure of 35% over the age of 55 and for GPs there is a higher proportion of partners in the older age brackets. This is in a climate of fewer GPs wishing to become Partners.

Graph 4: Headcount profile by age and gender - all staff



Graph 5: Headcount profile by age and gender - GPs

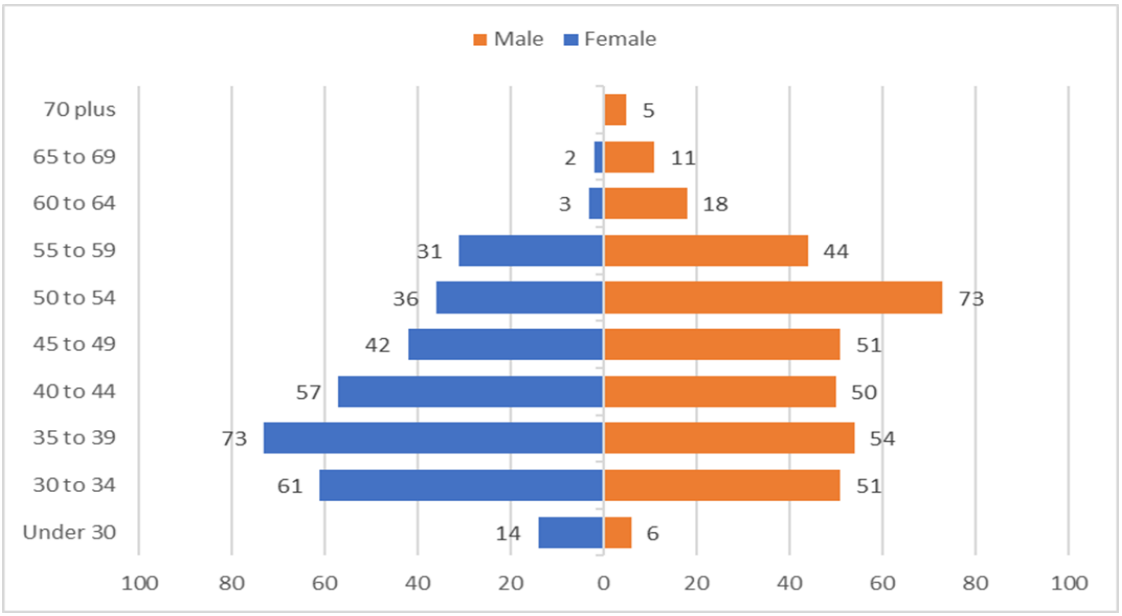


Table 9: Percentage of staff WTE aged 55 and over in LLR by main staff groups

Staff Group	Job Role	%Over 55
GP	Senior Partner	46.1%
	Partner	13.3%
	Salaried	9.2%
	Registrar ST3/4	0.0%
	Registrar F1/2	0.0%
	Locum covering sickness	0.0%
	Locum covering vacancies	0.0%
	Locum -other	30.3%
Nurses	Advanced Nurse Practitioners	31.4%
	Extended Role Practice Nurses	46.2%
	Nurse Specialist	26.1%
	Practice Nurses	29.6%
	HCA	19.5%
Direct Patient Care - other	Direct Patient Care - other	26.2%
Admin and Clerical	Admin and Clerical	29.4%
Total	**Total**	**26.0%**

4.1.3 Locum Doctors

In previous iterations of the workforce data, NHSE did not count Locum doctors within the denominator. With the shift towards Locum status, these figures were added. When asked, our practices provided detailed data on the number of Locums and the sessions that they undertook which equates to nearly 40 WTE. Although the numbers count towards the denominator and there is a need for locum doctors to fill some capacity gaps, they cost up to 45% more to employ than a salaried GP and often do not complete the same level of work. The numbers of GPs working as locums is significant and if this trend continues could destabilise some practices financially and through excessive workload for remaining employed GPs.

Table 10: Locum numbers in LLR

CCG Name		Locum-covering sickness/maternity/paternity	Locum-covering vacancy	Locum - other	Grand Total
NHS East Leicestershire and Rutland	Headcount	4	30	14	48
	WTE	2.28	4.38	3.28	9.94
NHS Leicester City	Headcount	1	5	30	36
	WTE	0.44	3.44	21.23	25.11
NHS West Leicestershire	Headcount	3	2	8	13
	WTE	1.64	0	2.75	4.39
LLR	Headcount	8	37	52	97
	WTE	4.36	7.82	26.26	39.44

Although this workforce plan is based on the LLR footprint, it is clear that the workforce numbers are very different across each CCG and therefore there may need to be a specific focus on greatest need and reducing inequalities, as this plan continues to be implemented.

What have we learnt?

- There are 5% fewer GPs in LLR than in September 2015
- Leicester City CCG has the lowest n/1000 Clinical staff in LLR
- There are significant locum doctors working in LLR
- There is an ageing workforce, especially of Registered Nurses

Chapter 5 - Modelling our Supply and Demand

What will this chapter tell you?

- National toolkits have been used to model supply and demand based on a series of assumptions
- Local data and evidence of staff movement has been used to gain an accurate picture
- The scenarios provide clear evidence to focus the local implementation planning

5.1 Modelling Tool

The LLR GP Workforce group have been working closely with the HEE team from Midlands and East in utilising their GP Forecast Model. The purpose of the model is to inform the development of workforce plans and facilitate discussions about workforce solutions required to bridge the gap between forecast supply and demand.

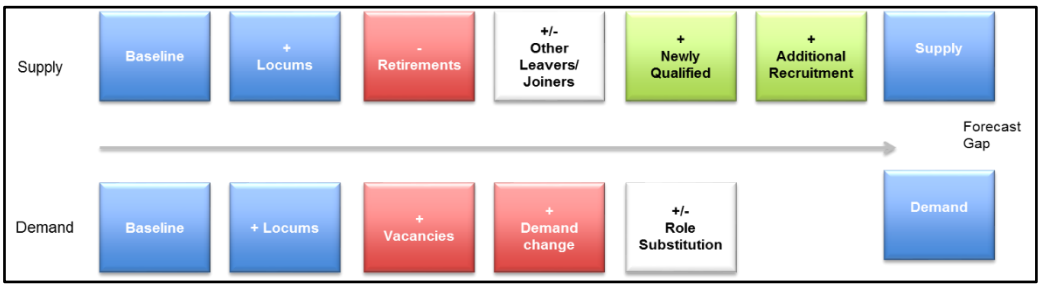
The model assists with forecasting the following:

- The supply of General Practitioners (GPs)
- The gap in supply of GPs under chosen demand and supply assumptions;
- Recruitment levels of other staff working in General Practice required to match future demand.

It has been used in LLR to provide as realistic a future as possible while recognising that this is not an exact science

This tool examines the balance between supply and demand in the following way:

Figure 8: HEE Supply and Demand methodology



It utilises a set of assumptions that can be modified to reflect local knowledge and to test potential ways forward.

5.2 Baseline Data and Assumptions

Workforce and recruitment is an ongoing process without set timescales, but for the purpose of this plan, the target numbers are set for September 2020. The assumptions for supply and demand are therefore based on the next 3 years.

Any model is only as good as the assumptions made and it is not an exact science. In the following scenarios the information used is based on the best evidence available to us.

Table 11: Baseline and assumptions

Leavers and Joiners	Numbers	Assumptions and Evidence
Baseline		
Number of WTE GPs in LLR Based on the data received from the 137/138 practices at October 2017	541	Based on the workforce returns by practices and 9 sessions being used as a WTE
Leavers		
Number of WTE GPs over the age of 55	87	There is evidence based on HEE Midlands and East data that a significant proportion of GPs over the age of 55 will retire within the next 5 years. In this modelling a number of GPs retiring per annum is used.
Proportion GP workforce reducing sessions or leaving prior to retirement age	N/A	HEE national data shows that there is a trend towards GPs reducing clinical sessions or leaving prior to retirement age. For each scenario this has been modelled
Joiners		
Newly qualified GPs in LLR over the next 3 years	153	The number of trainees qualifying over the next 3 years. An assumption has been made on the number of remain in LLR and also those that become Locums or work less than 9 sessions
Other recruits due to International Recruitment	30	The share of the national target for International recruits in LLR is 39. The figure of 30 has been used, as in Wave 1 in LLR for 2018 15 Practices have expressed a firm interest in wishing to recruit
Other Health Professionals / Role Substitution	28	There is a national view that there should be at least 1 clinical pharmacist per 30,000 patients. Also that ANPs can undertake many of the traditional roles of a GP, especially with new models of care. In this modelling a role substitution ration of 3 to 1 has been used for these staff as GP substitutes

5.3 Scenario Planning

Three Scenarios have been used to illustrate the workforce supply and demand. Each of these provides a different picture according to the assumptions and interventions within LLR over the next 3 years.

Scenario 1:

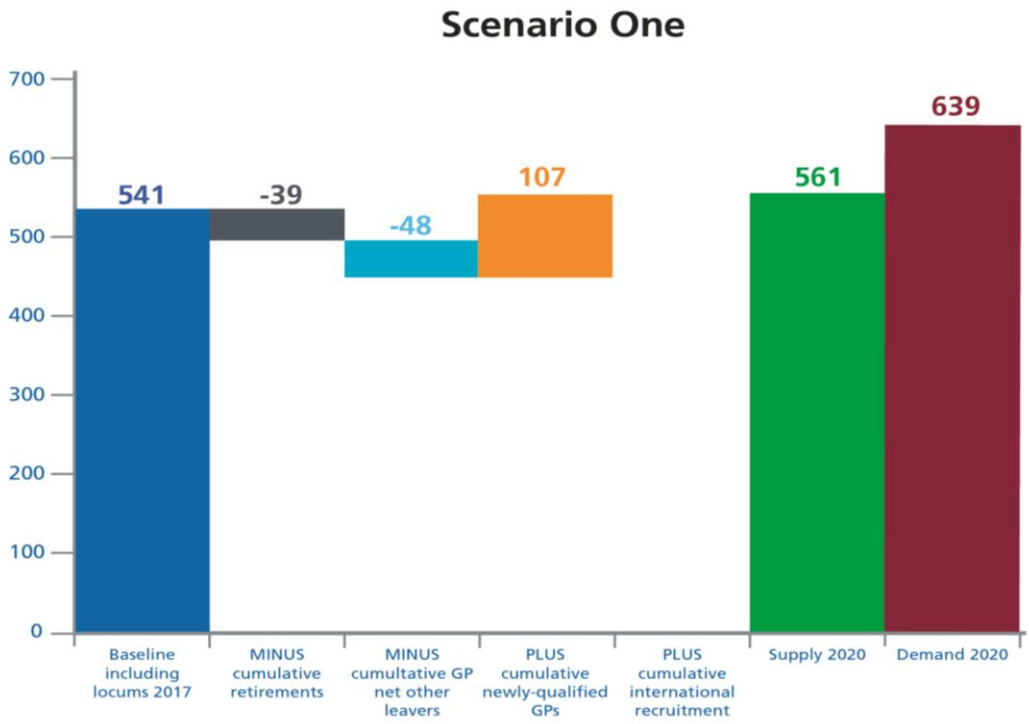
Base position

This scenario is based on a realistic assumption of leaver and joiners, with no additional funding, schemes in place or role substitution.

Table 12: Scenario 1

	Baseline	Local Assumptions	Number over three years
Baseline Figure			541
Number of WTE GPs over the age of 55	87	Lose 15% per annum	-39
Proportion GP workforce reducing sessions or leaving prior to retirement age	541	Lose 3% of sessions per annum	-48
Newly qualified GP trainees	153	70% remain in the workforce	107
International Recruits	0	0	0
Position in 2020			561

Graph 6: Scenario 1



Scenario 2:

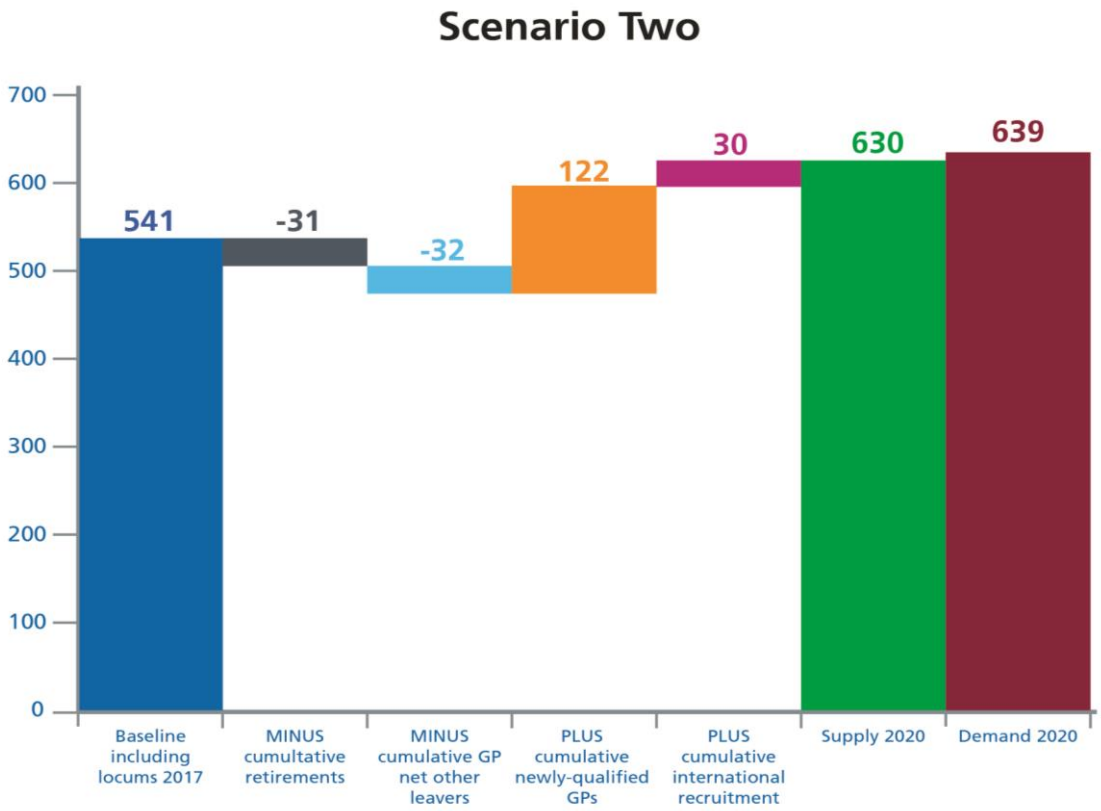
Improving GP supply through International Recruitment and improved GP Retention

This scenario assumes that by improving the working patterns of GPs, managing the workload and improved funding for the General Practices sector, there is a possibility that there could be an improved retention of existing staff, a reduction in the number of GPs that retire early and additional GPs enter the system through International Recruitment

Table 13: Scenario 2

	Baseline	Local Assumptions	Number over three years
Baseline Figure			541
Number of WTE GPs over the age of 55	87	Lose 12% per annum	-31
Proportion GP workforce reducing sessions or leaving prior to retirement age	541	Lose 2% of sessions per annum	-32
Newly qualified GP trainees	153	80% remain in the workforce	122
International Recruits	0	30	30
Position in 2020			630

Graph 7: Scenario 2



Scenario 3:

Same Assumptions as Scenario 2 – Adding Other Clinical Staff as Role Substitution

To cope effectively with the increasing demand in primary care, change will need to take place across the whole General Practice team. Some of the work previously undertaken by GPs will need to be done by others, for example, routine administrative tasks, medicines management and advice. The effect of role substitution by Clinical Pharmacists and ANPs was tested with the assumptions shown below

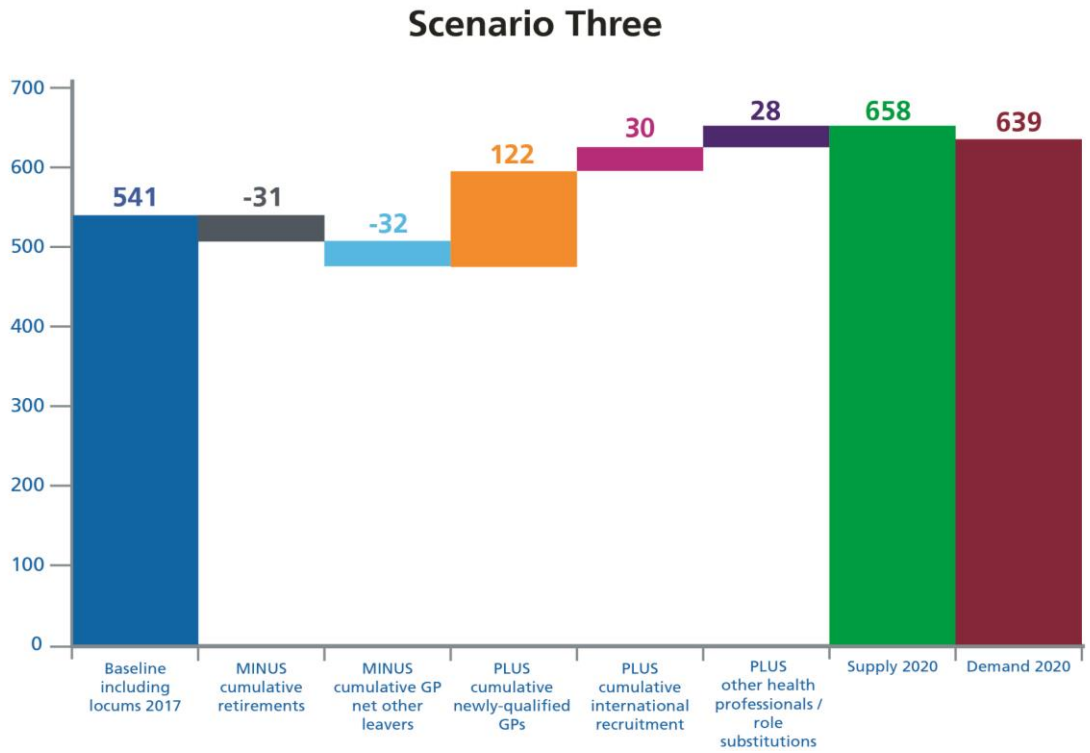
Table 14: Scenario 3

	Baseline	Local Assumptions	Number over three years
Baseline Figure			541
Number of WTE GPs over the age of 55	87	Lose 12% per annum	-31
Proportion GP workforce reducing sessions or leaving prior to retirement age	541	Lose 2% of sessions per annum	-32
Newly qualified GP trainees	153	80% remain in the workforce	122
International Recruits	0	30	30
Other Health Professionals / Role Substitution	1 Pharmacist per 30,000 patients (n=35) and 50 additional ANPs	85 with a ratio of 3:1	28
Position in 2020			658

This Scenario is based on every initiative being successful and the funding being available in the system. In reality, it is more likely to be the aspiration that will help to mitigate against the following

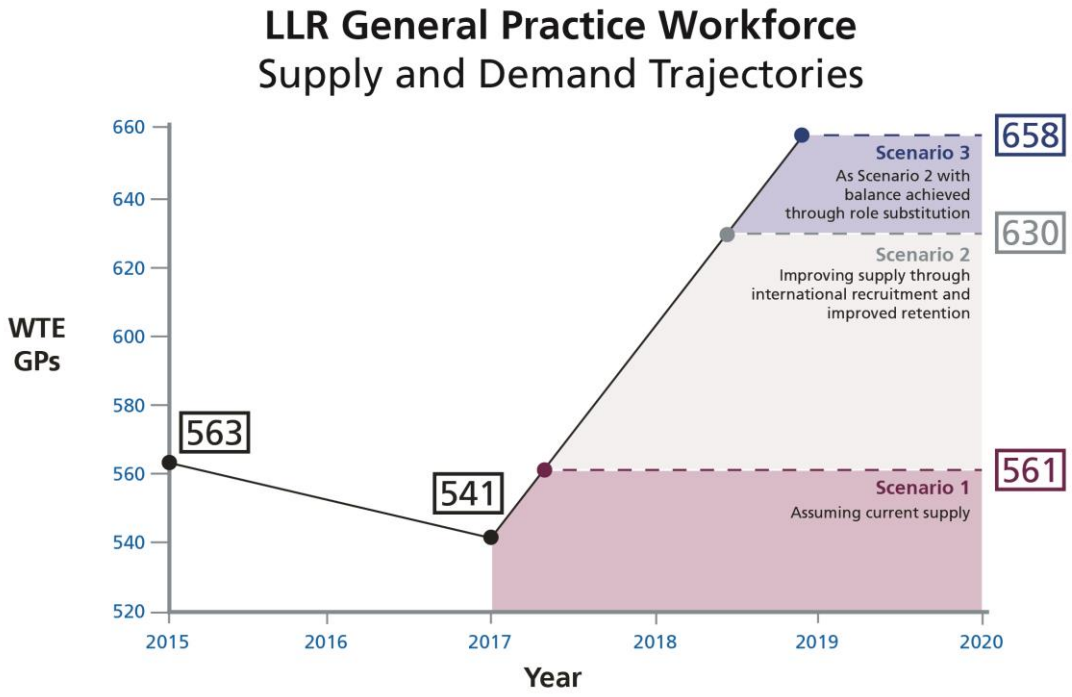
- More GPs leaving or retiring (not an exact science)
- The newly qualified going part time not full time therefore reducing the number of WTE
- More people becoming Locums. (However local figures show that there are at least 97 GP Locums in the system. If our plans work, we can make assumptions that more of them will enter the salaried workforce and improve the overall WTE figure)

Graph 8: Scenario 3



These three scenarios enable a realistic trajectory to be created to support the planning and implementation of local workforce initiatives

Figure 9: Trajectory based on potential outcome of the three scenarios



The three scenarios provide a clearer understanding of the demand and supply issues being faced in LLR, based on the assumptions that can be made. Although this does not answer the problem of where all of the additional staff could come from, it is a very helpful guide in understanding what outcomes the LLR workforce initiatives can achieve if successful and more to the point, the opportunities to meet demands through role substitution. It is clear that this is a very difficult challenge and will require a whole system approach to delivery.

LLR STP will therefore pursue scenario 3 as the approach most likely to succeed in ensuring we have an adequate GP workforce for our population.

What have we learnt?

- Focusing on leavers and joiners will not resolve the workforce by itself however, increasing retention of newly qualified GPs locally, and encouraging delayed retirement are essential components of any strategy to ensure adequate GP numbers
- Introducing international recruitment and increasing retention should improve the workforce position
- Role substitution in addition to increased retention and international recruitment will help to address the future workforce requirements
- Scenario 3 is the most likely approach to help deliver our goals in having an adequate GP workforce

Chapter 6 - Local Workforce Initiatives

What will this chapter tell you?

- The National workforce initiatives underway in LLR
- Details of our local initiatives
- What we've achieved so far
- What we will do in the future to support General Practice Workforce

To achieve the vision of a resilient primary care will require change in models of care and recruitment and retention strategies for General Practice staff. At the same time we recognise that there are also opportunities to reduce the administrative burden on healthcare professionals.

With practices finding it increasingly difficult to recruit and retain staff, and fewer GPs choosing to undertake full-time clinical work, combined with a continued trend of which fewer doctors are aspiring to become partners, we accept that for LLR we need to have truly innovative workforce initiatives that make us stand out from the 43 other STPs across the country.

We acknowledge that this is a complex problem with multiple risks and challenges which as an STP we are working through by developing this plan. Rising to this challenge, we have identified a number local workforce initiatives, all of which are in varying project phases however these are not the only initiatives we will be exploring over the next 3 years, as we will build on these foundations as the LLR population grows and the NHS workforce landscape evolves.

Within LLR we have a commenced the implementation of a number of workforce initiatives some of which have been locally developed to target the needs of the STP population, others based on national strategic direction. These initiatives are detailed below and set out by skill mix or profession.

6.1 General Practitioner

International Recruitment of GPs (IRGP)

The CCGs by working collaboratively have developed in partnership with HEE, LLR LMC, a truly bespoke IRGP scheme, which complements the LLR workforce vision to support and retain the existing GP workforce.

Through our work with Leicestershire County Council, (Syrian vulnerable person's resettlement scheme) and Inclusion Health (Assist Asylum Service for Leicester City) we recognise that a key factor to our local scheme being a success it must have a robust Integration & Orientation Support Package. Our package includes support with housing/accommodation, finding English language classes, local schools, religious organisations, specialist food products etc.

Working with LLR LMC we have developed a Memorandum of Understanding for participating practices, used the model BMA contract as the template for the GP contract which includes local incentives into the Terms and Conditions.

We will be submitting applications in a 2 phased approach to NHS England; phase one in November 2017 and phase 2 in January 2018.

There are 3 major risks to this initiative; lack of engagement from member practices across LLR, uncertainty around whether the application will be approved by NHS England, and if this initiative will meet the target set by NHS England of 39 WTE. Whilst we've seen interest across LLR, at the time of writing the actual total number of practice applications for phase 1 is 14.

GP Induction and Refresher (I&R)

Working with HEE EM we have developed a GP specialty trainee placement scheme that sees the trainee assigned to one of our wide variety of placements across LLR from inner city, ethnically diverse practices through to suburban and rural settings. This programme provides an initial 20 months meaning the trainee has more GP time than elsewhere in the country. In addition we are looking to recruit a small group of trainees who, through a 4 year programme, will be able to develop skills in clinical teaching in addition to completing their GP training. We are currently developing an extensive communication and promotional plan.

NHS England target via I&R is 10 recruits per annum. Currently there are 3 GPs in LLR on the scheme, therefore there is a gap of 7 this financial year, uptake of the scheme remains the biggest risk to achieving this target.

GP Retention and Portfolio

Working with HEE EM we have taken the national scheme and developed our local scheme to fit LLR. The GP must commit to a maximum 208 sessions per year which includes protected time for continuing professional development, educational support and an annual review. This also includes a package of financial and educational support to help these doctors, who might otherwise leave the profession, remain in clinical General Practice.

Each practice employing a RGP will be able to claim an allowance relating to the number of sessions for which their retained doctor is engaged. The practice will qualify for a payment of £76.92 per clinical session (up to a maximum of four) that the doctor is employed for. This allowance will be paid for all sessions including sick leave, annual leave, educational, maternity, paternity and adoptive leave where the RGP is being paid by the practice.

Areas of portfolio work include but are not limited to, family planning, sexual health, urgent care, dermatology, migrant health. The Retained GP applies directly to HEE to join the scheme. We currently have 1 GP on this scheme, and are planning further and extensive promotion across LLR.

GP Locum Chambers

For some GPs being a locum is their chosen career path, this can be because of the financial risk of becoming a partner in a practice, or the flexibility it offers to their work/life balance.

Our GP Federations are working collaboratively to develop a platform to connect locum staff with LLR practices that require additional sessions. There are a number of benefits attached to locum chambers as opposed to traditional locum agencies and these include:

- GPs trained in local pathways and good working knowledge of local IT
- Clinical governance meetings to discuss SEAs, complaints, best practice, clinical case studies.
- Free educational events
- Supporting the GP will all aspects of GP appraisal

This would be a long term investment, with benefit realisation taking place over a significant number of years, by which time the landscape of local GP workforce may have changed. A major risk is the start-up costs associated with setting up chambers, with the CCGs not having any slippage in their budgets, would mean that these would need to be self-funded.

6.2 General Practice Nursing

Working with HEE EM the LLR Training hubs are developing a recruitment programme specifically targeted to newly qualified nurses to work in General Practice. Under this scheme the nurse trainee would be employed across multiple practices, with a lead practice as the named employer. This multi-practice approach encourages cross-practice experience and collaboration as practices start to 'own' the training of new GPNs. The trainee practice nurse must enrol on the DMU programme, and on successful completion of the DMU programme, nurses would be available for employment amongst the participating practices.

We are exploring further with HEE EM and DMU the development of Nurse Associate roles and Assistant Practitioner Level 5 Foundation Degree, and developing a return to General Practice Nursing programme, and targeted promotion of GPN as a first destination career with our GP Federations and Training Hubs.

6.3 Other Healthcare Professionals

Physician Associate (PA) Training Programme

The first PA programme to be delivered in the East Midlands commenced in September 2017 at De Montfort University Leicester. This programme has been developed with HEE EM, DMU and local General Practice. This offers student PAs clinical placements within the East Midlands. A GP/Consultant is identified as the Clinical Supervisor and provides learning opportunities, complete practice assessment documentation.

Clinical Pharmacists

The national Clinical Pharmacists in General Practice scheme has presented an opportunity for 11 practices in ELR, representing 93,000 patients, to submit an application for funding to support the recruitment of an additional three pharmacists to work across the practices to enhance and dovetail with existing arrangements and pharmacists recruited through the local CCG scheme.

The additional resource will enable an expanded team of pharmacists to contribute to an 'at scale' hub and spoke based service to provide participating practices with a centralised hub based service to deal with routine queries and advice relating to medicines five days per week. The team will rotate through the virtual hub and also provide clinical support directly to patients that will be tailored to the needs of their base practice or 'spokes'. They will be

integrated into practices to provide important additional capacity to enhance resource and increase face to face clinical contact with patients, helping with chronic disease management. This increase in patient facing contact will also have a meaningful impact on clinical workload. An application was submitted in September 2017 by ELR Federation and we await the outcome from NHS England.

LC CCG
Across Leicester Federation were successful in their application under Wave 1 of the national pilot, and was made on behalf of 9 member practices. The Pharmacists support the practices in efficient and safe management of prescribing; undertake medication reviews with patients and supporting patients with long term conditions with their medication. This has improved the quality of prescribing and care given to patients, particularly those with polypharmacy. It has also released GP time by taking work such as titrating medication away from doctors and to clinicians who are specialists in managing medications.

ELR CCG
A pilot study evidenced that having Pharmacists as part of the practice team, not only supports cost effective quality prescribing, but can help with workload on medicines reconciliation, waste, 3rd party ordering, shared care, and polypharmacy in Care Homes. ELR CCG has committed recurrent funding for their practices which provides the stability for them to directly employ clinical pharmacists within their team.

The funding was made available during 2016/17, as this was midyear it was pro-rata to £1.33 per registered patient, with a full year from 2017/18 to £2 per registered patient, making a total CCG investment of £650K. This funding investment by the CCG is on a recurrent basis.

WL CCG
The four federations applied for funding under Wave 2 of the national scheme. Hinckley & Bosworth Federation led the application for 9 clinical pharmacists.

In April this year a press release was issued by NHS England advised that the bid was successful, however, the Federation did not receive formal notification until June 2017 advising funding for 7 posts would be made available. At the same time they were advised that the payment criteria and mechanism would be at an individual practice level via CQRS, although the release of the funding is yet to happen, thus delaying recruitment to the posts.

All of the above has been viewed as a major barrier to proceed with the scheme for 3 of the 4 Federations; Hinckley and Bosworth Federation are currently caretaking a GP Practice. And as a result of these issues only Hinckley & Bosworth Federation have decided to continue.

6.4 Admin / Non Clinical Staff

Practice Managers Academy
Whilst this is still very much in its infancy, we have developed a training and education academy specifically for practice managers. The PM Academy is aimed at both new and existing practice managers. It boasts a locally designed induction course by Practice Managers in LLR for Practice Managers. It also offers One to One support sessions on practice related topics for PMs and a mentorship programme is being explored further.

This personal approach to developing and strengthening our Practice Managers will give them confidence and motivation to build on their existing skills and we believe that this will ultimately lead to retention in the workforce.

Funding of £15k has been secured via HEE ME to deliver this scheme, although this has not yet been released. As HEE is responsible for not only attracting the right people to the NHS, but also for developing people already working within healthcare, making sure they have the education and training, and the flexibility, to deliver high quality care to patients now and in the future. Through this funding, it will help GP Practices achieve this from the support available via the Academy.

We have designed a local PM Conference that offers delegates knowledge and tools to transform their practice, improve efficiency, and retain key resources as well as being an opportunity for practice managers to network with colleagues across LLR, whilst at the same time offering career development.

Administrative non-clinical staff

Nationally NHS England has promised funding of £45 million over the next five years (2016/17 – 2020/21) to develop the capabilities of the practice workforce for these new ways of working. In the first year, £5 million will be available, and £10 million will be available in each of the subsequent four years.

Central funding will be allocated to clinical commissioning groups (CCGs) on a per-head-of-population basis the level of funding is outlined below:

Table 15: GP5YFV funding for workforce initiatives

LLR Funding	2016/17	2017/18	2018/19	2019/20
	£95K	£190K	£190K	£190K

The 2016/17 funding of £95K has been secured for investment in 2017/18 and will be held by the LLR Training Department.

For 2017/18 we have focused on 2 key areas Active Signposting and Correspondence Management. Practices and Federations across LLR were invited to apply for funding to pilot innovative ways of upskilling the administrative workforce.

Phase 1 of Active Signposting is underway; there are 17 staff across 6 practices participating in the pilot. Receptionists have received training to enhance their ability to connect patients directly with the most appropriate source of help. When patients contact the practice, the receptionist identifies what their need is. They are then able to refer to information about services in the practice, other NHS providers and the wider care and support sector. Evaluation of the phase 1 pilot will take place shortly.

From October 2017 across LLR a number of Correspondence Management pilots commenced. These vary from individual practice, to 5 practices working in collaboration that will test protocols for incoming and outgoing correspondence, whilst ensuring patient safety is not compromised. This will also improve to an increase in the standard of READ coding and quality of record keeping.

The following table details the local LLR initiatives to support all of these professional groups within our workforce

Table 16: National / Local initiatives undertaken in LLR

Initiative Name	FYFV	Local
International Recruitment	✓	
GP Induction & Refresher	✓	
GP Retention & Portfolio	✓	
GP Locum Chambers		✓
New Models of Care		✓
Primary Care Home Model	✓	
Think Tank - Locum conversion to Substantive		✓
Think Tank - Retaining our Registrars in LLR		✓
Reducing Workforce Inequality across STP		✓
Trainee Nurse Programme		✓
Assistant Practitioner Level 5		✓
Nurse Associates		✓
Advanced Clinical Practice		✓
Return to GPN	✓	
Practice Nurse Conference		✓
Physician Associates	✓	
Clinical Pharmacists in Practice	✓	
Practice Managers Academy		✓
Practice Managers Conference		✓
Care Navigators/Active Signposting	✓	
Correspondence Management		✓

6.5 Aspiring to reach our future ambition

We recognise that the initiatives outlined above will not alone meet the gap in recruitment, therefore our future plans are also based around our new models of care concept. We strongly believe that these will help to deliver a sustainable workforce for the STP footprint.

By building on the Rutland Primary Care Home Model, Federation development and the MCP model we have developed a Models of Care toolkit for General Practice. We believe that this toolkit can support practices to consider exploring new ways of delivering health care at varying scales according to the needs of their patients.

The Toolkit has been specifically designed so that practices can explore the different models that could work for them. It includes a resilience tool which allows practices to assess their capacity and guides them through the toolkit to identify different models of collaborative working, such as informal working arrangements, shared clinical staff with a lead employer, expanding the skill mix through the use of other health professionals. It also offers guidance on how to include their patients in shaping the future of General Practice.

To get a better understanding of what we can do, we will work with the LMC, HEE and other stakeholders to commence a number of task and finish group across our GP workforce. By working with these groups, we aim to explore what would keep them in the system and defer

retirement, what makes a Locum GP move to a substantive role, are the Salaried GP contracts and offers “attractive” and how do we move towards a GP workforce that is Partner based?

There is also a plan to work with our medical students and registrars to understand why they don’t take up posts in General Practice and why they don’t always stay within LLR after qualifying and what makes becoming a locum more attractive? We need to explore the different incentives used by Practice when recruiting; golden hellos, sabbaticals etc.

We need to build on the different approaches taken by our training practices in LLR. For example Northfield Medical Centre in Blaby, which is a training practice, has a high retention rate of registrars becoming Salaried GPs. They put this down to their open door policy of the trainers, which although increases the workload of the trainer, the long term benefits far outweigh the time commitments and bring a great sense of teamwork to the Practice.

Downing Drive Surgery in Leicester City, has moved from the traditional partnership model of 8 clinical sessions, and introduced a flexible sessional option, and flexible working hours which has allowed a number of their Registrars to move in to Partnerships roles and not become locums. This has also helped to retain partners that were thinking of retiring or leaving.

Castle Medical Group in West Leicestershire CCG has in the last twelve months, recruited three new partners, two of whom were previous registrars. They promoted the partnership as allowing flexibility to develop a portfolio role both in and out of the practice and being able to offer flexibility on the sessions together with a senior existing partner as a mentor.

Supporting innovation and providing the tools and for new models of care as well as the transformation funding to stimulate new ideas, the LLR workforce group will work in partnership with practices to develop a practical approach to recruitment and retention..

What have we learnt?

- Our local initiatives are progressively to plan
- National initiatives alone will not reduce the workforce gap
- We need to understand why LLR and General Practice, isn’t the number one career choice of medical students
- This is not just a General Practice/CCG issue, joint working is needed across the LLR STP

Chapter 7 - Financial Modelling

What will this chapter tell you?

- The current funding into General Practice and trajectory to meet national deadline
- Assumptions of where existing funding could be reinvested
- Options for how to increase funding into General Practice
- The current financial gap to meet the national target and new models of care

7.1 Financial Analysis

The target set by NHSE is to spend a minimum of 10.9% of total annual CCG budgets by 2020, but with an aspiration of 11.3% of total CCG allocation year-on-year into General Practice services by 2020. The following table shows the financial trajectories for each CCG to achieve this goal. This trajectory does not include any additional funding from left shift or transfer of services but does account for growth, including population increases.

Table 17: LLR CCGs General Practice funding trajectories

GPFV Expectations															
	2016/17 £'000			2017/18 £'000			2018/19 £'000			2019/20 £'000			2020/21 £'000		
PRIMARY CARE FUNDING	ELR	City	West	ELR	City	West	ELR	City	West	ELR	City	West	ELR	City	West
CCG Allocation £'000	398,780	477,730	457,845	406,645	487,902	466,838	414,470	497,978	476,518	423,132	508,865	486,906	438,967	528,694	505,832
Primary Care Funding - Co- Commissioning	40,192	50,246	44,990	41,593	50,335	45,956	42,170	51,420	48,212	43,099	52,819	50,460	44,818	54,453	52,555
Co-Commissioning Allocation as % of Overall CCG Allocation	10.1%	10.5%	9.8%	10.2%	10.3%	9.8%	10.2%	10.3%	10.1%	10.2%	10.4%	10.4%	10.2%	10.3%	10.4%
Primary Care Discretional Spend	5,787	3,900	4,750	5,862	3,950	4,750	5,943	4,005	4,750	6,002	4,045	4,750	6,062	4,085	4,750
Total Primary Care Spend	45,979	54,146	49,740	47,455	54,285	50,706	48,113	55,425	52,962	49,101	56,864	55,210	50,880	58,538	57,305
% of CCG Budget Spent on Primary Care	11.5%	11.3%	10.9%	11.7%	11.1%	10.9%	11.6%	11.1%	11.1%	11.6%	11.2%	11.3%	11.6%	11.1%	11.3%

This trajectory shows that there is an increase in funding across all CCGs, but this must be put into context of;

- Inflation cost
- Population growth
- Historical funding differences between CCGs
- Increased NHSE expectations of CCG and General Practice delivery funded through existing baseline budgets (e.g. Indemnity and increased practice sickness costs in 2017/18)

There is a clear case for increased investment to support resilience, growth in demand and patient need based on morbidity and demographic change. The increase in left shift of work from other sectors also needs to be factored in either on a planned basis where funding follows the patient or on an unplanned basis where, incrementally, work is flowing into primary care.

There are ways of mitigating this growth in demand and need for workforce through education and self-care, reduced workload though the transferring care safely programme, and high impact actions. This capacity will also be supported with new models of care across groups of practices, federations and MCP models creating economies of scale and freeing up funding for more clinical staff.

It must be recognised, though, that with the current and predicted growth in demand, it is unlikely that this trajectory will do little much more than keep up with growth.

As a system, LLR will need to consider how services are commissioned from General Practice and whether it is possible to meet the national expectation of increased GPs as well as new models of care.

7.2 Financial Implications of Workforce Assumptions

There remains a challenge as to how CCGs fund General Practice to bring in new or upskill existing clinical staff to support new models as well as investing in trying to bridge the gap in GP numbers

It must be recognised though that it is not the direct responsibility of the CCGs to fund GP numbers. The CCGs buy services under the General Practice finance regime, using the national formula and on a population basis. It is down to local practice determination as to the skill mix of staff that they use to deliver their contractual obligations.

The role of the CCGs is to quantify the real gap in funding for GP numbers and how any additional funding levels can be allocated through commissioned services.

Theoretically if the gap between the current number of GPs and the NHSE target of 98 WTE additional GPs were to be funded from scratch, this could equate to a potential cost of £112,000 Per annum per GP (based on a Salaried GP, working 9 sessions per week at £10,000 per session PA, plus pension and indemnity costs, equalling £112,000). This is also making an assumption that these doctors are actually available.

This is of course an unrealistic and inflated figure, as there is currently funding within the core GP baseline that is not being used to directly employ GPs. This funding can be broadly split into three categories

- **Role Substitution**: Clinical staff, such as nurses or pharmacists, have been employed as direct replacements for GPs to deliver direct clinical services.
- **Locum Doctors**: Either employed to meet vacancies, sickness, maternity or capacity. These often cost as much as 45% per session per annum (£5,000) more than a salaried GP. These GP numbers are counted within the LLR HEE figures, but it could be argued that fewer locum doctors and more employed staff would cost less and therefore fund more GPs in the system
- **Vacancies:** It also needs to be recognised that there are a reported 18 GP vacancies across LLR. This is a figure of 3%, which is out of line with the national figure reported as 12%. An assumption has been made that there is an under reporting across LLR of approximately 3% (18 GPs). This is still half the nationally reported figure. This is because of practices either being unable to find, unwilling to fund or unable to afford more GPs.

These figures, however do not account for any of the £6 per patients for extended evening and weekend services in line with the GP5YFV expectations or other urgent care / extended access services commissioned by CCGs.

This is a real gap in the data collection by HEE and NHSE. There is currently significant commissioned General Practice services by all three CCGs in the form of Urgent Care Centres, evening and weekend hubs and day time services (as seen in **Table 5**). These services employ doctors, nurses, ANPs and ECPs, but as they are not working directly for one of the 138 surgeries in LLR they are excluded, even though they provide in excess of 200,000 appointments per annum.

This level of capacity is important in supporting core General Practice and the system as a whole and adds both clinical numbers and funding, which when added to these assumptions of the level of funding currently in the system were correct, this would mean that there is significantly less of a shortfall than the figure of 98 WTE would suggest.

7.3 Potential sources of Funding for General Practice workforce

Any financial planning has to be set in the context of a challenged health economy, where there are significant pressures on resources. There is rarely new funding and where there is, it often is wholly taken up by growth in demand, inflationary pressures or added workload.

The CCGs within LLR are acutely aware that funding for workforce will require an innovative approach. This will require exploring potential contracting options to ensure resources are targeted at service delivery and keeps up with the changing models of care within both primary and secondary care.

GPFYFV

There is new and recurrent money allocated through the GP5YFV to fund extended General Practice Services in the evening and weekend. This has already been allocated and utilised in the first wave by LCCCG as part of the Prime Ministers challenge fund. This has delivered significant additional capacity and clinical staff numbers.

In both ELR and WL CCGs this funding will be invested in delivering the additional services expected, which can only be achieved with increases in the primary care workforce. Even if these additional clinical staff numbers are not directly accounted for in the HEE workforce numbers the investment will support the system.

The total available of £6 per registered patient will bolster GP numbers and directly or indirectly will see increased funding for General Practice staffing

There is also non-recurrent funding for this programme for specific projects, these include

- Premises
- Online consultation
- Upskilling Administrative staff
- IM & T solutions

Left Shift

- Option to commission a left shift of work into General Practice
- This is challenging though as;
    - Any changes have to be negotiated in advance through the contract
    - Capacity is required to fulfil this activity, which although will need new GPs and other clinical staff to support the numbers, will not necessarily improve capacity to support a resilient Core General Practice

Spend to Save / QIPP

- Invest recurrently into General Practice with a clear QIPP programme attached for reduced ED attendance, Emergency admissions, Outpatient attendances and prescribing costs
- Transact this with acute providers to enable funding to be recurrent

Transformation

Each CCG has allocated £3 per registered patient across 2017/18 and 2018/19 and has been accounted for through existing resource aligned to each operational financial plan.

Each CCG will use this funding in slightly different ways, but all are already committed to supporting the continued development of GP Federations and the ability for General Practice to adopt new models of care

7.4 The Scale of the Financial Gap

A resilient and sustainable General Practice sector, with the appropriate workforce to meet the growing needs of the population in LLR is critical to the delivery of the STP. It is the role of the CCGs in LLR to find a way, in a very testing financial climate to commission the appropriate level of service to meet this need.

Quantifying this gap is not an exact science. There are many assumptions and variables in the system, which means that the confidence intervals do not give a final figure. In addition to this, even if the funding were available, it does not guarantee there will be the workforce in the system to employ.

The majority of funding that becomes available from the GP5YFV is non-recurrent or has significant demands on delivery of additional capacity attached to the resource.

The aspiration of the LLR system is to meet the workforce challenge, whether through additional GPs or using other clinical staff to meet patient need. To fund the NHSE expectation of 0.58WTE GPs per 1000 patients and to have one clinical pharmacist per 30,000 patients and role substitution through ANPs and PAs will have a real financial implication.

The LLR CCGs request that NHSE supports the development of new models of care and innovative solutions to workforce capacity and provides additional recurrent funding to enable the challenging targets to be reached.

What have we learnt?

- There are financial pressures in meeting the NHSE target
- Increased investment is planned, but this will cover little more than growth
- The CCGs in LLR need to consider innovative ways of investmenting into General Practice

Chapter 8 - What next for LLR – Actions and Delivery

What will this chapter tell you?

- Highlight the workforce risks within the system
- The need for a whole system approach to delivery
- The requirement for more funded training posts
- The support needed from NHSE

The workforce statistics paint a stark picture of dwindling GP numbers and a Nursing retirement time bomb. The reality in some areas is significantly worse, with real inequity between geographical boundaries. The strained environment within the NHS could further exacerbate this problem with fewer medical and nursing students considering General Practice as a career option and those that do, often choose to be Locums, Agency staff or part time.

This is all in the context of a campaign from the General Practitioners Committee (GPC) who are pushing for a "Safe Working in General Practice" following their publication of a report entitled, "Responsive, safe and sustainable: our urgent prescription for General Practice" in April 2016 in an attempt by the profession's representatives to quantify what is considered as safe workload to protect GPs and patients, which if successful could lead to a greater capacity gap.

The difficulties encountered through workload, declining incomes and recruitment shortages have led to a natural and holistic adaptation of the service delivery model. Many practices or groups of practices have turned to new clinical staff models to provide care for their patients with positive impact on morale and outcomes.

To ensure a resilient and sustainable General Practice sector there are now a number of actions and requests of the system at both a local and national scale. Without all of these in combination, the challenge will become increasingly difficult.

8.1 General Practice Specific Workforce Initiatives- The start of the Journey

It is only in the last eighteen months that LLR has established a General Practice working group to focus on these issues and working closely with colleagues across the system through the Local Workforce Action Board to support collaborative delivery.

The task is to develop an attractive system whereby new GPs enter on an employed basis and those already in practice do not reduce clinical sessions or retire early. Even if this were to be achieved and a successful International Recruitment Campaign brings numbers in to LLR, there is a gap in training numbers and the system is discouraging medical students to be GPs. LLR as a system needs to do more to make the area and the General Practice environment an attractive place to work.

There have been a number of successes for example, with the development of three education hubs and significant numbers of pharmacists working in a General Practice setting. The GP5YFV initiatives are all progressing and with a clear and detailed understanding of the real situation in LLR, the next phase of workforce initiatives should support the system to support a sustainable and resilient General Practice sector.

The workforce supply and demand analysis shown in Chapter 5, illustrates a number of scenarios that through improved recruitment, retention and substitution of GPs with other healthcare professionals will help to bridge the gap. These trajectories will be challenging, but there is a system wide aspiration to deliver the staffing to provide the services LLR patients need for their health care.

8.2 LLR System Actions to Deliver the Workforce

In order to consider delivering against the trajectories set by NHSE, there are a number of challenges for the system to respond to:

- Ensuring the future workforce supply is aligned to new models of care
- Ensuring the system can make the capacity shifts required
- Ensuring staff have the right skills and capabilities to perform in the new system
- Ensuring effective management of change and development of the 'system' culture
- Ensuring that there are adequate training placements and that people stay in LLR once qualified
- Ensure that there is a focus on under doctored areas within the STP footprint in all our initiatives. This requires a focus on the City and any areas in the County that have particular recruitment issues.

The LLR workforce system, will need to work together in order to mitigate the system wide risks, challenges and interdependencies. This work stream will need influence the future commissioning of training provision, and understand the capacity risks.

8.3 Training Opportunities

General Practice remains at the heart of patient care, but there are real opportunities for services to be delivered through joint working and different staff groups to improve outcomes and efficiencies. This is a shift from traditional models of delivery, but offers opportunities and incentives to improve the patient pathway and become a more diverse and attractive place for clinicians to work

The reality is that without a resilient General Practice sector the system will have great difficulty in managing patient demand. There is a need to ensure there are the increased numbers of appropriately trained staff to deliver the new and existing models of care in a General Practice setting. There are currently some opportunities and initiatives to support this, but there remains a gap in numbers and training places available.

The local education offer through Leicester and De Montfort Universities offer a number of doctors, nurses, pharmacists and other health professionals each year. There is, however, a real gap in the availability and funding of placements to upskill clinical staff to take on broader and more autonomous roles.

This is most clear with nursing posts. This plan set out the need to train existing and new nurses to take on wider roles in the primary health care team. The numbers are not yet quantified, but would need significant training placements each year. These placements are important to the success of the new models of care, but will require national funding. Locally, practices will also need support to release these staff members on a regular basis during their training

8.4 Staff Mobility

With the proposed left shift of services out of a hospital setting and opportunities for other health professionals to work in a General Practice setting, there will be a need for staff groups to be able to move across organisational boundaries. This again will require careful planning, training and upskilling to support the right care to be provided. The system will need to work closely to plan the pathway for staff and the training available to ensure a smooth transition.

8.5 Organisational Development and Leadership

Ensuring effective management of change and development of the 'system' culture requires a whole system change and the need for clear leadership. Working across LLR, the GP workforce group will link with the LWAB, LWAG and Leadership Academy to deliver the appropriate solutions. This will include;

- **Developing Culture:** It is recognised that the differences in culture between respective partner organisations could be a barrier to successful delivery of the programme.
- **Staff engagement and change management**: The OD group will support the Clinical Leadership Group (CLG) to identify clinical leaders in the system to enable effective support and engagement
- **System leadership capacity:** Working with the East Midlands Leadership Academy (EMLA), we have produced a set of competencies around system leadership, together with a programme of support.

8.6 Finance and Transformation

A resilient and sustainable General Practice sector, with the appropriate workforce to meet the growing needs of the population in LLR is critical to the delivery of the STP. It is the role of the CCGs in LLR to find a way, in a very testing financial climate, to commission the appropriate level of service to meet this need.

This could require a movement of existing commissioning resource into a General Practice setting and will need system wide recognition of an enhanced out of hospital sector funded appropriately.

8.7 The Ask of NHSE

There is no challenge from the CCGs in LLR that there is a need for significant workforce planning and a concerted effort to develop a strategy and implementation plan that supports the delivery of a sustainable and resilient General Practice sector.

There does, however need to be a recognition that General Practice services in LLR are not just commissioned through traditional channels and that there are significant number of clinical and non-clinical staff providing a high quality and accessible service in addition to Core GP contracts, that should be recognised in the HEE workforce tool.

There also needs to be recognition that the system in LLR has already shown real innovation in adapting to the lack of GPs, by developing models that are staffed by highly competent clinical staff that provide excellent services to patients. This model of role substitution is at the forefront of many proposed models and this may mean that practices choose not to employ GPs in the long run.

We would envisage NHSE as having a key role in supporting funding into the system, not just non recurrently or to increase opening hours in the evenings and weekends, but to support training placements to upskill existing staff; Medical, Nursing and Pharmacy places in higher education, nationally negotiate indemnity costs which will support more clinical staff to work out of hours and finally support system design that enables General Practice the flexibility to innovate and create a sustainable future.

What have we learnt?

- An overview of workforce risks within the system
- An agreed accountability across the LLR system for delivery of the workforce plan
- The need for training placements to support upskilling and new entrants into General Practice
- Innovative ways of funding for sustainability
- The need for NHSE to support LLR in delivery of the workforce challenge

Chapter 9 - Governance, Assurance and Delivery

What will this chapter tell you?

- Details of the programme governance
- Assurance of delivery of this plan
- Implementation and timescales
- Register of Risks

9.1 Programme Governance

The System Leadership Team (SLT) has been established to oversee the development and delivery of the Sustainability and Transformation Partnership for the LLR footprint.

The SLT has the overview for the GP Five Year Forward View, and has established the GP Programme board as the Leadership and implementation group responsible for design and delivery of the GP Five year forward view and the GP resilience programme of the LLR STP.

9.1.1 GP Programme Board (GPPB)

The GPPB is responsible for design of the 5 year strategy of sustainable transformational change in General Practice that meets local needs and delivers the GP 5 year forward view

The Board provides leadership in the design, development, planning and delivery of a sustainable General Practice.

There are three direct groups that feed into, and are held to account by the GP STP Programme Board, these are;

- Primary Care Workforce
- IM&T
- Implementation

The GPPB monitors the progress of work streams led by its subgroups; they will identify and report blockages and barriers, which are escalated to the SLT. Data is reported monthly through the highlight reports. Additionally the GPPB reports monthly to NHS England GP Five Year Forward Group and provides local highlight report submissions.

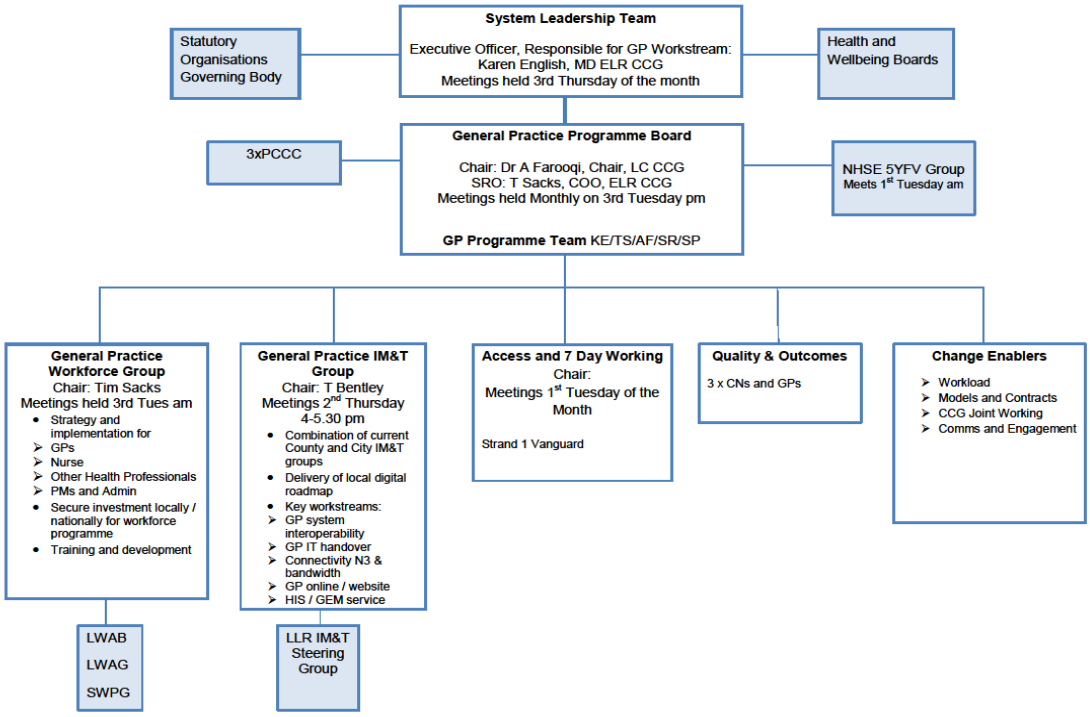
Membership of the GPPB comprises of the following:

- Chair Prof A Farooqi, Leicester City CCG Chair
- Deputy Chair, Tim Sacks SRO (ELR Chief Operating Officer)
- Clinical Lead from ELR and WL CCG
- Senior Manager from LC and WL CCG
- Local Authority representatives from Rutland / Leicester / Leicestershire

- A representative from Healthwatch Rutland / Leicester / Leicestershire
- NHS England Representative
- UHL representative

- A representative from the Leicester, Leicestershire and Rutland Local Medical Committee
- GP Provider perspective from Federations (1 member per CCG representing the Federations)

Figure 10: Structure chart for LLR STP GP reporting and governance



The GP Programme Team is responsible for the day to day programme management for the GPPB this includes, design of project templates, collation of project detail, whilst seeking assurance against timelines and delivery against plan. Detailed below are some examples of the governance mechanisms that have been put in place:

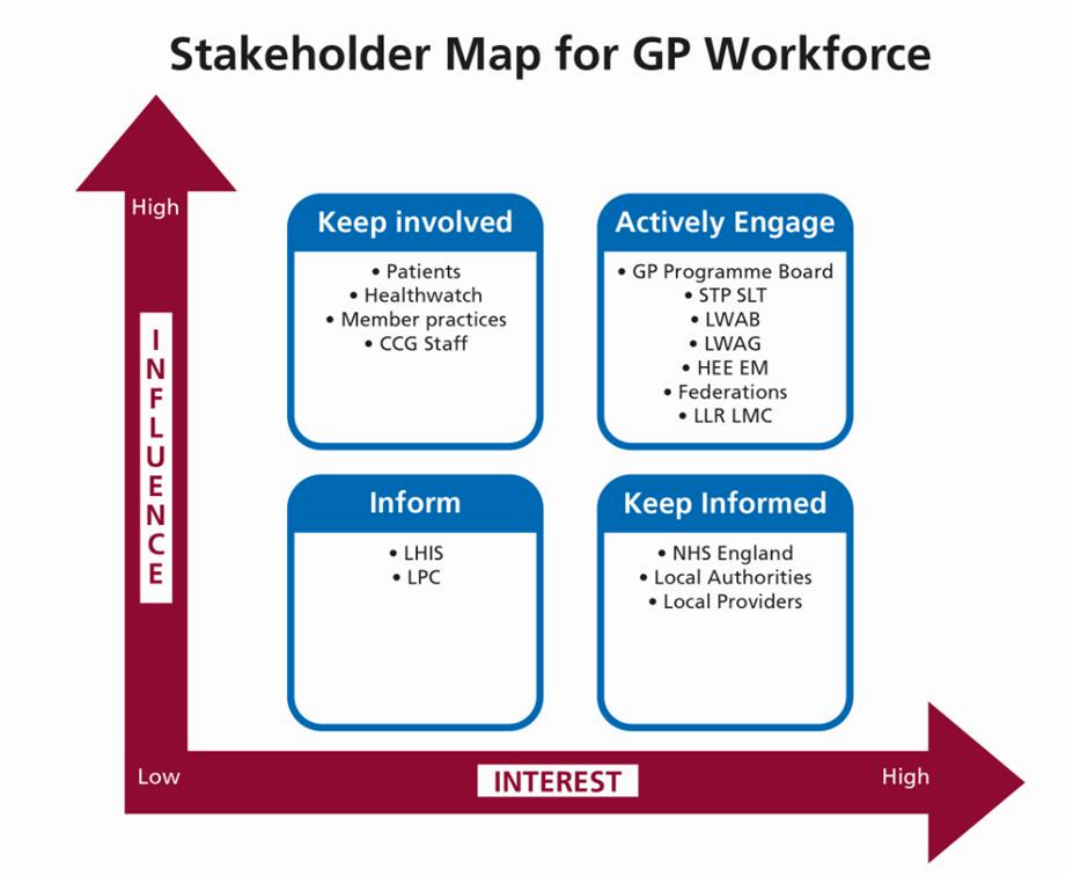
- Project Initiation Documents (PIDs)
- Highlight Reports
- Risk Register
- Overarching project plan for all projects within this work stream

Each project within the GP Five Year Forward View has an appointed project manager, a clinical lead and where required a project team.

We have used the following map to identify stakeholders but also for determining the best way or ways to manage their expectations. We recognise that different stakeholders may

have different level (s) of influence or involvement during project life cycle, this ranges from occasional to frequent.

Figure 11: Stakeholder map for GP workforce



9.1.2 Workforce Governance

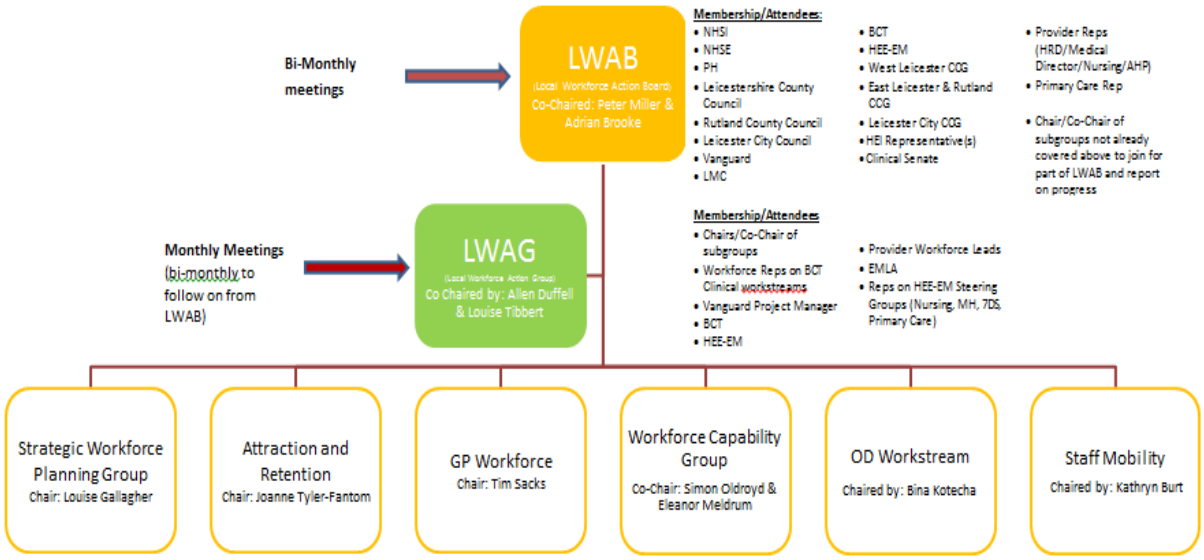
The main purpose of the of the LLR Workforce group is to ensure that the LLR Primary Care Strategic Direction is aligned to the STP GP Strategy and the FYFV in terms of sustainable and resilient workforce. This group meets on a monthly basis.

The GP Workforce Group provides assurance to the GPPB and LWAB that appropriate workforce activities and programmes are in place to deliver the LLR Workforce requirements. They do this by ensuring that organisations work together collaboratively to address the challenges and deliver the solutions.

All projects developed are supported with project documentation such as project initiation document (PID), risk register and appropriate delivery monitoring and reporting schedules.

The following structure chart provides an overview of the reporting and governance arrangements for LLR General Practice Workforce Group. It should be noted that the group reports to the GPPB, but also has strong links in to the Local Action Workforce Board (LWAB), Local Workforce Action Group (LWAG).

Figure 12: LLR Workforce governance Structure



9.2 Assurance, Delivery Plan and Risk Management

We have developed a robust and inclusive framework of assurance, and appointed a GP programme team office. The GP programme office team is responsible for the overall programme management of the individual work streams. The team monitors performance and delivery against individual project plans, milestones and KPIs whilst highlighting any slippage in delivery to the GP PB.

This assurance role is independent of the Project Managers, but works in close collaboration with the Project Managers and the Project Board in providing direction and advice.

As part of the delivery plan the programme office team maintains a full risk register which, importantly, sets out local actions being taken to mitigate the potential impact of these.

Not surprisingly therefore, a plan with this level does come with significant risks to delivery, in particular:

- ✓ CCGs are unable to underwrite the financial commitment required
- ✓ Ability to secure engagement across and mobilise the support of 138 General Practices run as independent contractors
- ✓ Capacity and Capability of our current workforce
- ✓ Recruitment initiatives will not meet current vacancies across LLR
- ✓ Availability of workforce to support new ways of working and care models
- ✓ Acceptability of new skill mix models to patients used to a more traditional GP focused model of care
- ✓ Retention initiatives does not reduce staff loss across

We recognise that it is important to monitor the workforce measures that allow evaluation of whether our implementation plan is closing the workforce gaps.

Workforce planning is both a dynamic and an iterative process, influenced by the internal and external environment the CCGs operate in. These drivers change over time and our workforce plan needs to be reviewed and adjusted to reflect them. By monitoring KPIs, we will be able to identify changes and developments in the workforce, and this will inform the workforce plan evaluation and review.

All work streams within the workforce programme have been included in the delivery plan, and includes finance and communication.

Progress against the workforce plan will be reviewed monthly, and through highlight reports presented to the GPPB and SLT. The Programme Lead, together with Project and Clinical Leads develop action plans in support of the priority work streams. Exception reports for all action plans will be monitored by the GPPB through the group minutes and the data contained within any plan will be updated as required.

Working with HEE, we will receive a quarterly report to assess whether changes that have been implemented for the workforce are taking place. We will monitor progress of the delivery plan to ensure initiatives are delivered on time and within budget using KPIs and milestones.

KPIs identified will be used to evaluate success, however, it is recognised that some benefits realisations have a time lag and, as such, the KPIs may not reach the desired target until enough time has elapsed since implementation.

We will evaluate the effectiveness of our workforce plan to understand whether it has succeeded in addressing the identified workforce gaps. Looking at the specific strategies and initiatives, and whether these have been effective, to enable us to improve the next iteration of our workforce plan.

The workforce plan will be updated in line with the yearly or six-monthly (mid-year review) business planning process, and following evaluation of our workforce plan, we will be able to make adjustments and improvements.

We will conduct a full-scale workforce planning review process every 12 months, but rather adjust the current plan to incorporate new data and ensure coverage for the next 12 to 18 months. Any adjustments will be presented to GPPB and SLT for approval and sign off before being implemented.

Overview of key steps within delivery plan

- ✓ Quarterly Workforce Survey
- ✓ HEE analysis and evaluation of quarterly survey
- ✓ Monthly KPI monitoring
- ✓ Monthly Benefit realisation
- ✓ Six-monthly refresh of plan in line with business planning process
- ✓ Annual full review of workforce programme

What have we learnt?

- How the programme governance works to support delivery
- We have implemented a robust governance and assurance process
- An overview of the programme risk register and how we manager these risks
- How we will deliver this plan

Figure 13: General Practice Workforce Delivery Plan

No.	Key deliverables	Position	Action/Milestone	Action Owner (Organisation)	Milestone Delivery Date	Success Measures	KPIs/Plan Trajectory
1	**Workforce Data**	**Commenced**	• Baseline of current workforce numbers and skills in General Practice • Map the future workforce needs • Continuous Data Collection - Quarterly basis • Evaluation and Analysis of quarterly data • Review workforce plan	GP Programme Board	2017-2020	• To identify the future primary care workforce needs and gaps • Quarterly real-time workforce data	•LLR roll out and 100% reporting via workforce tool •Next data submission due quarter 3 • Plan refresh following data submission Jan 2018
2	**Models of Care Explorer Sites Practice Toolkit**	**Commenced**	•Actively lead the implementation of all ILTs across LLR based geographic footprints across General Practice. community services and social care. •Each Integrated Locality Leadership Team to complete EMLA development programme. •Explore the potential of the specialist GP role •Integration of new roles within practices, contributing to MDTs • Develop primary and community MCP model and enact through an MCP contract •Toolkit for Practices launched • Explorer Sites Pilot - evaluated • Consider implications to workforce plan and update	GP Programme Board	2017-2019	•Fully developed ILT which wrap around the patient and their general practice, extending the care and support that can be delivered in the community settings. •Best practice models evidence of impact to quality service provision •Focusing of Primary Care MDT Capacity to maximise impact •Improved outcomes for Care home patients and target populations •Increase in General Practice resilience •Multifunctioning MDT working across Primary Care •Sustainable and high quality Practices •Federation/collaboratively led integrated community services •Federation/Collaboratively led approach to core service delivery •Slow the rate of growth in use of acute emergency services and increasingly meet peoples needs in lower acute settings •Secondary care spend for high-risk patients reduced	•ILTs launched - number of patients identified vs cared for via ILT •Delivery of LLR Workforce Plan •Transformational workforce programme roll out across LLR •Localised KPIs agreed •Number of practices adopting the toolkits, thereby increasing access •100% practice engagement across LLR •Achieve contractual compliance •Decrease the number of patients seeking non-urgent healthcare in secondary care •Increase the number of patients successfully treated within a community setting
3	**General Practitioner:** **a) IRGP** **b) I&R** **c) Retention** **d) Locums**	**Commenced**	**a) IRGP** • LLR Phase 1 & 2 IRGP application submitted to NHSE •Commence overseas recruitment with NHSE recruitment partner **b) I&R** • Increased awareness and uptake of I&R scheme in LLR **c) Retention** • Increased awareness and uptake of Retention • Commence Task & Finish groups with Medical Students and Registrars and Locums **d) Locums** • Locum Chambers launched in LLR • Establish and implement across system working	GP Programme Board	2017-2020	•Supporting the existing primary care workforce to improve recruitment and retention •Effective implementation of national initiatives • Working with HEE EM understand the future needs for a sustainable workforce • LLR GP recruitment gap reduced **a) IRGP** •IRGP bids submitted and approved by NHSE •Successful recruitment to vacancies from overseas •Overseas GPs remain in LLR workforce **b) I&R** •Increased uptake of scheme across LLR • Successful completion of I&R scheme **c) Retention** •New & updated programme launched across LLR •Increased participation in Retention scheme **d) Locums** • Reduction of GPs leaving substantive posts • Successful launch of LLR Locum Chambers • Reduction of Medical Students becoming locums	•Maximise the national opportunities for staffing through FYFV programme •Increase the number of GP trainees that remain in LLR after scheme completion •Working with HEE EM launch programmes for portfolio GP role •Increase the number of Partner and Salaried GPs in the workforce •Reduce the number of locum doctors in the system •Locum chambers to be set up across LLR to enable flex of staff when practices require clinical support •In collaboration with HEE EM, utilise the National GP refresher and retainer schemes •Working with HEE EM identify programme of upskilling GPs

4	**General Practice Nursing**	**Commenced**	• Launch of GPN Training programme • Increased awareness and uptake of GPN Fellowship scheme across LLR • Evaluate Nursing Associate pilot • Launch Learning Beyond Registration applications 2018/19	CCG Nursing Leads/ HEE EM	2017-2020	•Actively utilising the three training hubs to support nursing training •Increased uptake of GPN Fellowships across LLR •Roll our of Nursing Associate role across LLR	•Training programmes for nurses in place to support autonomous working • Increase number of nurses returning to practice in LLR • Reduction in the number of agency nurses in the system • Increase the number of practice nurses applying for fellowship positions
5	**Other Healthcare Professionals /Clinical Pharmacists Physician Associate**	**Commenced**	• Placement of 2nd Cohort Physicians Associates • Relaunch HCA Apprenticeships in LLR • Explore & develop ECP role for LLR • Launch Medical Assistants role for LLR	GP Programme Board/LWAG	2017 - 2020	•Identify new capabilities, competencies, skills and behaviours required to make an enhanced primary care offer •Number of HCAs increase in primary care •Launch of ECP programme in LLR	• Pharmacists in primary care workforce supporting every practice • Other health professionals such as PAs and ECPs employed across LLR • Programme of upskilling HCAs to enable every practice to retain staff
6	**Workload HIA Care Navigators**	**Commenced**	• Wave 2 pilot Correspondence Management • Evaluate Active Signposting pilot • LLR Role out of CLAP courses, incorporating active signposting and social prescribing. •Review implementation and effectiveness of the support offered to practices	GP Programme Board	2017-2021	•Practices prevented from reaching crisis through identification and ongoing support •Number of changes made targeted at reducing the workload of General Practice •Primary care staff with increased knowledge and confidence to implement quality improvement initiatives •Quality improvement leaders identified across LLR •Number of practices reporting time freed up by changes made •Number of practices reporting positive outcomes following participation in the schemes	•Participation in engagement events •Run Collaborative Learning in Action Programme focusing on HIA •Rollout of transformational workforce/work load programmes across LLR •Successful implementation of support rolled out across LLR
7	**Practice Managers**	**Commenced**	•Fund the Practice Managers Academy to support this important group to enable change in General Practice •Launch of Practice Managers Academy • Pilot PM Mentor scheme • Evaluate pilot and launch across LLR	GP Programme Board	2017-2020	•Identify new capabilities, competencies, skills and behaviours required to make an enhanced primary care workforce •Practice Manager Academy launched in LLR •Retention of PM workforce	•Participation in engagement events •Training programmes for PMs that support autonomous working •Collaborative working in LLR •Reduction in stress/sickness through mentorship •Development of highly skilled PMs to help deliver sustainable general practice
8	**Administrative Non Clinical Staff**	**Commenced**	• Promotion of Administration Apprenticeships in LLR • Practice Care Navigators in all practices in LLR	GP Programme Board	2017-2020	•Increased offer of apprenticeships across LLR •Increased number of apprentices in LLR •Practice Care Navigators trained and in posts across LLR •Reduction in patients being misdirected around "system"	•Making every contact count fully embedded in LLR •Supported by HEE EM - Bespoke training package of upskilling staff

9	**Education & Training**	**Commenced**	•Map the existing programmes of training education and development for all staff groups within general practice in LLR, identifying gaps and risks •Increase the skillset of the new workforce •Actively utilise the three training hubs, support undergraduate medical, nursing and pharmacy training and GP training at a federated level •Second intake Nottingham Medical Students •Commencement of Pharmacy students placements •Year 10 work experience placements across LLR •University of Derby nursing student placements in LLR •Launch Frailty Nursing scheme •Launch Return to Nursing programme •Launch of Practice Managers Induction •Launch new Appraisal training programme for PMs •Develop Admin Apprenticeships for LLR •Refresh HCA apprenticeship scheme	GP Programme Board	2017-2020	•Continue through the STP and GP Workforce Groups to develop a dynamic and responsive programme co-ordinated and held to account through the Local Workforce Action Board •Maximise funding for LLR training hubs •Programme to ensure retention of trainees and increase of clinical staff to choose LLR s a place to work •Nursing training programmes in place to support autonomous working •Support existing primary care workforce to improve retention •Continue through the STP and GP workforce groups to maximise funding for LLR training hubs •Identify new capabilities, competencies, skills and behaviours required to make an enhanced primary care	•Enhanced bespoke training package offered to LLR by Primary Care Training Team • With HEE and HEE EM continued development of nursing and other health care professional training programme •Map the number of placements for GPs in LLR •Map the number of Nurses training placements across LLR •Additional funding identified via national and local initiatives •Successful feedback following induction scheme •Continue working with EMLA on system leadership •LLR Academy implemented
10	**Staff Mobility**	**Commenced**	• Implementation & integration of Neighbourhood Teams across LLR • Identify any HR support to deliver interdependencies re-skilling and redeployment of LLR workforce • Explore LLR estates for co-location of teams •Identify any risks including financials, for co-location of teams	LWAG	2017-2020	•Successful redeployment of staff across the system •Upskilling of current workforce in system •Fully embedded Neighbourhood Teams in LLR •Co-located teams across LLR	•Successful testbed pilots for MDTs •Delivery of Integrated Locality Teams •Rollout of HR process for redeployment of staff •Delivered on time and within budget
11	**Organisational Development**	**Commenced**	•Vision and Direction agreed •Staff engagement events launched •Support the system to work more collaboratively •Develop induction package "The LLR Way" • Finalise the system leadership support programme •Launch clinical leaders recruitment	LWAG	2017-2020	• Launch of LLR system culture to support delivery of workforce programme • Induction package introduced across LLR STP • 100% of staff know and understand the LLR Vision • Staff access the system leadership support programme across LLR •LLR implementation of cross system learning together • Successful recruitment of clinical leaders using talent management approach	•Successful feedback following induction scheme •Continue working with EMLA on system leadership •LLR Academy implemented

12	**Finance & Indemnity**	**Commenced**	•Quantify funding implications for workforce recruitment gap •Quantify funding requirement for new models of care • Apply to NHSE for non-recurrent funding via GPFYFV initiatives • Identify Spend to Save/QIPP investment for General Practice • Transact with Acute providers to release funding for General Practice • Monitor CCG transformation funding • Quantify additional indemnity funding required to support existing workforce	CCG Chief Finance Officers	2017-2020	• Appropriate and adequate funding to deliver LLR FYFV plan agreed by NHSE •Recurrent funding agreed by NHSE •Additional baseline funding from NHSE •Delivery of QIPP against spend to save schemes •Transformation funding delivers sustainability in LLR	•Identify and apply for all FYFV available funding to help deliver the workforce plan •FYFV non-recurrent funding secured •Quantify the funding gap across LLR •Identify QIPP/Spend to Save schemes for LLR •Agree and transact Acute Contractual changes
13	**Communication & Engagement**	**Commenced**	• LLR FYFV branding agreed • GPPB and SLT sign off Communication plan • Increase practice engagement across LLR • Commence Patient, Stakeholder and Public engagement events • Continued promotion of FYFV vision across STP footprint	GP Programme Board / CCG Comms Leads	2017-2020	•Recognised LLR FYFV brand •Increased public and stakeholder awareness	•Draft plan in development for GP PB approval for submission to SLT for approval

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Figure 14: Implementation Plan

Workforce Strategy Implementation Plan														
Number	Detail													
Workforce Data Mapping		Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Q1 18-20	Q2 18-20	Q3 18-20	Q4 18-20
1	Workforce Data Mapping													
2	Models of Care & Explorer Sites													
3	General Practitioner IRGP, I&R, Rention & Locums													
4	General Practice Nursing													
5	Other HealthCare Professionals													
6	Workload, HIA & Care Navigators													
7	Practice Managers													
8	Admin & Non Clinical Staff													
9	Education and Training													
10	Staff Mobility													
11	Organisational Development													
12	Finance & Indemnity													
13	Communication and Engagement													

KEY	
	Planned
	Complete
	Critical Milestone
	Issue

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Figure 15: Workforce Risk Log

Project Risks & Issues Log

Workstream	Resilient General Practice
Project Name	Workforce Delivery
Executive Sponsor	Karen English
SRO	Tim Sacks
Project Lead	Sharon Rose
Clinical Lead	Azhar Farooqi
Finance Lead	Richard George
Comms	Richard Morris
Activity (Maybe CSU)	0
Contracting Lead CCG	ELR CCG

Risk RAG

Red

Likelihood	Consequences				
	1 (Insignificant)	2 (Minor)	3 (Moderate)	4 (Major)	5 (Catastrophic)
1 (Rare)	1	2	3	4	5
2 (Unlikely)	2	4	6	8	10
3 (Possible)	3	6	9	12	15
4 (Likely)	4	8	12	16	20
5 (Almost certain)	5	10	15	20	25

Narrative for current Risk RAG

A significant number of risks to this programme are reliant on other oganisations and adequate funding to support in addition to the nature of general practice.

Risk Number	Risk Description: describe the cause (hazard), and effect (risk)	Original Likelihood Score	Original Impact Score	Original Risk rating	Risk Level	Date Added to Risk Register	Mitigating Actions/Controls Required	Responsible Organisation	Reviewed Likelihood Score	Reviewed Impact Score	Reviewed Risk rating	Risk Movement from last	Risk Status	Workstream
R001	Training for posts for Doctors / Nurses / Phamacists	4	4	16	Significant	09/10/2017		HEE/HEEM	4	4	16	◂ ▸	Open	Workforce delivery
R002	Doctors in training who become GPs - Locum / Part Time	5	5	25	Significant	09/10/2017	•International Recruitment. •National Recruitment	LLR / HEE / HEEM	5	5	25	◂ ▸	Open	Workforce delivery
R003	Nurses in training who work in practice	4	3	12	High	09/10/2017		LLR / HEE / HEEM	4	3	12	◂ ▸	Open	Workforce delivery
R004	Retention. •Workload •Pension Rules •Indemnity costs •Finance •Increasing vacancies creating additional workload pressure	4	4	16	Significant	09/10/2017	Schemes - GP5FV Portfolio working New Models of Care	LLR / NHS E	4	4	16	◂ ▸	Open	Workforce delivery
R005	Age of Workforce	5	3	15	Significant	09/10/2017	Retention Return to Work	LLR	5	3	15	◂ ▸	Open	Workforce delivery
R006	Training to upskill existing staff in general practice or other health settings moving to general pracices	4	4	16	Significant	09/10/2017		LLR / HEE / HEEM	4	4	16	◂ ▸	Open	Workforce delivery
R007	Practice engagement in new models of care	3	3	9	High	09/10/2017			3	3	9	◂ ▸	Open	Workforce delivery
R008	International recruitment - Fails to deliver	4	4	16	Significant	09/10/2017		LLR	4	4	16	◂ ▸	Open	Workforce delivery
R009	Intiative designed to reduce workload in general practices does not deliver	3	4	12	High	09/10/2017	Close KPI monitoring and delivery throughout pilot and implementation phases	LLR	3	4	12	◂ ▸	Open	Workforce delivery
R010	Finance Commissioning doesn't release funds	5	4	20	Significant	10/10/2017		LLR	5	4	20	◂ ▸	Open	Workforce delivery