NHS Milton Keynes Clinical Commissioning Group

NHS Luton Clinical Commissioning Group

NHS Bedfordshire Clinical Commissioning Group

BLMK Sustainability & Transformation Plan

General Practice Workforce Plan and Development Programme

Stabilise, Sustain and Transform

Delivering the GP Five Year Forward View

February 2018

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Executive Summary

The challenges facing the Bedfordshire, Luton and Milton Keynes (BLMK) Accountable Care System within General Practice are not dissimilar to the national picture. Recruitment and retention challenges for GPs and the wider primary care workforce are requiring us to think differently about how we build teams and staff which will stabilise, sustain and transform our future workforce.

Our local workforce modelling indicates that our current vacancy levels for GPs are at around 13 % with a high utilisation of locum GPs supporting these shortfalls. When known retirement profiles and our target allocation for GP expansion is layered into this profile, a GP workforce gap averaged at 27% is revealed.

Build into this modelling the future supply of GPs coming through the national training scheme and the increased requirement for GPs due to population growth, it becomes clear that simply doing more of the same and recruiting the number of GPs required into like for like job roles is untenable. Similarly General Practice is faced with high numbers of retiring Practice Nurses and Practices Managers.

The future vision for primary, community and social care across BLMK is predicated on a strengthened, primary care led, integrated out of hospital service. A standardised approach to care co-ordination and an invigorated approach to self-care, self-management and the use of social capital and prescribing. BLMK have adopted Primary Care Home as its out of hospital care model. The model is underpinned by an enhanced General Practice offer, which is supported by a health and social care integrated multidisciplinary workforce.

This will be delivered through new ways of working within general practice and primary care, providing strengthened, enhanced GP services and also supported through a wider health and social care workforce, wrapped around GP services, to offer coordinated, joined up, place-based care . This approach enables us to think differently about how teams of staff support general practice workload and consider what aspects of GP care could be delivered by a range of other staff groups. The Health Education England Primary Care workforce tool enables us to explore opportunities for ‘role substitution’ for up to 10% of GP workforce requirements over the next 3 years.

Our General Practice Workforce Plan and Development programme covers a range of new roles and ways of working, recruitment and retention and education, training and development initiatives that address these workforce challenges. ICS indicative costs currently demonstrate the requirement for significant investment of over £11.5 million to develop General Practice workforce. Further in depth modelling is progressing with support of the National Association of Primary Care to further refine and test these assumptions.

1. Introduction

Our GP workforce plan and development programme reflects both the significant progress made to date to achieve our goal to stabilise, sustain and transform the General Practice workforce within the BLMK ICS across our 108 practices and also describes the challenges we collectively face.

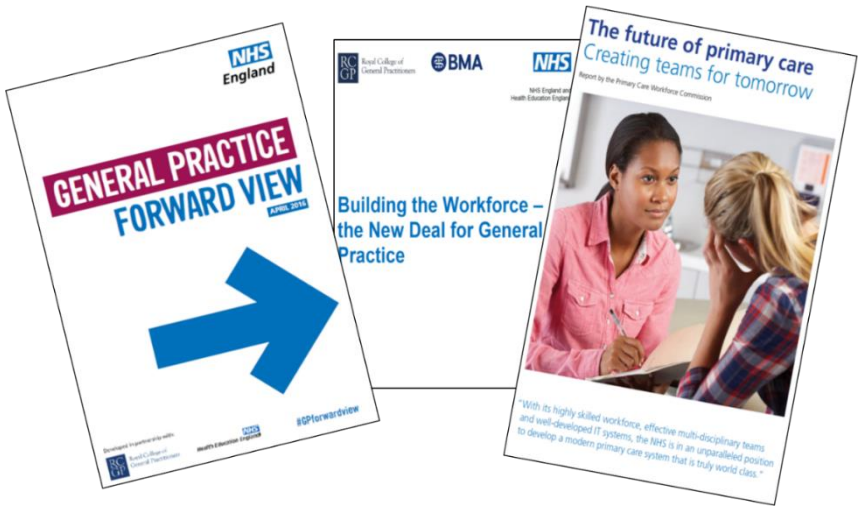
Underpinned by a vision for implementing the Primary Care Home model, we place patients at the centre of an enhanced primary care offer, supported by the wraparound of integrated multidisciplinary health and social care teams.

We describe our ambition for recruitment and retention, new roles and ways of working and an infrastructure that supports training, education and development of staff supported to work at the top of their licence. Our plan delivery will be driven by a centralised community and education provider network (CEPN) and assured through our ICS governance framework.

The investment and resource implications for the development of our most valued asset, our workforce, is substantial and we look forward to working in partnership with NHS England to co create robust financial frameworks that assure sustainable delivery of our plans.

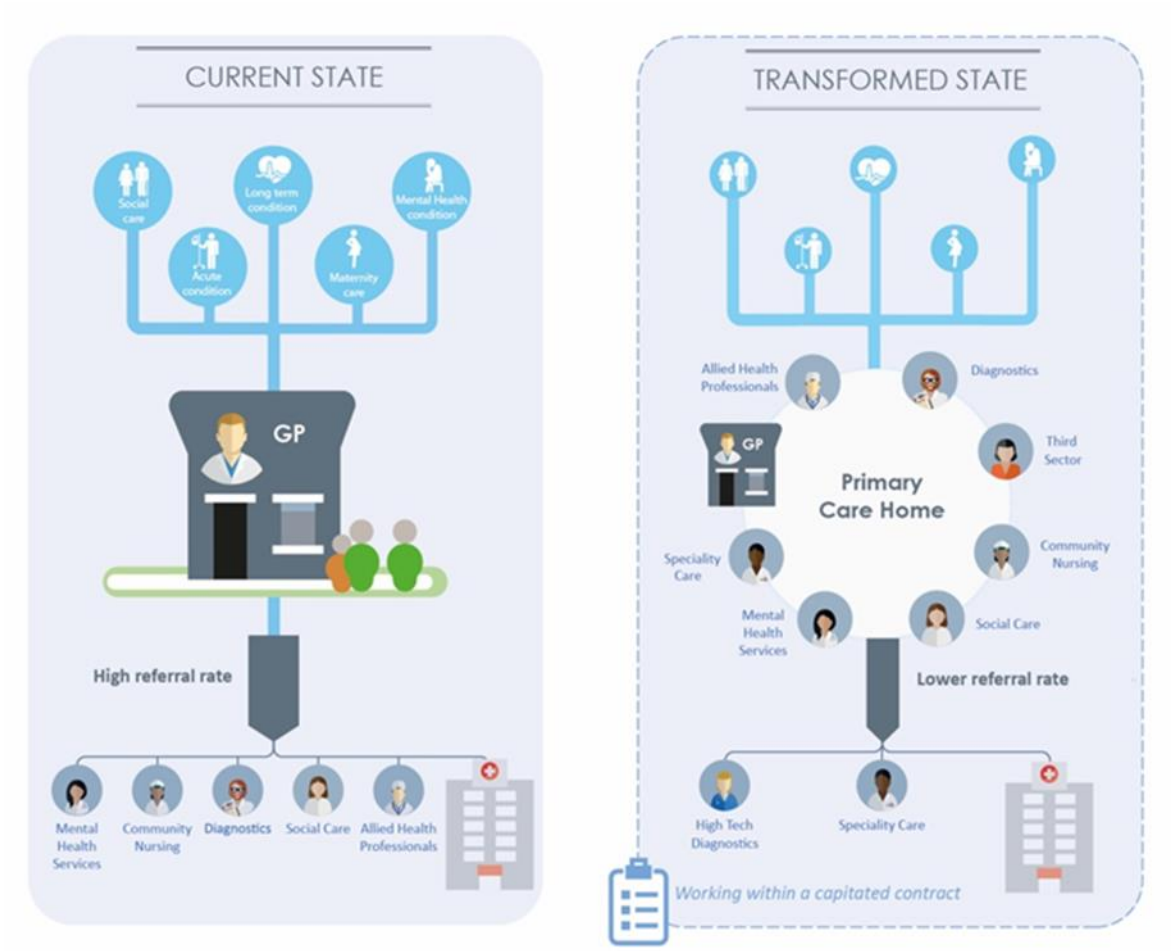
2. National and Local Context

The challenges facing the BLMK ICS within General Practice are not dissimilar to the national picture, with recruitment and retention challenges for GPs and the wider primary care workforce requiring us to think differently about how we build teams and staff which will stabilise, sustain and transform our future workforce.



The future vision for primary, community and social care across BLMK is predicated on a strengthened, primary care led integrated out of hospital service. A standardised approach to care co-ordination and an invigorated approach to self-care, self-management and the use of social capital and prescribing. BLMK have adopted Primary Care Home as the out of hospital care model. The model is underpinned by an enhanced General Practice offer, which is supported by a health and social care integrated multidisciplinary workforce.

Figure 1. Current vs Transformed State



Ensuring the sustainability of General Practice services and the delivery of future models of care is reliant on the recruitment, retention and development of a motivated, resilient workforce coupled with the introduction of new roles, enhanced skill mix and new ways of working.

2.1. Current workforce – key risks and issues

Significant workforce challenges face primary care across the Bedfordshire, Luton and Milton Keynes STP footprint. Compared to the East of England we have the second highest proportion of GPs due to retire in the next 5 – 10 years, which is 4% above the national average. There are more patients per GP and patients are younger than the average regional and national patient profile, with half the regional rate of dispensing practices.

In contrast, the ratio of patients per nurse sits between the regional and national averages however, 27% of our practice nurses are over 55. The percentage of advanced or specialist nurses ranks second in the region ranging from 34% in Bedfordshire to 24% in Milton Keynes. Proportionally, Bedfordshire CCG has the fewest health care assistants, whereas across Luton Health Care Assistants make up 85% of the direct patient care staff. The vacancy rate for Mental Health Nurses is 19% with 15% over 55, Learning Disability Nursing has 17% vacancies with Social Care posts sitting at 12% vacancy rate and 27% turnover.

Impending GP and Practice Nurse retirement, GP emigration and wide variation in the ability to recruit to vacancies and attract trainees, resulting in posts remaining unfilled or practices relying on long term locum support continues to put pressure on the existing workforce.

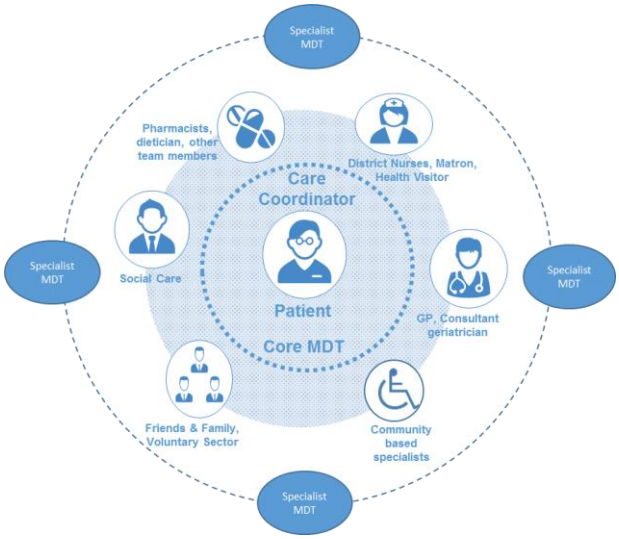
Historically, a lack of comprehensive primary care workforce data has hindered the ability for effective workforce planning, impacted by a lack of focus on workforce development, career pathways and succession planning. In addition, practices' resilience issues are affecting their capacity to support increased training in primary and community care settings or provide the appropriate level of support and supervision to new roles such as Clinical Pharmacists or Physicians Associates.

2.2. Vision for Primary Care Workforce

New Models of Care: Workforce Implications

Underpinning the Primary, Community and Social care model within BLMK are the primary care home principles of a single integrated and multidisciplinary team, working to provide comprehensive and personalised care to individuals.

Figure 2. New Models of Care



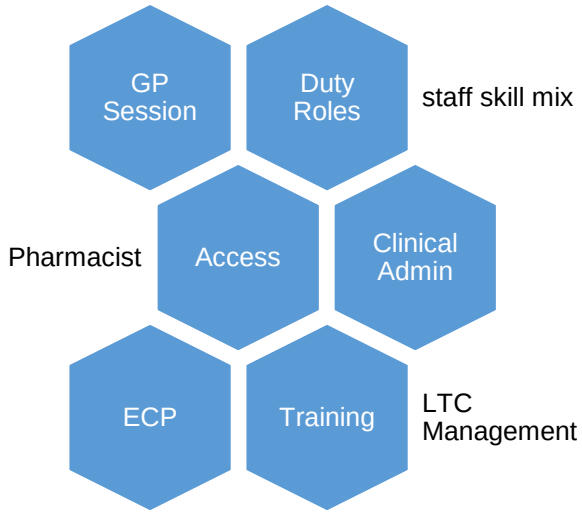
This will be delivered through new ways of working within general practice and primary care, providing strengthened, enhanced GP services and also supported through a wider health and social care workforce, wrapped around GP services, to offer coordinated, joined up, place-based care .

This approach enables us to think differently about how teams of staff support general practice workload and consider what aspects of GP care could be delivered by a range of other staff groups. The Health Education England Primary Care workforce tool enables us to explore opportunities for 'role substitution' for up to 10% of GP workforce requirements over the next 3 years (Section 4.3, table 4).

New Ways of Working in Primary Care

The Primary Care Home initiative in Luton provides a test bed for new ways of working in General Practice that will be rolled out across BLMK to develop strengthened, enhanced GP services.

Figure 3. Roles within Primary Care



Since May 2016 Lea Vale Medical Group in Luton have revolutionised the general practice team, introducing new ways of working and new roles with significant results:

- GP capacity increase by 44%
- DNA rate reduced from 8% to 2%
- Patients seen by most appropriate clinician = 16% of GP work moved to nursing team, ECP and practice pharmacist
- Team based working = reduced stress of whole team

Enhanced Primary Care Services at the heart of Community Integrated Health and Social Care Teams

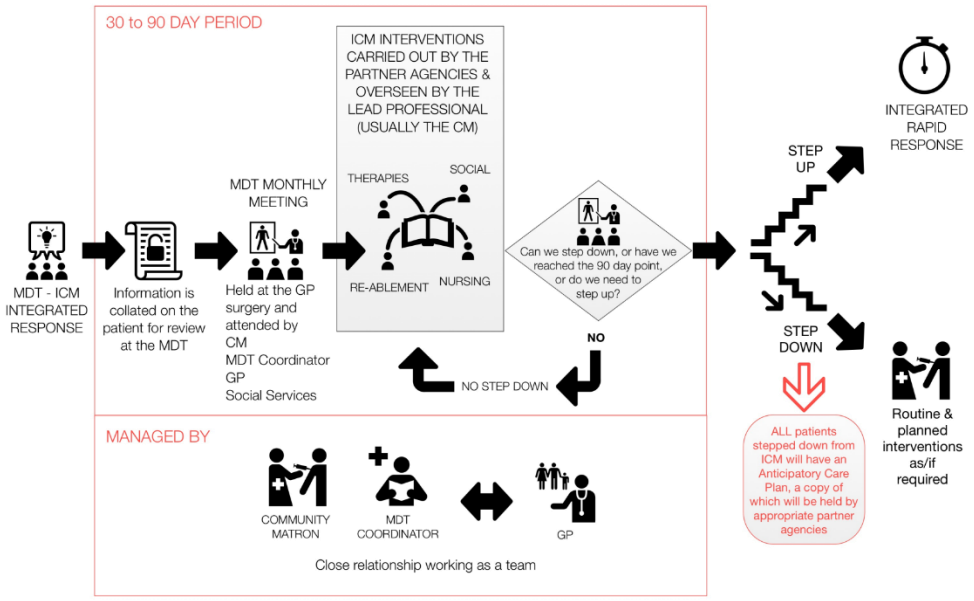
Wrapped around enhanced, strengthened Primary Care and jointly providing coordinated, joined -up care, community integrated health (including mental health) and social care multidisciplinary teams will provide intensive case management and rapid response services.

Intensive Case Management

By working with GPs and using a pro-active risk stratification tool the physical & mental health, and social care management of people that are identified as ‘high risk’ of emergency hospital admission will be improved.

Over a 30 to 90 day period, Community Matrons provide intensive support with case management provided by MDT Coordinators. Both work closely with the patients GP.

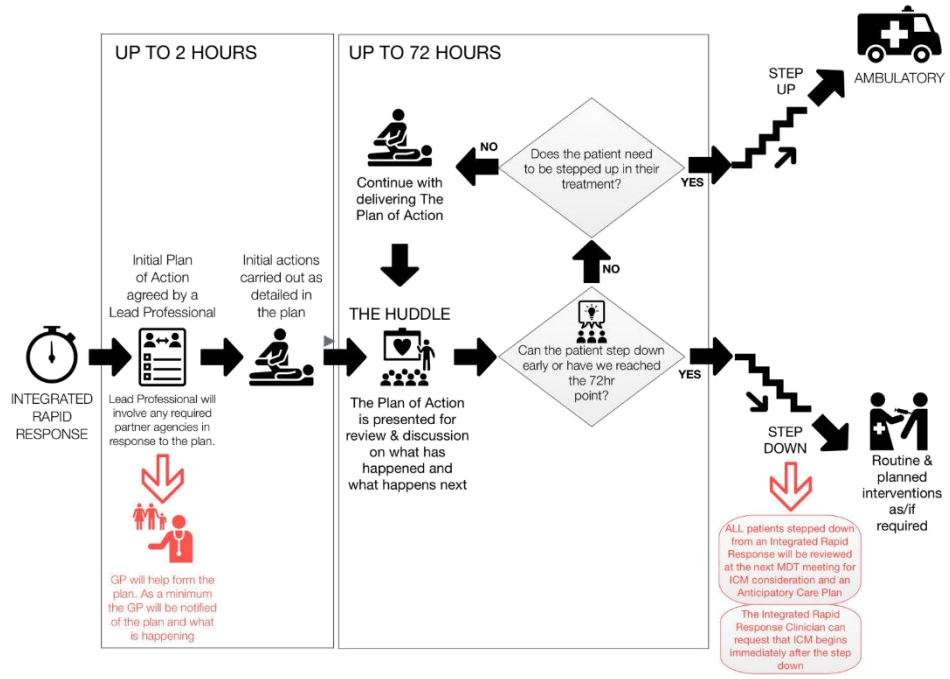
This approach builds a holistic ‘Anticipatory Care Plan’ that enables the patient and carers to access appropriate support services and information and to escalate if their health needs urgent assessment and treatment in order to remain at home.



Rapid Response

The Integrated Rapid Response service has the overarching aim to stabilise and support the patient to remain in their own home thus avoiding, if appropriate, a hospital admission. It unifies and coordinates the efforts of other community health and social care teams such as:

- Rapid Response Nursing
- Social Care
- Re-ablement
- Therapies



These services are supported by a single point of access for all professionals, including Primary Care Staff, which provides multidisciplinary clinical triage and a response from the appropriate teams/service within 60 minutes.

What does this mean for Primary Care?

The wrap of multidisciplinary teams around enhanced primary care services means that GPs and wider primary care staff will be able to work in a coordinated way to provide patients with timely access to the right professional within an out of hospital setting. This will enable:

- The development of a wider, virtual practice team, working with aligned MDT Coordinators (clinical navigator roles) and mental health workers (Primary Care Mental Health Link Workers)
- Access to timely and efficient pathways of care which ensure patients see the right professional in the right setting
- Support to work in proactive, anticipatory care approaches for patients with complex needs
- Further reductions in clinically unnecessary GP appointments
- Coordinated working across differing sectors, organisations and professional

As a result GPs and wider practice staff will continue to build rewarding roles that support recruitment and retention of staff and offer a wider diversity of opportunities to work in a portfolio career and develop enhanced skills.

Maximising sharing of back office functions within General Practice

Across the Luton CCG footprint, a high level proposal for the creation of a Business Support service, as part of the Accountable Care System's offer to GP Cluster members has been developed by their Provider Alliance. The proposal considers how capability, capacity and synergies within and across Parties to the Alliance could be developed into a 'traded service'.

This would offer the opportunity to invest in and specify the development and creation of a single business function to manage human resources, IT, finance, contracts, and public engagement across General Practice in Luton.

The list below, which is not exhaustive, are examples of the perceived benefits for General Practice in choosing to access the proposed Business Support offer:

- Reducing waste and duplication of effort
- Improvement in both the consistency and quality of the performance and functions of business support across General Practice
- Improved the patient/customer experience
- Opportunities to upskilling staff and developing career pathways
- Improved selection, recruitment and retention of business support staff across General Practice
- Improved work life balance for GPs
- Enable GPs to spend more time 'with the patient'
- Releasing time to explore opportunities to gain additional skills and support career development
- Increased job-satisfaction for GPs

- Be a positive factor in attracting, recruiting and retaining of GPs
- Support and stabilisation to General Practice

Across the Chiltern Vale Locality of Bedfordshire CCG the ten practices have been working together for some time to review their back office functions, policies and procedures to maximize opportunities to streamline, reduce duplication and work collaboratively. We will continue to work with our clusters of practices through their transformational plans to look at further options to accelerate this work.

The Milton Keynes GP Federation was formed on 1st April 2017 and is currently in the process of scoping to understand which back office functions could be shared across Milton Keynes General Practices.

The learning, opportunities and risks emerging through each of these pieces of work will be shared across BLMK through the centralized ICS CEPN.

2.3. Approach to workforce planning

Across the STP footprint workforce planning is approached through the Local Workforce Advisory Board (LWAB), which has comprehensive and coordinated oversight of the inter-related system-wide workforce challenges and assures collective action. The LWAB includes representation from each of the three CCGs, STP partner organisations, Health Education England, education providers, Community Education Provider Network (CEPN) leads and the Local Medical Committee. The LWAB is responsible for the workforce strategy and transformation plan and reports directly into the STP CEO group.

2.3.1. Community Education Provider Networks

Bedfordshire's Community Education Provider Network (CEPN) was established in April 2016 and draws together key system partners including the local HEI, LMC, GP educationalists, practice nurse and practice manager representatives. With funding support from Health Education England, the network collectively plans local primary care recruitment and retention initiatives, strategies for increasing pre and post registration training placements and mentors and the development of wider multi-professional education and training.

Luton and Milton Keynes CCGs have been successful in their applications for wave 3 CEPN status. The three CCGs will work increasingly more closely to develop a centralized CEPN to share learning and maximise opportunities to work collaboratively and at scale, on workforce initiatives across the STP footprint with the aim of;

- increasing resilience through new ways of working
- providing education and development to create a system-wide energised and sustainable workforce
- motivating, valuing and engaging existing teams
- creating vibrant organisations, interesting roles, career structures and supported development opportunities
- attracting more people to want a career in BLMK through targeted marketing campaigns
- working in partnership with our provider organisations to develop a flexible workforce made up of skill mixed teams and extended teams that reflect the needs of the population

- supporting the implementation of new approaches to the delivery and organisation of care such as integration, extended roles in risk stratification, care planning and case management.

3. Current and Future Models of Care and Workforce

3.1. Forecast Trends

The transformed Primary Care Home (PCH) model will need to reflect differences in the future workforce and move away from traditional approaches to workforce planning for general practice staff. National examples of learning from early PCH sites demonstrate that traditionally accepted ratios for GP's to registered population can be safely altered as alternative general practice professionals adopt increasingly wider ranges of care interventions historically within the remit of the General Practitioner. Given the existing significant workforce challenges facing general practice, however, there is a need to stabilise existing workforce numbers as the implementation of PCH models progress across BLMK ICS.

National targets and shares as a result of GP Forward View requirements are also required to be modelled into local workforce plans for General Practice.

3.2. Current and Future Roles

The enhanced General Practice Team will be made up of a variety of roles that support new ways of working. Underpinning the principles of the Primary Care Home model is the understanding that the blend of these roles per cluster/practice will need to vary according to population health needs. These roles include:

- **GPs, Practice Nurses, Health Care Assistants, Practice Managers**

The recruitment and retention and education and training elements of this workforce plan describe the proactive initiatives we are implementing to stabilise, sustain and transform this essential core general practice team.

- **Advanced roles**

Advanced roles are characterised by high levels of clinical skill, competence and autonomous decision-making. The type and blend of practitioner required is likely to vary at cluster/network population level, as local population health need will determine the care functions and interventions most required. Our joint work with national bodies to support the modelling of the PCH MDT will occur at cluster/network level and define more detailed workforce profiles, ultimately across all 18 clusters. However, best practice examples describe progress against utilisation these roles within an enhanced general practice team and the benefits this has provided.

- **Support Roles**

Developing the roles of existing staff, such as receptionists, creating new roles such as clinical administrators and expanding the portfolio of staff to include mental health therapists in practice settings will also develop the blend of team that enables a new way of working within general practice.

3.3. National Workforce Modelling Project: Primary Care Home

There is currently a significant shift in the way national bodies are moving to support workforce planning and development. As the foundation of all emerging new care models, the Primary Care Home national team are coordinating with the leads of the Accountable Care System Programme, NHSE, NHSI, Health Education England and Public Health England to develop and roll out consistent approaches for workforce design that improves population health outcomes.

The National project leads are keen to work with the BLMK ICS as a national test site. This will have a significant impact upon supporting the development of our workforce plans. This initiative reports to the LWAB will be completed and evaluated by April 2018, and will enable us to model at scale.

4. Workforce Demand and Supply

4.1. Baseline Measurement

As part of their statutory commitments to the GP Five Year Forward View each of our three CCGs are committed to maintaining up-to-date workforce baseline data for General Practice staff, providing a current picture, capturing plans for retirement and introducing new roles.

CCG	**Baseline Survey Completion Date**
Bedfordshire CCG	Completed February 2017
Luton CCG	30 October 2017
Milton Keynes CCG	8 September 2017

4.2. Workforce Baseline Numbers

The local workforce survey was specifically designed to capture workforce baseline data across the whole general practice team, including vacancy rates, impending retirements, age profiles, utilisation or plans for utilisation of new roles, number of Advanced Nurse Specialists, Prescribing Nurses and Chronic Disease Management Nurses, as well as training, supervisory and mentorship capacity. Within Bedfordshire CCG a training needs analysis has also been completed for all Practice Nurses and Health Care Assistants which provided the evidence base for the planning described in *item 9.3 Education and Training.*

Local workforce profile survey data has enabled us to model the following GP baseline numbers, vacancy rates, assumptions on GP loss rates via retirements for 2017-18 and factor in the impact of the GP expansion targets;

*Table 1. Current GP workforce baseline numbers including assumptions on GP loss rates and GP expansion targets for **2017-18***

	(A)		(B)	(C)		(E)			(F)		
Profession: GP	**Baseline excl locums (Local workforce survey Oct 2017 GP WTE)**	**% of Locum / Baseline**	**No. vacancies (WTE) (Local Survey Oct 2017)**	**No. retirements within 12 months (Local Survey Oct 2017)**	**% of GPs over 50**	**GP Expansion Target WTE 2017-18 (in addition to vacancies)**	**International Recruitment Target WTE (2017-18)**	**Recruitment target excl IR (2017-18)**	**Indicative workforce gap 2017-18 (B+C+E)**	**Workforce gap 2017-18 excl targets (B+C)**	**% difference between baseline (A) and indicative workforce gap (F)**
BLMK	409	11%	52.5	18	38%	41	13	28	111.5	70.5	27%
BCCG	224	4%	20.5	10	34%	20.5	6	14.5	51	30.5	23%
LCCG	79	25%	19	3	43%	10	3	7	32	22	41%
MKCCG	106	18%	13	5	43%	10.5	4	6.5	28.5	18	27%

Our combined baseline surveys indicate that our current vacancy levels for GPs are at around 13 % with a high utilisation of locum GPs supporting these shortfalls. When known retirement profiles and our target allocation for GP expansion is layered into this profile, a GP workforce gap averaged at 27% is revealed.

We will continue to utilise the local workforce profile survey data to model the impact of vacancy rates, retirements and expansion targets for 2018-2021. The GP vacancy rates are current at the time of collection and retirement rates predicted at practice level. 38% of GPs within BLMK are over the age of 50, further data is required to fully understand the predicted retirement profile (2018-2020) for this age group.

GP Expansion Targets

For the purpose of this modelling the GP Expansion Targets, including International Recruitment Targets, have been allocated evenly across the three years 2017-2020 (merely to demonstrate the indicative GP gap). However, in recognition of the lead in time associated with recruitment initiatives, for example International Recruitment, GP expansion target trajectories will predominately focussed on years 2 and 3 (2018-2020).

The local workforce profile data outlined in the table below, clearly illustrates the high number of Practice Nurses (79%) and Practice Managers (69%) over the age of 50 across the BLMK ICS. The steps being taken to support the recruitment, retention and development of Practice Nurses and Practice Managers are described in section 5.2.

*Table 2. Current Practice Nurse workforce baseline numbers **2017-18***

Profession: PN	Baseline (WTE)	No. of PNs over 50	No. planning retirement in the next 12 months	PN Vacancies
BLMK	**178**	**139**	**17**	**14**
BCCG	**93**	**64**	**7**	**4**
LCCG	**26**	**32**	**6**	**4**
MKCCG	**59**	**43**	**4**	**6**

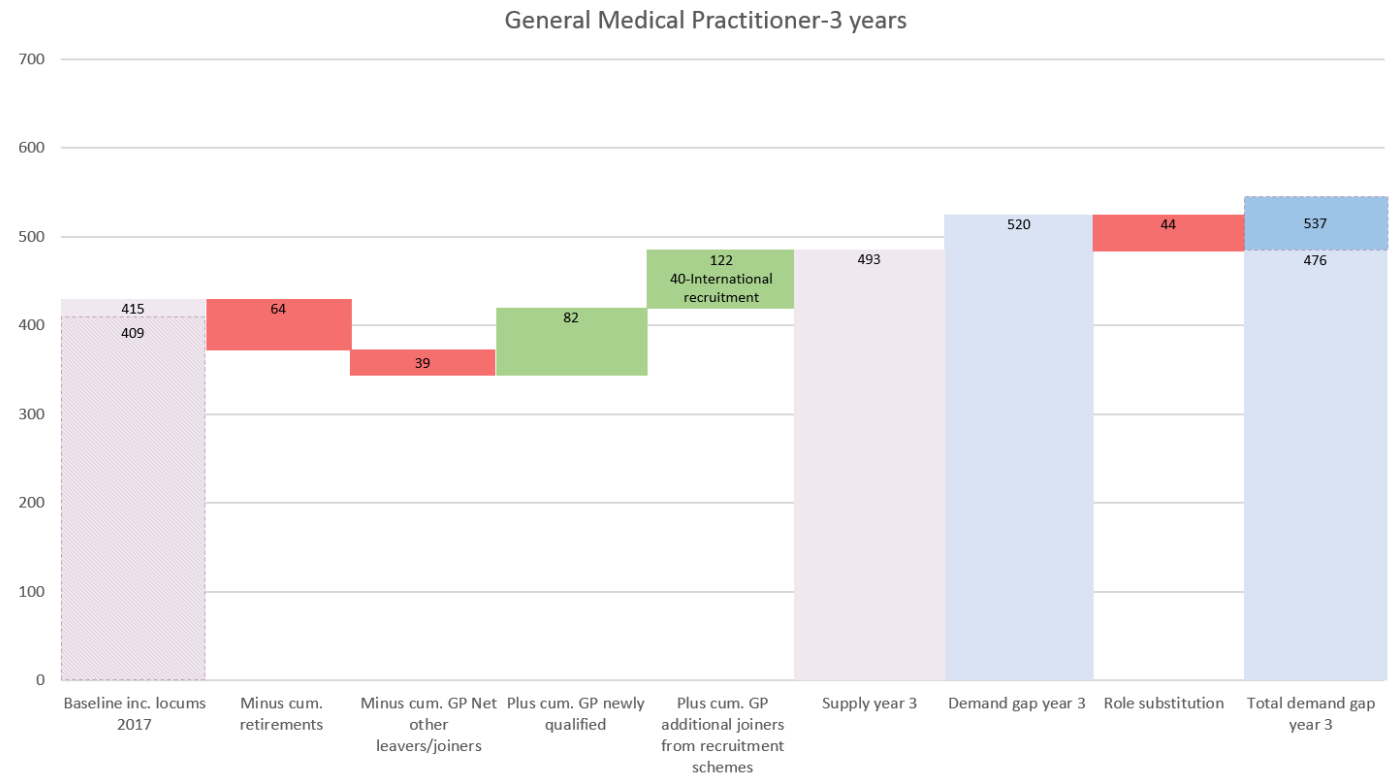
*Table 3. Current Practice Manager workforce baseline numbers **2017-18***

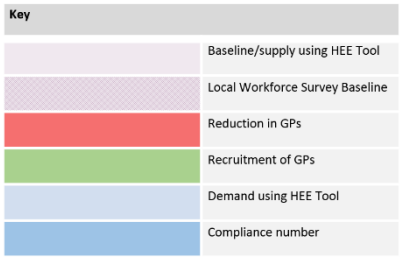
Profession: PM	Baseline	No. of PMs over 50	No. planning retirement in the next 12 months	PM Vacancies
BLMK	**106**	**73**	**3**	**3**
BCCG	**50**	**31**	**2**	**1**
LCCG	**29**	**17**	**1**	**2**
MKCCG	**27**	**16**	**0**	**0**

4.3. Local Supply and Demand Data

The Health Education England (HEE) Primary Care Tool has been utilised to explore the impact of the GP workforce gap against local supply of GPs, future demand for GPs based upon population growth, the requirements to fill national targets for GP recruitment and the potential for alternative recruitment into wider practice team roles and the substituted effect for GP workforce requirements. NHS England assurance processes have required the NHS Digital Baseline for 2017 to be utilised for workforce modelling (415 GPs), this is not dissimilar from our own workforce survey baseline of 409 and is indicated in the Bridge Diagram below (Table 4). The HEE Primary Care Tool then enables a bridge to be built that incorporates assumptions for GP supply, population demand and roles substitution. The tool also includes our national share allocation for 78 GPs, 40 of which are to be supplied through International Recruitment. As a result of NHSE assurance processes this share allocation has been increased from 78 to 123. This is because the national share target has been set on 2015 national baseline data, for BLMK this was 460 GPs. Because this national data set has indicated a drop in GPs from 2015 to 2017 (460 – 415 = 45 GPs), BLMK are expected to fill this GP Gap in addition to increasing the number of GPs by the national share allocation. This in total equates to 123 GPs.

Table 4. Bridge to demonstrate local supply and demand within HEE Primary Care Tool (updated to include NHSE compliance numbers)





Modelling within the HEE Primary Care tool suggests that 'role substitution' i.e. recruitment into alternative roles that can support GP workload, can reduce BLMK ICS requirements for GP expansion by 10% (see Appendix 1). Significant caution must be heralded to this modelling approach. Limited national evidence exists to support assumptions for role substitution for GP workload and there is a high risk of error within this relatively crude planning approach. The PCH workforce modelling project commencing within BLMK will work alongside practices utilising more sophisticated workforce planning tools and expertise to plan future workforce requirements. As this work progresses plans will need to be adjusted to reflect more credible trajectories.

Risk, however, must also be identified in accepting NHSE compliance numbers for GPs. As the bridge diagram depicts GP expansion numbers are now higher than population demand (520) and, when the potential impact of our PCH model for a wider practice team and MDT working is modelled within the role substitution approach, than need (476 GPs). Given the national context for challenges in recruiting GPs, this places significant risk in our ability to meet these compliance GP expansion numbers which also increase unfunded financial shortfalls.

4.4. Target trajectories, tracking and monitoring

Based upon analysis of local workforce survey profiles and the modelling undertaken through the HEE Primary Care tool.

Table 5. Target trajectories planned for General Practice workforce plans

	2017/18	2018/19	2019/2020	Total
Clinical Administrators*	53	4	3	**60**
Clinical Pharmacists**	12	11	10	**33**
Physician's Associates***	3	9	10	**22**
Registered Nurses (increase from baseline)		8	5	**13**
Mental Health Therapists ******	15	10	10	**35**
GP Need (67)	4	32	31	**67**
GP Compliance (56)		18	38	**56**

* *Training up existing reception staff; 53 trained in 2017/18*
** *12 clinical pharmacists in BLMK in 2017/18*
*** *3 qualified PAs in BLMK in 2017/18*
**** *2 models of mental health support to practices currently within BLMK, Primary Care Link Workers in Bedfordshire and Luton, therapy team across 4 practices in Milton Keynes; reflected in 2017/18 numbers*

Table 6. GP workforce recruitment profiled across 3 areas

GPs	2017/18	2018/19	2019/2020	Total
Fellowships *	4	5	5	**14**
International Recruitment		20	20	**40**
Recruit, Return & Retain		7	6	**13**
Compliance Numbers		18	38	**56**
				123

** 2 existing post CCT fellowships in place, an additional four planned in 2017/18 and future trajectories to reach a total of 16 planned.*

The split of target trajectories per CCG is as follows:

GPs		BCCG	LCCG	MKCCG	BLMK
2017/18	Fellowship	2	1	1	4
	International Recruitment	0	0	0	0
	Recruit, return * Retain	0	0	0	0
	Compliance Numbers	0	0	0	0
Total		**2**	**1**	**1**	**4**
2018/19	Fellowship	2.5	1	1.5	5
	International Recruitment	9.5	4.5	6	20
	Recruit, return * Retain	3.5	1.5	2	7
	Compliance Numbers	9	4	5	18
Total		**24.5**	**11**	**14.5**	**50**
2019/20	Fellowship	2.5	1	1.5	5
	International Recruitment	9.5	4.5	6	20
	Recruit, return * Retain	3	1.5	1.5	6
	Compliance Numbers	19	9	10	38
Total		**34**	**16**	**18**	**69**
Total		**60.5**	**28**	**34.5**	**123**

These targets have been calculated on a proportional basis according to each CCG's population size and will be refined as further work progresses.

Tracking and monitoring of these target trajectories, alongside any requirements to amend/refresh plans as a result of our PCH workforce modelling project, will occur through our GP Workforce Plan delivery framework (section 7 and 8). GP Compliance Numbers are at high risk of target trajectory failure as described within the risk log (appendix 3).

5. GPFV Workforce Initiatives

5.1. Recruitment and Retention Strategy

The solutions to the workforce challenges faced within General Practice in BLMK will derive from a change of focus. An expanded workforce will include increasing our GP workforce numbers in line with the ambitions of the GPFV, however, a wider range of care staff will increase their role in patient care and enabling the wellbeing of local people. Our recruitment and retention strategy therefore focuses on both the GP workforce and the wider General Practice Team.

5.1.1. General Practitioners

Our workforce planning profiles reflect the national requirement to expand our share of GP numbers by 123 WTE GPs by December 2020, address the existing vacancy gap averaged at 10% across BLMK ICS and mitigate the retiring trends of our local GP workforce.
We will adopt a multifaceted approach to this workforce gap.

- **International GP Recruitment**

Each of our three CCGs will apply for the January 2018 wave of the national GP International Recruitment Scheme. Our allocated share of International GP Recruitment is 40, with annual targets currently set until across 2018/19 to 2019/2020.

- **GP Recruitment, Retain and Return**

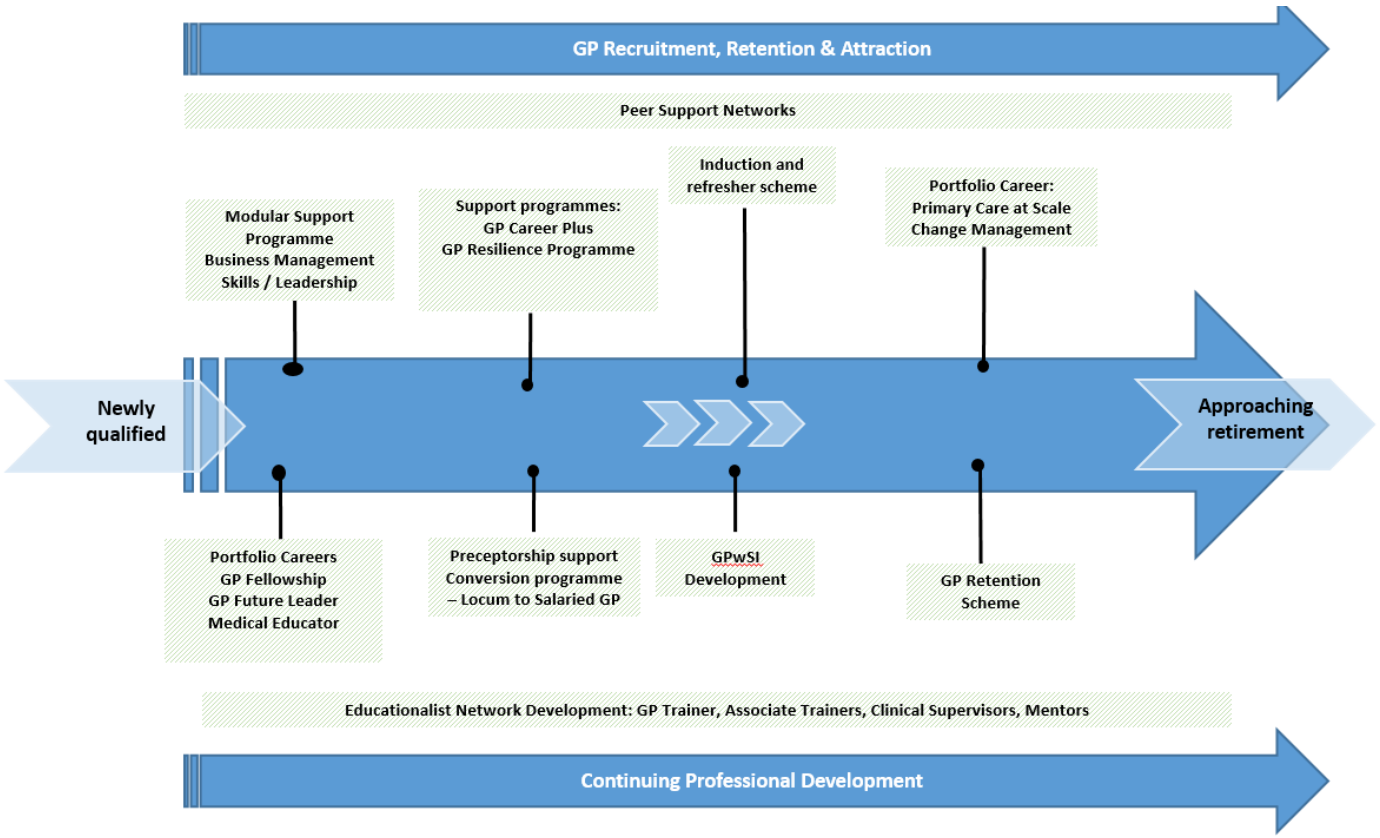
The remaining GP workforce gap will be filled through a variety of initiatives that focus upon boosting GP recruitment and retention. We have undertaken work with our local LMCs and GPs to identify drivers that impact the decision making of GP trainees when choosing where to work, the type of working patterns and employment preferences of new GPs, the incentive opportunities for returners and the reasons GPs leave their jobs.

What local Trainees and GPs have told us...

- New GPs want to experience working in a practice before committing to a salaried or partner position
- Structured support to new GPs during this phase impacts the GPs choice to commit to a practice
- Flexibility of working times and conditions is paramount
- The practice vision for future practice development and forward-looking optimism is very important
- Schemes such as GP Future Leaders and GP fellowships have been positively evaluated by new GPs, offering development, structured mentorship and a portfolio career

- **GP Trainees; attracting newly qualified GPs**

This local intelligence has informed our approach to developing a variety of recruitment and retention initiatives:



Initiatives to attract and retain qualifying doctors into our practices include:

- Providing sessions on training programmes that are not traditionally offered within the Vocational Training Scheme (VTS) such as Business Model and Management, Project Management, Commissioning and Business Intelligence skills
- developing buddying systems between training practices and non-training practices to develop a wider local training / support network offer
- Developing a preceptorship style approach for newly qualified GPs
- Developing a locum to practice preceptorship
- Supporting local GPs to develop in clinical supervisor and educational supervisor roles and promoting access to associate trainer development.
- Create training hubs around clusters/networks to provide more effective training support and opportunities for pre and post registration medical and non-medical general practice workforce
- attending HEE workshops to market local recruitment and attraction
- working with local government to develop placed-based attraction strategies as part of a wider workforce recruitment and retention initiative
- working with local schools to promote general practice as a career
- Developing programmes that offer portfolio career options such as clinical or commissioning placements e.g. GP Future Leaders or GP Fellowships.

- **Existing GPs: Attract, Retain and Return**

We are developing a local Primary Care 'offer' that underpins our GP Workforce Development Programme. It provides information regarding workforce initiatives, new roles and ways of

working and new business models and outlines opportunities to access development and training. The implementation of this offer will enable:

- Adoption and spread of new ways of General Practice team working that more effectively manages workload and increases job satisfaction, for example workflow optimisation utilising trained Clinical Administrators
- Promotion of bursary incentive schemes such as the national GP Retention Scheme and the Induction and Refresher Scheme to promote recruitment of International GPs and returners through innovative systems such as the NHS England Midlands and East Different Practices initiative.
- Increasingly developing portfolio career opportunities through development opportunities for;

    - *Future Leaders*

Within BLMK we currently have 5 GP Future Leaders working within Bedfordshire and Luton CCGs. These 3 year programmes are specifically aimed at attracting the clinical commissioning leaders of the future and offer:

- Fully funded MBA qualification
- Part time supportive employment within a GP Practice
- 1 day per week in a clinical commissioning leadership placement
- CCG Executive mentorship

    - *Post CCT GP Fellowships*

BLMK currently employ 2 GPs within 1 year fellowship schemes in Bedfordshire. Fellowships are based on a model where primary employment is within a general practice setting, with additional sessions where the GP will provide service delivery in another healthcare setting, such as secondary care or out of hours or within a commissioning environment, plus time for personal development. This is a 1 year programme designed to promote career progression and offers:

- Health Education England fully funded educational options to post graduate certificate level
- Part time supportive employment in a GP Practice
- 1 day per week paid clinical or commissioning placement
- Mentorship with a GP Tutor

Within 2017-18 across BLMK we have planned to support an additional 4 post-CCT GP Fellowships, expanding this opportunity year on year, so that by 2020/21 we plan to provide this development opportunity to 16 GPs.

- **Alternative employment frameworks**

As the Primary Care Home model becomes increasingly embedded within the BLMK ICS and integrated multi-disciplinary team working more effectively supports GP workload, there will be more opportunities to develop new GP business models, which facilitate employment frameworks that are more attractive to GPs. These include:

- Increasing salaried versus partnership employment opportunities
- Place-based locum/bank pools
- Opportunities for part and full time employment and flexible working
- An increasing range of portfolio career opportunities
- Development posts that enable specialism

- Targeted approaches for attracting Locums to the salaried workforce

5.1.2. Framework for the wider General Practice Team

Our recruitment and retention strategy for the wider General Practice team focuses on actively promoting a career in General Practice and the evolving opportunities that are arising for enhanced skill mix, alternative roles, career development and job satisfaction. It embraces all roles in General Practice including:

- Practice Nurses
- HCAs
- Practice Managers
- Advanced and Support Roles

An important element of recruitment, retention and attraction is increased focus on the training, placements, development and support for these staff groups, as outlined in the Training and Education section.

5.2. Impact to date – *What's working well*

A number of workforce initiatives have already progressed under the GPFV Workforce Programme agenda and through the remit of the CEPNs, with plans for expansion.

- **General Practice Nursing**

In line with the ten point plan for General Practice Nursing, Bedfordshire CEPN have progressed a number of work streams to develop Practice Nurse confidence, capability and capacity. Through the centralised CEPN these initiatives will be developed at scale across BLMK.

Table 7. NHS England Ten Point Action Plan for General Practice Nursing

	Local Action	Future Action
1. Raise the profile of General Practice Nursing and promote General Practice as a first destination career	Joint HEI / CEPN event to promote General Practice Nursing as a career – Jan 2017 General Practice promotion – in year student nurses General Practice student nurse placements increased	CEPN working with BLMK system partners, Health Education England, HEIs and local schools to build on existing work and promote General Practice as a career Expand opportunities for student placements, shadowing and apprenticeships
2. Extend Leadership and Educator Roles	CEPN Practice Nurse Tutor appointed Oct 2016 Practice Nurse leads established in all localities All funded education and training opportunities require commitment to deliver annual educational sessions	Identify Practice Nurse Leaders and Tutors across BLMK (linked to OD and Leadership section of plan) Further extend GPN mentorship capacity, maximising opportunities to access joint training with local providers

		Develop BLMK wide networks of GPNs providing peer support, clinical supervision, education and training
3. Increase the number of pre-registration placements	Number of pre-registration placements increased by 6 2016-17	Establish a baseline of placements available pan BLMK Expand number of pre-registration placements across BLMK working in partnership with local HEIs and practices at cluster and locality level Increase the number of GPNs leads to support accreditation of the learning environment
4. Establish inductions and preceptorships	BLMK funding secured to offer 6 GPN preceptorships CEPN / HEI designed Introduction to General Practice Nursing course (GPN Fundamentals) cohort two in delivery Mentorship capacity Bedfordshire increased to 27 with 6 'sign-off' mentors BLMK mentorship capacity mapped – Oct 2017	Develop a hub and spoke provision of induction and preceptorship across clusters / groups of practices as part of a suite of preceptorships offered within a Primary Care Home model of care Expand the number of GPN mentors and sign off mentors Develop a BLMK induction and preceptorship model and framework
5. Improve access to return to practice		BLMK promotion of the opportunities available through return to practice Development of a bespoke localised support package to aid return to practice (linked to GP initiatives)
6. Embed and deliver a radical upgrade in prevention		Work in partnership with local Public Health to ensure all GPNs/HCAs and 'new roles' embed a continued focus on prevention, health promotion and self-care
7. Support access to educational programmes	Practice Nurse Tutor support to access GPN Fundamentals, Flexible Nursing Scheme, local Nursing Associate Programme and multiple educational options specialist LTC training, Health Coaching prescribing and Minor Illness	Continue to commission education and training to support the development of specialist skills and embed new skills to meet the population health needs
8. Increase access to clinical academic careers and advanced roles in practice	Development of Practice Nurse Specialists by cluster in Diabetes, Respiratory, Prescribing and Minor Illness with supported educational delivery element	Promotion of the HEE Advanced Clinical Practice Framework Promotion of nursing research pan BLMK
9. Develop HCSW, apprenticeship and	Linked to local Nurse Associate Programme	Ongoing input into the BHT Nursing Associate Programme

nurse associate career pathways	Delivery of HCA training and support to access Flexible Nursing Scheme	Implementation of apprenticeship career pathways for HCSWs in partnership with local providers Exploring rotational posts, placements and shadowing opportunities
10. Improve retention	Embedded Practice Nurse Forums in each locality for peer support, clinical supervision and case study management	Continue to expand clinical supervision for GPNs and HCSW Explore opportunities afforded by the Primary Care Home model to offer rotational posts, placements, shadowing and development of alternative specialist skills

- **Advanced Nurses**

There are a variety of examples where practice nurses have developed specialist expertise to offer long term condition management or where practices have appointed community matrons. In our four place-based geographies some of our clusters are exploring closer working arrangements between community nursing and practice nursing roles.

Across the BLMK ICS we have successfully been allocated Health Education England 'Beyond Registration Learning' funding to plan and commission education and training to develop our Practice Nurses with specialist prescribing, diabetes, respiratory, COPD and minor illness skills.

- **Practice Managers**

Work is underway in partnership with the LMC to develop a support programme for Practice Managers. Designed and informed by Practice Managers the programme will look to provide resilience support, leadership and change management development and be underpinned by a Practice Manager 'buddy' system and coaching methodology.

- **Clinical Pharmacists**

Milton Keynes CCG and Bedfordshire CCG have participated in this national scheme and there are currently 12 clinical pharmacists working across Bedfordshire and Milton Keynes. Across the BLMK ICS both Luton CCG and Bedfordshire CCG have put forward Wave 3 applications for a further 5 Clinical Pharmacists across Luton CCG and 6 across Bedfordshire. These roles will form an integral part of cluster working and provision of enhanced skill mix in the general practice setting. By 2020-21 BLMK plans to have a total of 33 clinical pharmacists in post.

- **Emergency Care Practitioners (ECPs)**

We currently have a small number of ECPs working within General practice across BLMK, 4 WTE in Milton Keynes, 1.8 WTE in Luton and 1 WTE in Bedfordshire. Each of our CCG's Five Year Forward View Plans commit to expanding the utilisation of these roles. At a systems level, however, it is important not to deplete this valuable and at times hard to recruit resource from stretched paramedic resources. We are therefore working with local ambulance providers to develop a 'rotational' system, whereby ECP placements could be backfilled with alternate resource such as a portfolio GP or Emergency Care Nurse and therefore offer wider development opportunities across the system.

- **Physician Associates**

Physician associates are educated in universities and trained in medical schools to work alongside GPs. The responsibilities of a physician associate include taking medical histories, carrying out physical examinations, treating patients with chronic conditions, and performing diagnostic and therapeutic procedures. There is currently 1 Physician Associate student placed within Bedfordshire CCG, 2 Physician Associates in Luton and 1 in Milton Keynes CCG. The STP was successful in a bid to Health Education England to offer 4 Physician Associate preceptorship placements across BLMK ICS during 2017-18. By 2020/21 BLMK plans to have a total of 22 qualified Physicians Associates in post.

Locally, Physicians Associate programmes are underway at the University of Hertfordshire and Anglia Ruskin University. We have built links with the Universities to progress the placement of Physician Associates students within BLMK and ensure general practice is a core part of their experience during training and offers an exciting career option once qualified. There will be Physician Associates 22 qualifying from Anglia Ruskin University in July 17 and 24 from University of East Anglia in spring 2018. The intention is for Hertfordshire to double the number of places from September 2018. We are working closely with Hertfordshire colleagues to ensure we maximise the opportunities to place students across BLMK.

- **Mental Health Therapists**

We currently have a blend of approaches across the BLMK footprint to support Primary Care mental health interventions. In Bedfordshire and Luton Primary Care Link workers have offered support and expertise to practices through East London Foundation Trust services. Alongside IAPT workers, these roles will be redesigned to form part of the Primary Care Team, complimented by consultant psychiatry and psychotherapy input. In Milton Keynes a 6 month pilot is in progress supporting 4 practices with a team of mental health professionals, including nursing and consultant support through CNWL. As such mental health therapist input into Primary Care will be provided by our mental health service providers, but importantly forming part of the Primary Care Team. As these initiatives are in development plans to have a total number of 35 mental health therapists in post across BLMK are tentative at this stage. We anticipate a more formalised approach aligned to the NHSE requirement for an STP response to the national mental health workforce diagnostic by 22/12/17.

- **Apprentices**

We are working alongside our Local Workforce Action Board and regional partners to explore the opportunity for apprenticeships in Primary Care, this could include cross sector health and social care opportunities to develop health and wellbeing roles working across organisational boundaries.

5.2.1 10 High Impact Actions

Significant work has been undertaken to promote and embed the High Impact Actions 1. Active Signposting and 5. Productive Workflows across the three CCGs. Within Bedfordshire 10 practices have participated in the NHS England Time for Care programme and plans are in place to actively promote Quality Improvement Tools at practice / cluster level. Further work to promote and embed the remaining High Impact Actions has been identified as a key work stream, illustrated in Figure 7. ICS Governance and Assurance Framework.

- **Clinical administrators**

Clinical administrators are trained to support GPs by processing letters coming into the practice. Within a clear protocol it is agreed which letters are automatically forwarded to the GP e.g. where it involves a child under 5, a serious/complex diagnosis or other issues around safeguarding/mental capacity. The clinical administrator can then take a variety of actions with the remaining letters such as entering read codes and other data into the practice system; booking a follow up appointment or blood tests with the patient; or following the agreed DNA process for patients who missed appointments. GPs do not see these letters. It has been estimated in some practices that this has reduced GPs administrative time by up to 70%.

Across BLMK there are currently 53 trained Clinical Administrators. 29 in Bedfordshire, 14 in Luton and 10 in Milton Keynes. Bedfordshire are the national pilot site for HERE and currently testing a reframed offer of training based on e-learning and ongoing practice-based support to ensure implementation and sustainability.

Within Bedfordshire one cluster of practices has established a hub and spoke approach to GP Supervision and mentorship of Clinical Administrators and are employing a peer support / train the trainer approach to ensure sustainability of workflow optimisation across the cluster. By 2020/21 we aim to increase that number a total of 60 Clinical Administrators across the whole of BLMK.

- **Reception - Active Signposting**

Reception staff are trained to access to a directory of information about services, in order to help them direct patients to the most appropriate source of help or advice. This may include services in the community as well as within the practice. In some practices reception staff are also trained to take patient information which ensures patients are booked an appointment with the right member of the practice team first time, adopting a practice-based care navigation function.

Luton CCG have trained 93 receptionists in active signposting, across Bedfordshire and Milton Keynes training is planned for Q4 2017-18. By 2020-21 we aim to increase the total number of receptionists trained in active signposting to in excess of 200.

- **Health Champions - Social Prescribing**

There are a range of approaches currently being piloted across the BLMK footprint to develop social prescribing opportunities, which have different workforce implications. This includes community health champions working at practice level and care navigator/local area coordinator roles supporting the needs of older people/those with complex care needs. These initiatives are governed through our Priority 1; Prevention programme, where impact will be evaluated and monitored, supporting planning for future system approaches.

- **Voluntary sector / patient group input**

We have described our ambition to work increasingly closely with voluntary and charitable organisations within our STP plans. There are, however, already examples of patient participation groups within BLMK playing an active role in providing support and information, for example for people with Diabetes, to promote self-care and management of long term conditions. These initiatives will continue to be actively supported by our CCGs.

5.3 General Practice Development Programme

The ***BLMK ICS Leadership and OD Plan*** (appendix 4) is targeted at all staff groups, at all levels, across all organisations and sectors. It supports the development of relationships and culture that underpins systems working. Whilst BLMK has made some progress towards implementation the PCH model and enhancing the practice-based team, it is recognised that an on-going focused General Practice Development programme is required across the ICS to galvanise energy and pace of change. The BLMK ICS Leadership and OD plan, therefore, identifies a specific initiative for General Practice Development:

- **Leadership and Care Models Development**

The plan identifies initiatives, which although not specific to just the GP workforce, can also be accessed by Primary Care teams to:

  - Create multi-professional and sector training opportunities to increase understanding and skills between professions
  - Provide a – 'stepping into my shoes' interchange offer, where, for example a hospital consultant can spend the day shadowing a GP and vice versa
  - Create health and social care apprentice roles which can work across organisations and sectors, including general practice, in for example, Wellbeing Champion roles

Local workforce pilots exploring implications of emerging new models of care have also identified training and development requirements for the General Practice workforce. These include:

- **Team working and delegation**

The CCGs GP Five Year Forward View plans reflect best practice examples, such as within Lea Valley Medical Centre in Luton and Newport Pagnell Medical Centre in Milton Keynes where new ways of working, as part of a wider team, have revolutionised GP workload and improved patient access and experiences of General Practice. Learning from these examples, however, demonstrates that team working and delegation to alternative roles is not traditionally part of a GP culture and that additional development support in these areas would enable GPs to embrace new ways of working more whole heartedly.

- **Clinical Leadership of Change**

Clinical leaders and champions are critical to developing new GP business models and system models of care. Only more recently have these areas begun to be considered within GP training programmes and there is variance across geographies in if/how this is approached. GP Future Leaders and GP Fellowships programmes help address some of these development needs but these GPs are few in number and this approach will not address the development needs of our experienced GPs. Future opportunities have been identified for cross organisation development, such as GPs participating in the Medical Leadership programme being developed at the Luton & Dunstable Hospital, however, on-going opportunities for GP leadership development need to be planned for.

- **Transformation Methodologies** *e.g. Quality Improvement, Co-Design of workforce and service change with staff and local people, Right Care*

National development programmes such as the Time for Care GP Development Programme (which includes support around the 10 High Impact Changes) and the National Primary Care

Home programme will support individual participating GP practices with development of these techniques and skills, however, a coordinating ICS approach to ensuring consistent development across the BLMK geography would benefit development at scale and pace.

- **New business models and ways of working**

The work with NHSE and the LMC within the GP Resilience Programme helps our most vulnerable participating practices consider new business models and ways of working, however, in order to spread our best practices examples we need to consider additional methods, such as within learning sets, to support innovative thinking for changing models of GP provision, which increasingly utilise alternative workforce and digital solutions to change ways of working.

Additional organisational development support is offered through the National Association of Primary Care sites, within BLMK we now have practices within 5 our GP Clusters participating as deep learning sites in this programme to support the organisational and business development requirements for embedding PCH.

Delivery of the Development Programme

We are currently working with Health Education England and the Leadership Academy planning targeted development opportunities, such as provision of the Midlands and East GP Triumvirate Programme and development of bespoke Master classes to support these identified learning and development needs.

6. GPFV Workforce Cost Impact

Table 8 below outlines the additional establishment costs to the BLMK ICS. Costs for registered nurses and GPs are for additional numbers planned above the existing baselines. Where some posts are already within 2017/18 establishment's costs have been excluded for this year.

Table 8. Workforce Cost Impact

Costs (£'000)	2017/18	2018/19	2019/2020	Total
Clinical Administrators*				
Clinical Pharmacists**	240	568	987	**1795**
Physician's Associates	***	384	427	**811**
Registered Nurses		426	178	**604**
Mental Health Therapists	***	294	294	**588**
Sub total				**3,798**
GP Need (67)	480	3,600	3,960	**8,040**
Sub total				**11,838**
GP Compliance Number		2,160	4,560	**6,720**
Total				**18,558**

**Existing practice reception staff; no additional costs*
*** Costings developed on sliding scale for part national funding year 1-3*
**** 2017/18 within existing establishment, therefore no further cost*

Table 9. Pay Assumptions

Role	Wage per annum	Plus On-Costs @ 20%
Physician Associate	Midpoint Band 7	£42,668
Registered Nurse	Midpoint Band 6	£35,552
Mental health Therapist	Midpoint Band 5	£29,456
GP	Average £100,000	£120,000

The subtotal of £3,798,000 reflects the costs of the role substitution workforce requirements to mitigate the demand of GPs by 2019/2020 by approximately 10% (44 GPs) according to modelling undertaken within the HEE Primary Care Tool. Comparably, the salary costs of 44 GPs would be £5,280,000. Thus reflecting a more affordable workforce model of £1,482,000 per annum if role substitution modelling resulted in the acceptance of a GP target of 476 GPs (which would result in a GP target of 67 GPs from the CCG workforce baseline of 409).

NHSE assurance processes, however, have required BLMK to also target an increase of national share allocation of 78 GPs from a 2015 baseline, of which there has been a further reduction in baseline numbers by 2017 (460 down to 415 : national dataset). BLMK are therefore required to target an increase of 123 GPs in total, which is 56 more than our currently modelled need (67) at an additional cost of £6,720,000.

Costs have been depicted as an Accountable Care System. We recognise that as partners within this system some of these costs will fall to employers of staff within General Practices e.g. our GP employers, however we aim to work with NHSE once all three CCGs are in delegated commissioning status in April 2018, to determine the impact upon CCG allocations.

Costs also reflect the national GPFV funding support for Clinical Pharmacists (a 3 year sliding scale of support). Bursary allocations for retained and returning GPs, or funding for GP International Recruitment have not been factored.

6.1 Funded costs

Non Salaried Costs

Our GP Workforce plan identifies the critical role that an education and training infrastructure (section 9.1) and general practice development (section 5.3) plays in supporting the development of the development of an enhanced practice –based team and the wider multidisciplinary teams wrapped around general practice. These elements of the plan are fully funded.

Table 10. Funded Non Salaried Costs

Initiative	Funding Source	Impact
General Practice Development Programme	ICS Transformation Funding Year1 costs (2017/18) of Leadership and OD Plan	Support scale and pace of change in enhanced general practice delivery
Preceptorship support 4 GP post CCT Fellows, 2 Physicians Associate	HEE Funding	Supervision and support will be funded to enable a period of structured transition for each newly qualified healthcare

Preceptorships and 6 GP Nurse Preceptorship		professional to develop competence and confidence.
National funding Initiatives for Clinical Pharmacists, International GP Recruits, GP Retainer Schemes, Bursary's etc.	NHSE/HEE national funding schemes	BLMK is accessing all national offers/programmes, however, funding streams have variable impact on staffing costs, with majority of salary costs remaining employer's responsibility.

Salaried Costs

Identifying the proportion of salaried costs that are within the existing baseline of employers (GP Practices) involves rather crude planning assumptions at ICS level, however, funded assumptions are based upon the following planning principles:

1) An overall 27% GP workforce gap is identified at ICS level (table 1, pg 14), including vacancy rates and retirement profiles; therefore 24% of workforce costs are assumed to be funded within existing employers baselines.
2) There is a rise in demand for GPs over 3 years by approximately 16% due to population growth (table 4, pg 15). An increase in registered population will impact CCG Primary Care allocations following April 2018 when two of our three CCGs are in delegated commissioning status.

Table 11. Funded Salaried Costs

Costs	**£'000**
ICS Workforce Plan Salary Costs	11, 838
Funding Streams	
Existing Employers Baselines (27%)	3,196
Increased CCG Allocations (16%)	1,894
Total Funded Salary Costs	**5,090**

6.2 Funding Shortages

Approximately 43% of salaried costs of the ICS workforce plan are therefore funded with the remaining 57% reflecting an assumed funding shortfall of £6,748,000.

GP Compliance costs, however, create an additional unfunded shortfall of £6,720,000

To confirm this shortfall, however, as an ICS we are triangulating this most recent GP workforce activity planning assumptions with those made within our original STP planning submissions to compare workforce profiles and associated costs to identify any gaps within our financial bridge.

7. GP Workforce Plan Delivery

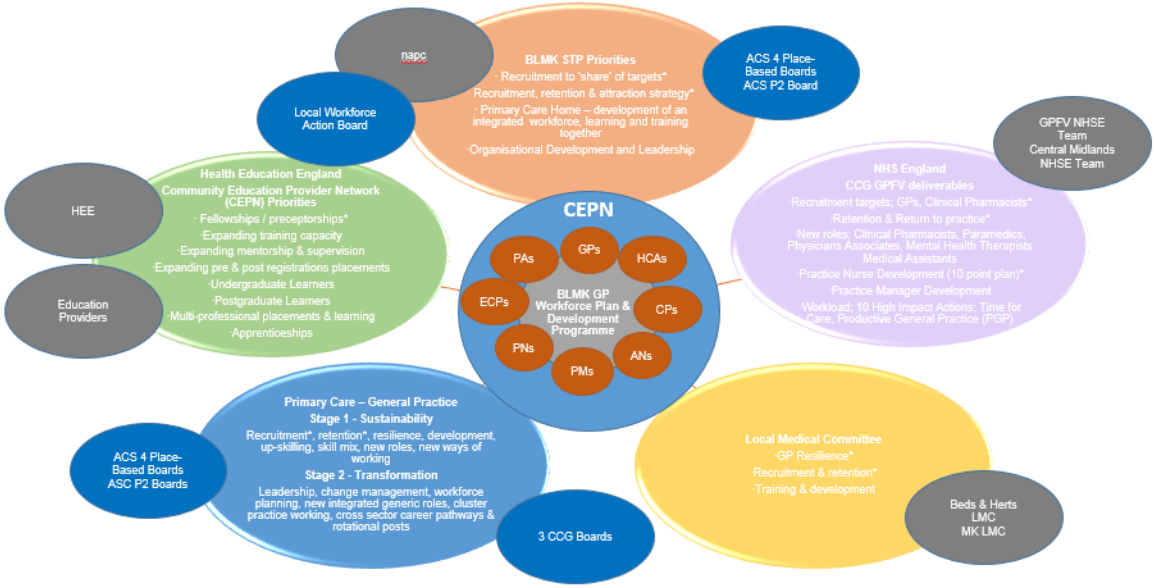
Stakeholder Engagement

We have actively engaged with our local GPs and member practices on our workforce development plans through our ICS Priority 2 Board, and via our GP Locality leads, Practice Manager meetings, the CEPNs and with the support of our Local Medical Committee. We are in the process of developing an ICS-wide online platform to house all information relating to workforce, education and training initiatives, alongside a wider Primary Care offer. This site

will be widely socialised to ensure all member practices are fully sighted on the recruitment, retention, education and development initiatives in place.

There are multiple agencies outlining requirements for development of the general practice workforce resulting in a range of local, regional and national stakeholder involvement (see Figure 4).

Figure 4. Stakeholder and Delivery Map



Key:

External partners

ICS Boards

Local stakeholders

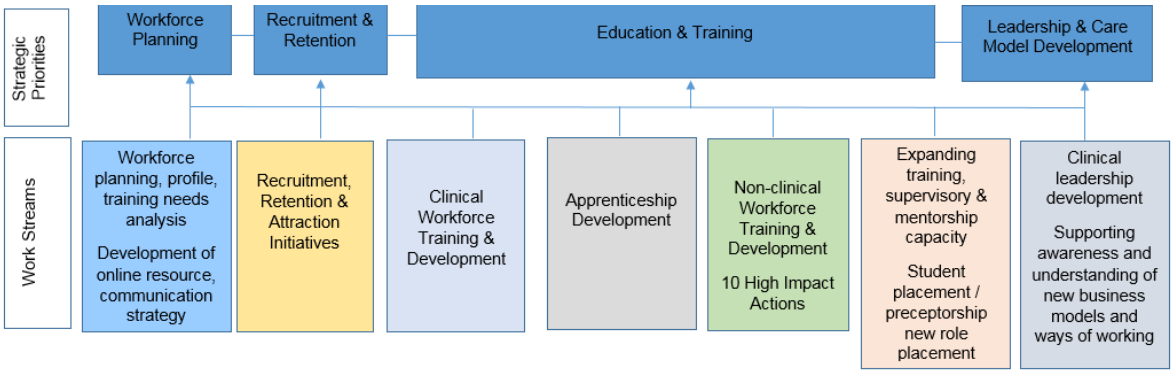
* indicates shared priorities

This depicts a complex framework of initiatives and a range of groups and staff involved within them. It is therefore important to develop a robust approach to plan delivery.

Plan Delivery

The GPFV Workforce Plan has been aligned within 4 strategic priorities and 7 work streams to enable a comprehensive approach to developing programme delivery of interdependent initiatives (see figure 5).

Figure 5. Programme Delivery



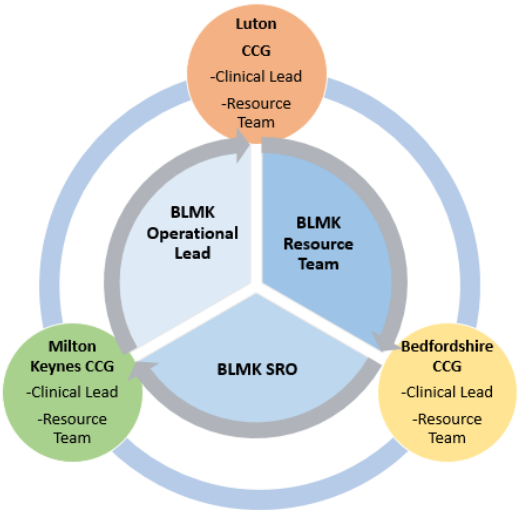
A high level project implementation plan for delivery years 2017/18, 2018/19 and 2019/20 is depicted within Appendix 2.

Plan delivery will be managed and coordinated by a centralised ICS CEPN.

Delivery Team

The delivery team compromises of staff supporting Primary Care within our 3 CCGs, supported by our external partners. The SRO for the GPFV Workforce Plan is Colin Thompson; Accountable Officer for Luton CCG and Executive SRO for the P2 Priority Board; Primary, Community and Social Care. To ensure a managed approach the team is coordinated around the centralised CEPN.

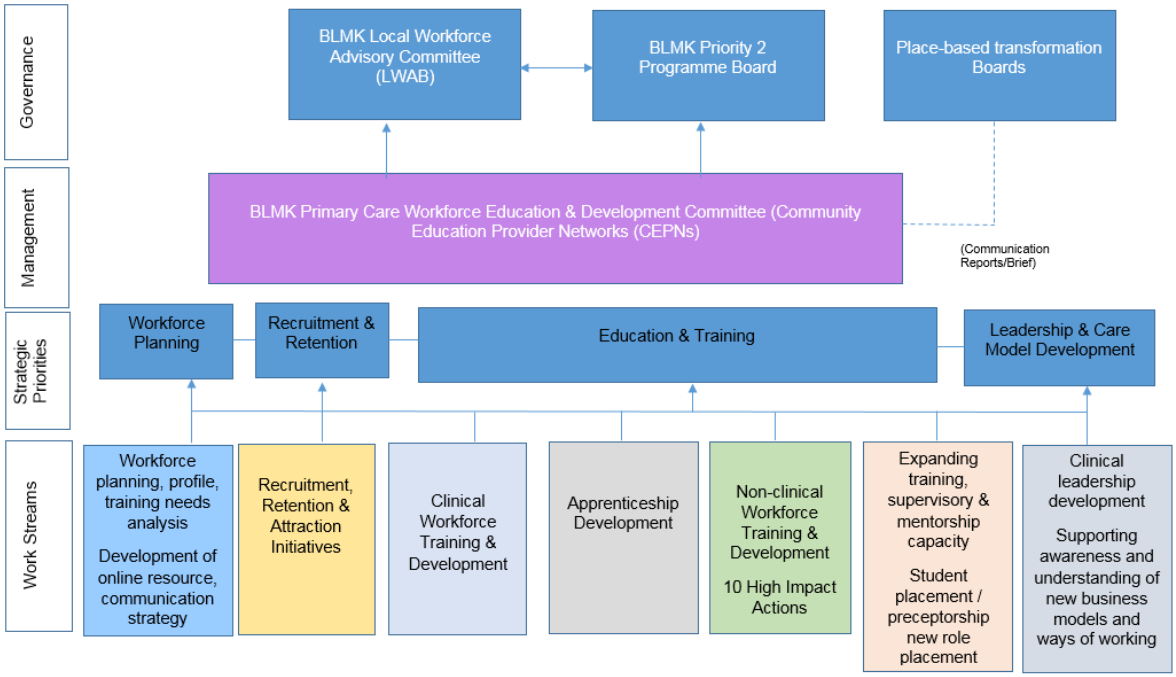
Figure 6. Delivery Team and Centralised CEPN



8. Governance and Assurance

The centralised CEPN will become the delivery vehicle for the GP Workforce Plan, with oversight and governance from the BLMK LWAB, Priority 2 Programme Board and our 4 Place- Based Boards (Figure 7).

Figure 7. ICS Governance and Assurance Framework



Risks

A risk log is attached within appendix 3. Our centralised CEPN will have operational oversight and monitoring of all risks. Risks will be escalated in accordance with individual CCG governance and reporting frameworks and through to relevant STP Boards and Programmes.

9. Interdependencies

9.1 Extended Access

Developing and upskilling our existing workforce, along with the introduction of new roles such as Clinical Pharmacists, Emergency Care Practitioners and Physicians Associates will be instrumental to enabling the delivery of extended access to our patient population. Our plan is predicated on enhancing skill mix and expanding the workforce's capability and capacity to work at the top of their licence and support the delivery of different types of consultations, to meet the needs of patients.

9.2 Urgent and Emergency Care

In recognition of the interdependency with the Extended Access work stream, within Bedfordshire CCG we are considering the opportunities for alignment with the Urgent Treatment Centre and integrated urgent care, in line with the NHS England Standards and the Five Year Forward View. A&E streaming went live on 8th October 2017.

Within Milton Keynes and A&E streaming service went live on 1st October 2017 and is currently streaming an average of 20 patients per day away from A&E to the Urgent Care

Centre. A pilot for Direct Booking of 'Contact Primary Care' dispositions from 111 into booked telephone call backs has gone live in one practice.

Across Luton CCG A&E streaming has been in place since 2012 and patients can be directly booked into the Urgent Treatment Centre from 111 for two dispositions. There are further plans to roll this out to 'in hours' practices and an increased number of dispositions, as well as moving the town centre surgery to a fully operational Urgent Treatment Centre. The Luton-based integrated Urgent Care service is a joint service contracted by Bedfordshire and Luton and work is underway to review the gaps against national guidance.

Key to the delivery of all of these services will be our workforce and our recruitment, retention and attraction strategy will encompass the urgent and emergency care context. We recognise the need to acquire a deeper understanding of preferences in terms of working practices, for example the proportion of our workforce that would prefer to work 'out of hours', but also the roles, competencies and skill-mix required to deliver these services.

9.3 Education, Training, Supervision and Mentorship

Critical to the recruitment of new GPs, new Practice Nurses, International GPs, GP Returners and the range of new roles such as Clinical Pharmacists and Physicians Associates entering general practice is the infrastructure to support them. In order to develop a sustainable workforce it is essential that these roles have the necessary level of support, supervision and mentorship and that practices have the capacity and capability to provide this.

Workforce challenges have resulted in fewer GP Tutors, Associate Trainers and Training Practices and the capacity to mentor, supervise and assess is significantly constrained.

There are also barriers to offering placements to pre-registration Nurses and Practice Nurses, due to constraints for mentoring, assessing and supervision.

These education barriers create further challenges to the recruitment and retention of General Practice Staff.

BLMK ICS is developing a centralised General Practice Community Education Provider Network (CEPN), as a vehicle to map the current education and training landscape and deliver a new model of education infrastructure to mitigate against recruitment and retention risks. For example, delivery of clinical supervision and mentorship via a hub and spoke model across groups / clusters of practices. Embedding a sustainable approach to training and supervision and to enable non-training practices or practices facing resilience challenges to take advantage of new roles in practice and being supported to provide the necessary supervision.

Through the workforce data survey each CCG has mapped its training capacity at practice level, capturing the number of training placements available, GP trainers and trained mentors. For the past year Bedfordshire CEPN has focussed on expanding training capacity mentorship capacity across practices and have mapped existing training and supervisory provision. The CEPN will expand capacity through implementation of a local Associate Trainer course devised to support both GP supervision and supervision of new roles. Plans are also in place to maximise the opportunities to access mentorship training and share multi-disciplinary training opportunities in partnership with our local providers via the CEPN networks.

Primary Care Home focuses its model on population level clusters of 30,000 to 50,000. As staff and services increasingly organise care around this population level, an ideal opportunity exists to create Education and Training Hubs. This would offer virtual arrangements for

aligning and sharing resources for GP tutors, Trainers, Associate Trainers, mentors and supervisors across the GP practices within a population level cluster.

This cluster approach to education and training infrastructure also enables collaborative place-based solutions to emerge, for example local community health services providers supporting mentorship and training up advanced/specialist nurses and a range of services offering clinical placements to GP fellows and Physicians Associates.

Across the BLMK ICS Health Education England has allocated funding to support 4 GP post CCT Fellows, 2 Physicians Associate Preceptorships and 6 GP Nurse Preceptorships. Light touch supervision and support will be funded to enable a period of structured transition for each newly qualified healthcare professional to develop competence and confidence.

9.4 Education and Training

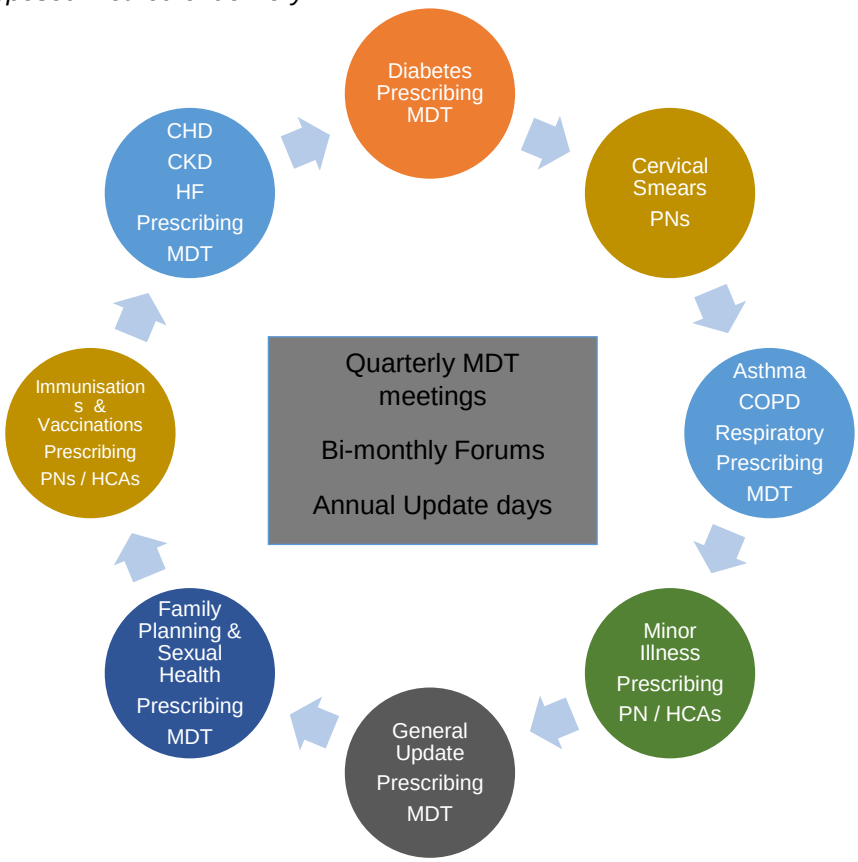
Whilst all staff will have a variety of mandatory and development training needs, specific requirements that support the population health needs and the primary care home model have been identified for:

- Management of Long term Conditions
- Health Coaching
- Management of childhood illness and injury
- Holding difficult conversations with families and patients for care planning

The development of multidisciplinary workshops within the four place-based geographies within BLMK ICS will support inter professional learning and relationship development across our place-based systems.

Regular training needs analysis will take place under the remit of the CEPN and linked with the wider system providers to ensure opportunities to train and learn together as a system are capitalised upon.

Figure 8. Proposed method of delivery



10. GPFV Workforce Plan Review

The ICS CEPN Workforce Strategy Group is forming and will regularly and consistently monitor the milestones and KPIs within the GPFV Workforce Plan. Leads within each CCG will be accountable to the ICS CEPN group for delivery against their key priorities and CCGs will review progress within their respective governance structures and with their member practices on a quarterly basis.

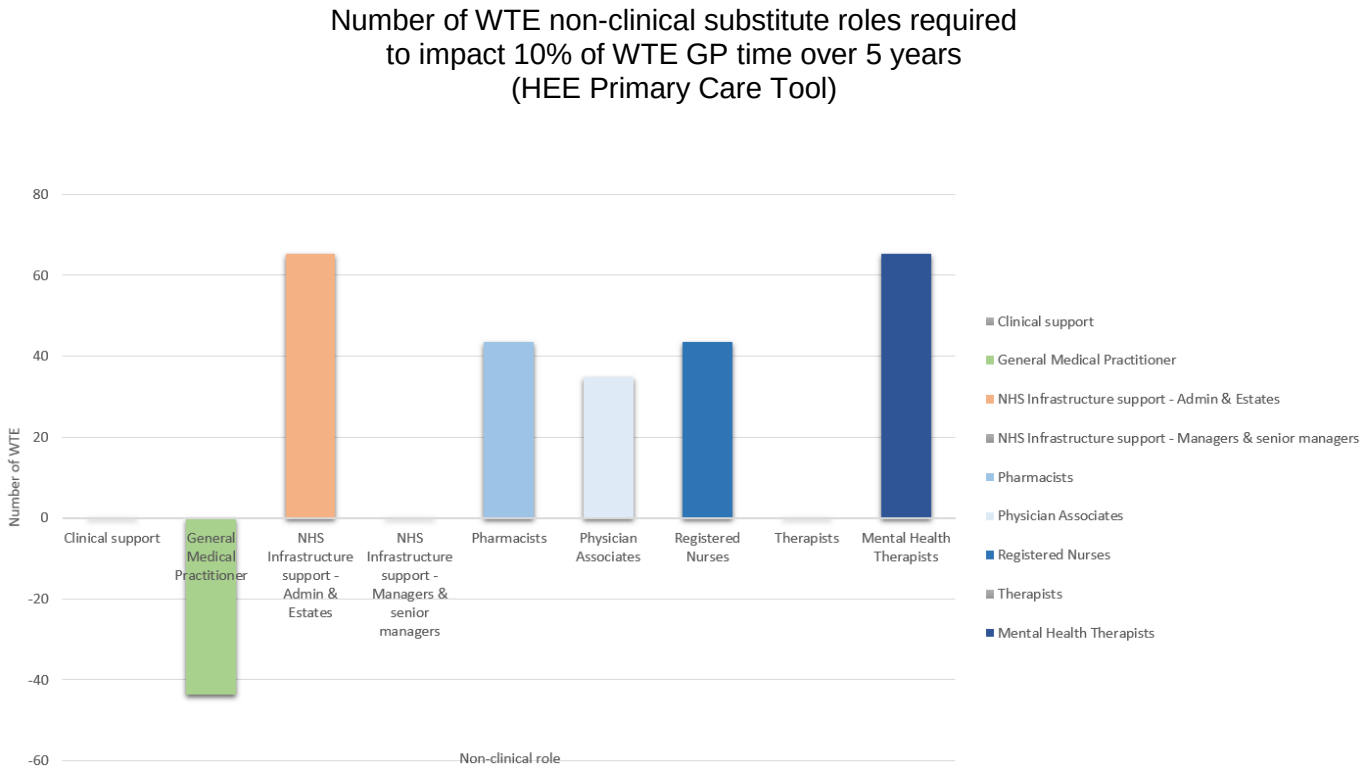
The GPFV Workforce Plan will be reviewed and re-assessed following each critical milestone in order that if necessary it can be reconfigured to factor in the outcome. For example, if an application to progress with International Recruitment is unsuccessful alternative plans will need to be made to meet the workforce gap.

The Workforce Plan draws together a multi-faceted approach to meet the multiple challenges and will incorporate an element of PDSA test and challenge, within an improvement environment to ascertain and measure greatest impact and how to move forward. This will ensure the overall primary care workforce development package is fit for purpose in each practice, each locality and each CCG and can deliver change across the whole STP footprint.

Progress reports against the implementation plan (appendix 2) and Risks (appendix 3) will occur at each CEPN meeting).

Appendices

Appendix 1 - Impact of Role Substitution



Appendix 2 – GP Workforce Plan

Work package title: GP Workforce Plan
Work package SRO: Colin Thompson

Activity	Output	2017/2018 Q3	2017/2018 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/2020 Q1	2019/2020 Q2	2019/2020 Q3	2019/2020 Q4
1 *Workforce Planning*											
1.1 *Complete CCG level baselines*	*1.Accurate, up to date workforce baselines 2. GP led practice-based workforce models*	■				■				■	
1.2 *STP aggregate level analysis and modelling*		■					■				■
1.3 *Develop and launch Web-Based resource*		■	■								
1.4 *PCH Test Cluster modelling*		■	■								
1.5 *PCH Modelling roll out*		■	■	■	■	■	■				
2 *Recruitment and Retention*											
2.1 *GP International Recruitment*	*GP numbers increased by 67 by December 2020*		■	■	■	■	■	■	■	■	
2.2 *Existing GPs: Attract, Retain and Return*		■	■	■	■	■	■	■	■	■	■
2.3 *GP Trainees; Recruiting newly qualified GPs*				■	■	■	■	■	■	■	■
2.4 *Alternative Employment Frameworks*				■	■	■	■	■	■	■	■
2.5 *Framework for the wider practice team*				■	■	■	■	■	■	■	■
2.6 *Implementation of the 10 Point GPN Plan*		■	■	■	■	■	■	■	■	■	■
2.7 *Recruitment to new roles*		■	■	■	■	■	■	■	■	■	■
3 *Education and Training*											
3.1 *Centralised CEPN*	*1. Centralised delivery of GP workforce Plan 2. Top of licence skilled workforce 3. Infrastructure to support education & training*	■	■								
3.2 *Infrastructure (supervision, mentorship & placements)*				■	■	■	■				
3.3 *Education & Training Delivery*				■	■	■	■				
3.4 *Apprenticeships*		■	■	■	■	■	■	■	■	■	■
3.5 *10 High Impact Actions*		■	■	■	■	■	■				
4 *Leadership and Care Model Development*	*1. GP Resilience 2. GP supported to develop new business models aligned to PCH*										
3.1 *GP Development Programme*			■	■	■	■	■	■			
3.2 *GP Resilience Programme*		■	■	■	■	■	■	■	■	■	■
3.3 *Time to Care*		■	■	■	■	■	■	■	■	■	■
3.4 *PCH Practices*		■	■								

Appendix 3 – Risk Register

ID	Date Raised	Risk Description	Mitigated Likelihoo	Mitigated Impact	Severity	Mitigation Plan
1	02/10/2017	As a result of data gaps for profiles for retiring GPs there is a risk that the GP workforce gap forecasts for 2018-2020 related to retirement are inaccurate, which may result in a GP workforce gap that is higher or lower than currently profiled.	3	3	9	1. Current planning assumptions have been based upon a flat rate. 2. Future local surveys will source data on anticipated number of retirements over next 5 years and profiles will be updated accordingly.
2	02/10/2017	As a result of a lack of access within the BLMK STP footprint to workforce profiling tools that align population health need to workforce planning, there is a risk that workforce profiles do not accurately reflect future demand.	5	3	15	1. The HEE Primary Care tool has been utilised to reflect increased demand through demographic population growth (this does not include health need related to complex morbidity etc.) 2. BLMK are partnering with napc to develop proposals to fund access to a consultancy-based approach for workforce modelling that aligns workforce modelling to population health need at cluster/network level (30,000 - 50,000). 3. HEE workforce transformation funding aligned to resource to support workforce modelling 09/17 - to recruit.
3	02/10/2017	As a result of insufficient access to workforce analyst/planning resource within the BLMK STP there is a risk that workforce planning and profiles are not robust, which may result in failure to produce a credible implementation and delivery plan.	5	4	20	1. GPFV Transformation Team, Central Midlands, NHSE requested requirements for planning 09/2017 - responded with need for workforce analyst/planning resource 09/2017. 2. Head of Leadership and Workforce Redesign, NHSE has raised this resource gap as a risk to all workforce planning requirements within the BLMK STP to the NHSE Transformation Board. 3. Secured advice and support from HEE for use of the HEE Primary Care Workforce Modelling Tool.
4	03/10/2017	As a result of limited national timeframes for developing the GP Workforce Plan there is a risk that insufficient levels of engagement and communication have been undertaken for plan development which may result reduced GP member support, adversarial publicity and reputational damage.	3	4	12	1. Each CCG maintains responsibility for GP member engagement and communication and engagement plans. 2 LMC engagement prior to plan submission. 3. Socialisation and engagement with plan commenced by all CCGs by Nov 17.
5	03/10/2017	As a result of constrained capacity there is a risk that the 3 CCGs will not align sufficient staff resource to the centralised CEPN group responsible for delivery of the plan within each CCG footprint, which may result in failure to execute plans to time and scale.	2	4	8	1. The 3 CCGs are meeting on 5th Oct and allocated resource from each CCG is to be agreed. 2. HEE have provided funding for each CCG to establish a CEPN and supports the intention of developing a centralised CEPN across the ACS. 3. First centralised meeting agreed for Jan 18.
6	03/10/2017	As a result of insufficient education/supervision infrastructure to support GP returners, International Recruits and new roles e.g. Physician Assistants there is a risk that workforce number projections cannot be fulfilled which may result in workforce shortages.	2	4	8	1. The BLMK GP Workforce Plan identifies Education and Training Infrastructure as a critical interdependency and outlines plans to enhance this framework. 2. HEE are reviewing models to support assessment and supervision of GPs within the Induction and Returner programme.
7	19/10/2017	As a result of a lack of national evidence to support planning assumptions for role substitution to impact GP workload requirements there is a risk that a reduction of 44 GP WTE is inaccurate which may result in failure to develop credible planning profiles and identify associated costs.	5	4	20	1. BLMK are partnering with napc to develop proposals to fund access to a consultancy-based approach for workforce modelling that works directly with practices and at cluster level to design credible, costed workforce plans that meet demand and population health need. This will commence with 2 clusters in 2017/18.
8	12/11/2017	As a result of an identified funding shortfall in salaried workforce costs of 57% there is a risk that financial exposure will result in failure to recruit the identified workforce profiles.	5	5	25	1. A review of this shortfall against current STP financial bridge will commence in Dec 17. 2 CCGs under delegated commissioning arrangements aim to work with NHSE to determine impact for allocations.
9	12/02/2018	As a result of NHSE Assurance requiring BLMK to increase our modelled GP trajectory requirement of 67 GPs by an additional 56 GPs, increasing our overall target to 123 GPs, there is a risk that GP Compliance Numbers will not be fulfilled.	5	5	25	1. Risk raised with NHSE Midlands and East leads. 2. To discuss at GPFV Assurance meeting 01.03.18.
10	12/02/2018	As a result of increased costs associated with NHSE GP Compliance Numbers there is a risk that financial exposure will result in failure to recruit these GP numbers.	5	5	25	1. Risk raised with NHSE Midlands and East leads. 2. To discuss at GPFV Assurance meeting 01.03.18.

Appendix 4 – BLMK ICS Leadership and OD Plan

BLMK ACS
Leadership & Organ