NHS
Wolverhampton
Clinical Commissioning Group

Meeting of the Primary Care Joint Commissioning Committee (Public)
Tuesday 4th October 2016
2.00 pm
PC108, 1st Floor, Creative Industries Centre, Wolverhampton Science Park

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE JOINT COMMISSIONING COMMITTEE

4th October 2016

Title of Report:	**Update- Primary Care Workforce analysis**
Report of:	Manjeet Garcha Chair PCPB
Contact:	Manjeet Garcha
Primary Care Joint Commissioning Committee Action Required:	☐ **Decision** ☒ **Information**
Purpose of Report:	To update the PCJCC on primary care workforce analysis undertaken by Navinder Dhillon
Public or Private:	Public
Relevance to CCG Priority:	1,2a,2b,3,4 &5
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 5:** Delegated Functions	**Domain 5: Delegated functions**: When approved this will include primary care and may, in time, include other services. This is in addition to the assurances needed for out-of-hours Primary Medical Services, given this is a directed rather than delegated function.

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1. BACKGROUND AND CURRENT SITUATION

1.1. The PCJCC requested an update on the Primary Care Workforce analysis undertaken by Navinder Dhillon during the period March 2016 and September 2016.

2. MAIN BODY OF REPORT

2.1 Progress of the work undertaken to date is evidenced in the following documents:

Report: Draft Workforce Strategy, this is being presented to the Primary Care Workforce Task and Finish Group on 29th September. A verbal update will be given re progress.

Appendix 1. Primary Care Workforce and Consultation and Scoping Report.

Appendix 2. GP workforce data (from national data submitted 2015. 2016 data to be submitted in October.

Appendix 3. Workforce numbers mapped with General Practice Models of Care

Appendix 4.Workforce Implementation Plan 2016

2.2 CLINICAL VIEW

The Primary Care Workforce Analysis was undertaken with clinicians and non-clinicians in general practice.

3. PATIENT AND PUBLIC VIEW

3.1 RISKS AND IMPLICATIONS

Key Risks

4.1 The data and intelligence is vital to the planning and delivery of the Primary Care Strategy.

5.0 Financial and Resource Implications

5.1 Funding streams have not yet been identified therefore, whilst some work can start, most cannot progress until there is known funding for the delivery of the courses.

6.0 Quality and Safety Implications

6.1 Quality and Risk Teams are fully sighted.

Equality Implications

7.1 A robust system has been put in place whereby all schemes have a full EIA undertaken at the scoping stage.

7.0 Medicines Management Implications

There are implications for primary care clinical pharmacists. This is being managed by another task and finish group, however, there is recognition of the overlap of work and resources.

8.0 Legal and Policy Implications

8.1 There are no legal implications.

9.0 RECOMMENDATIONS

9.1 To **RECEIVE** and **Note** the actions being taken.

Name: Manjeet Garcha
Job Title: Director of Nursing and Quality
Date: 28th September 2016

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Wolverhampton CCG
Primary Care Workforce Draft Strategy

‘Our Workforce Matters’

September 2016

Forward

Dr Helen Hibbs – Chief Officer

'Our vision for Primary Health Care in Wolverhampton ……. to deliver universally accessible high quality out of hospital services that: promote the health and wellbeing of our local community ensure that our population receive the right treatment at the right time and in the right place reduce early death and improve the quality of life of those living with long term conditions; and reduce health inequalities'. (Primary Health Care Strategy 2016-2020).

For WCCG, commissioning is about getting the best possible health outcomes for our local population, by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from local and regional health care providers. It is an on-going process, and WCCG must constantly respond and adapt to changing local circumstances.

We are responsible for the health of our respective populations and measured by how much we improves health outcomes along with improving quality of services that are commissioned locally. The populations for WCCG include those people registered with a GP in the CCG area and those people that do not have a GP but access health services.

To have a workforce that is sufficient, responsive and adaptable and puts the patients at the centre of their care is key to our success as a CCG.

Executive Nurse Director for Nursing and Quality – Manjeet Garcha

The publication of the NHS Five Year Forward View (2016), makes it clear that the NHS needs to be fit for the future, detailing a range of opportunities for primary care and acute providers to model and test out new health care delivery models to meet the increasing demand on the service and the requirement from the public to have a 21st century health care that is integrated and available seven days a week. A key enabler for this vision will be a workforce that is sufficient, competent, confident and fit for the future.

WORKFORCE, the right and sufficient WORKFORCE is one of the major enablers for delivery of all new solutions for health care provision, paying particular attention to meeting patient expectations of access and care closer to home, with increased integration of services and greater provision of services at weekends and out of hours.

To enable this to happen in a systematic way, we will have in place an achievable primary care workforce strategy with a clear vision and objectives for the CCG, which in time will also align with the broader Birmingham and Country Strategic Transformation Plan's workforce strategy.

1. Introduction

For Wolverhampton Clinical Commissioning Group (WCCG) to meet the national and local drivers to move health services and care out of secondary care, into general practice/primary and community care settings and adopt new general practice models that are of high quality and sustainable; will need strategies that build capacity and infrastructure that better aligns general practice with community service and social care providers and the **development of roles** that have competencies and skills to carry out more proactive and routine patient care, freeing our other clinicians to carry out more complex specialised and/or targeted care.

The General Practice five year forward view (DH 2016), also sets out a programme of work on how general practices can aspire, change and develop to deliver new models of health care provision. But more importantly it outlines what action is planned to support the growth and development of the workforce. There is a need to double the growth for GPs with an aim to achieve a net increase of 5000 full time equivalent GPs within the next five years. There are also plans to develop and fund other practitioners such as mental health therapists and clinical pharmacists in general practice and development monies for practice nurses, physician assistants, practice managers and receptionists.

Therefore, locally, as health and care providers and commissioners, we all need to have a clear vision on how the **current and future workforce** is attracted, developed, supported and retained in the system to meet the ambitions of a new fit for the future NHS within Wolverhampton.

2. Key Workforce Challenges - Wolverhampton

Primary care is largely still commissioned through the independent contractor model (one contract with one practice), which can limit getting a true representative of views of general practice as a whole. WCCG have been proactive in engaging with general practice and commissioned a consultation exercise with local general practices and their workforce, Local Medical Committee and key CCG senior management during the months of March – July 2016, to understand locally the key issues and opportunities for the local general practice workforce. This report and its outcomes are available in Appendix 1.

The challenges reported in the report have been grouped into the following high level statements which also reflect the national picture and link to other challenges general practice faces in light of new care delivery models, developments and investments in Information Technology (IT) and estates:

- Recruitment to GP posts – despite the national decision to increase the numbers of GP training opportunities available from August 2014 to meet the Government target to expand GP training, applications to GP training nationally dropped by 15%. The impact of this shortfall has been felt most acutely in under doctored GP workforce communities. This is also the case for Wolverhampton, though only one practice in the group consulted reported that they had not been able to recruit to a vacant post for past 12 months. Additional consultations with practices with primary care lead on practices vision on local clinical networking has highlighted several practices are in this situation.

- Increased workload for GPs - The rising service demands from patients, health policy changes and additional responsibilities such a taking up roles with clinical commissioning is increasing the pressure on general practitioners and general practice.

- There has been a lack of focus on workforce development in general practice due to the current commissioning model. A lack of personal development, career progression, increased workloads, and lack of succession planning have all led to a decrease in morale and job satisfaction within general practice over the recent years.

- General practice is often not seen as a desirable career for newly qualified doctors and nurses.

- Lack of integrated records and outdated IT systems increasing inefficiencies in care delivery across primary and community care providers.

- The estate for care outside hospital in Wolverhampton is often less than optimum following years of lack of investment; this contrasts markedly with investments which have been made in the local acute hospital.

- Whilst all Wolverhampton practices are exploring new models of care as Multispecialty Community Providers (MCP) sites, there remain issues linked to them operating as independent contractors and lack of exploration in ways to maximise efficiencies and share resources. E.g. shared business/practice management, workforce, and back office functions.

- Primary care workforce data collection has been poor in the past and lack of comprehensive primary care workforce data in Wolverhampton hinders the ability for effective workforce planning. The recent general practice workforce data publications by HSCIC does now provide some evidence which demonstrates the retirement age profile in traditional general practice roles which will continue over the next 5 years. This includes GPs, practice nurses and administrative staff. Please see appendix 2 for Wolverhampton general practice high level data as published in September 2015. (NB: there are gaps in the data as not all practices submitted data and the data submitted has not all been validated by HSCIC).

3. Vision for our General Practice Workforce

Our vision is to achieve a multi-disciplinary workforce in primary care which understands and is committed to delivering high quality care, is innovative, creative, diverse and sufficient. We will work with our workforce and other partners to ensure there are solutions and infrastructure in place attract and recruit, train and develop and retain the workforce in Wolverhampton that is proactive, adaptable, confident and competent, underpinned by systems that support workforce planning and modelling for future workforce requirements.

It is important to recognise there is no single workforce solution. We will need to adopt a multifaceted approach. An approach that looks at the skill sharing in the workforce and skills development would appear to be the most sensible approach. Clearly defined roles and standards of training for all working in primary care are essential to high quality and safe care. Further to this is how roles and skill sets are integrated to supported integrated health and social care service delivery with confident and robust workforce planning underpinned with clear financial trajectories.

With a clear vision and having a step by step approach the vision will be achievable with the following outcomes:

- Leadership culture enabling clinicians and non-clinicians drive service change and adopt new innovative models of care
- Sufficient integrated workforce that is competent and confident and not restricted by disciplines delivering high quality outcomes
- Wolverhampton general practices will be a place of choice to work and a career option for GPs and other clinical and non- clinical workforce.
- Practices able to share resources and reduce duplication in commissioning back office tasks
- Confidence in workforce data collection enabling future modelling and planning.

4. Current General Practice Service Models in Wolverhampton

The national view that England is too diverse for a 'one size fits all' care model has meant a small number of radical new care delivery models are being supported across England supported by the NHS national leadership team. For primary care in Wolverhampton as well as the standard general practice (GMS) model we have the following new primary care models emerging:

4.1 Adoption of a Multispecialty Community Provider Model – Primary Care Home. Wolverhampton Total Health Care is taking forward the first phase of this primary care model. This group comprises 26 General Practitioners providing Primary and Extended Primary Care to 47,000 patients through 8 Practices. Currently the teams are exploring:

- New ways of working with the extended primary care community care teams, local authority and voluntary sector.
- Adopting new roles within general practice to reduce the burden on GPs and increase access for patients

4.2 Integrated hospital and primary care provider (Accountable Care Organisation) – Vertical Integration model. Royal Wolverhampton NHS Trust and three local practices are piloting this model. This model has not been road tested in England before however, there is good evidence it works in North America and other countries. The rationale for this model is that it will allow for:

- Better utilisation of resources and providing flexibility on budgets, back office functions
- Improve ability to invest in staff, sharing of skill sets, extending roles and career options
- Stream line care pathways for patients and act at scale for defined patient populations

4.3 The Better Care Fund (BCF) is a programme that has pooled funds between the NHS and local authorities in every area throughout England - none of which is new money. 'Wolverhampton Better Care Fund' programme is working with all local service providers within three locality foot prints, which are not necessarily coterminous with the new Primary Care Home models or other clinical networks. However, it has brought together health, social care and voluntary sector providers and commissioners to redesign services putting patient's service users and carers at the centre. It has endeavoured to ensure that care is co-ordinated around the individual patient, that funding flows to where it is required and that care is provided by the most appropriate person in the most appropriate setting. The aim being to:

- reduce emergency admissions into hospital,
- reduce pressures across nursing and residential home placements,
- promoting independence and re enablement,

- ease pressures across social care
- work in a more integrated way of providing care - in turn saving money for both the NHS and local authority services.

4.4 'Intra health': a private provider of general practices services. Intra health currently has contracts with two practices in Wolverhampton. This provider is also offering a range of options of back office and clinical support to general practice especially single handed or those not keen to adopt any of the MCP models. They are currently also supporting networks of phase 3 for 'Primary Care Home' models.

4.5 Appendix 3 outlines potential network groups of practices following consultation with general practice colleagues and the CCG primary care team. The additional columns detail the workforce numbers per practice as submitted to HSCIC last year and published in September 2015. NB: there is a caveat that this data has not been validated so there are anomalies.

5. Key strategic workforce objectives:

The following are enablers that will support a sufficient, competent and confident workforce for Wolverhampton. The PC WF strategy group will work to build a workforce implementation plan with clear tasks to deliver on our vision.

5.1 Developing a leadership and succession planning

- Work towards developing a distributed model of leadership linking in with the HEWM leadership framework to support the delivery of the WCCG PC strategy vision at general practice level
- Facilitate a network of champions in primary care to influence change and promote new ways of working within general practice and wider primary care

5.2 Integrated, flexible and responsive workforce including new roles

- Enable general practice staff to effectively operate within multiagency, multi-disciplinary environments with focus on people, place and outcomes.
- Develop and enable new ways of working with clarity regarding future new models of delivery and requirement for new roles to support the new models.
- There is the potential to use even greater skill mix in delivering primary care services through a range of roles and professions. For example: advanced clinical practitioners, physicians' associates, clinical pharmacists, nursing associates etc.

5.3 Education and training

- Partnership working with Health Education WM and CEPNS, to influence education and training opportunities and outcomes for Wolverhampton and support increased clinical placements within primary care
- Partnership working with Health Education WM for GP training and offering innovative options to recruit and retain GP trainees within Wolverhampton
- Working in partnership with universities and other educational providers to influence curriculum where possible and identify courses that meet local education and skills requirements

- Explore with local hospital opportunities for practice staff to skill up in specialist areas and offer similar opportunities for hospital staff

5.4 Better informed workforce planning

- Partnership working with HEWM and the wider health community, along with the practices so that long term workforce data, including productivity data can be extracted and the anonymised data for workforce planning purposes. This data can be used to model workforce needs for the future, identify risks and opportunities and provide evidence to demonstrate resource requirements, including additional financial investment.
- There is national workforce planning tools being developed which are not being spread with across the patch, Wolverhampton needs to explore with HEWM and our local partners how these are shared across the patch at pace.

5.5 Promoting Retention and Enabling Return

- Explore options for - Returner schemes, investment in skilled clinicians for e.g. GPSIs,
- Maximising opportunities such as NHS England's retainer scheme to ensure it meets the needs of modern GPs and practices locally.
- Encourage experienced GPs to remain in practice through mentorship schemes, providing opportunities to develop a portfolio of career towards the end to working life,
- Clearer range of career pathways as well as access to NHS England's investment to attract GPs and other clinical professionals back into practice, targeting areas with the greatest needs.
- Exploring options across employers to increase workforce retention and participation following completion of training and early retirement.

5.6 Promoting General Practice as a career choice for all clinicians and non-clinicians

- Work with local employers for joint career fairs and raising profile of Wolverhampton as a place to work
- Partnership working with HEWM and local partners raising profile of career choices across partner employers and across disciplines

5.7 Infrastructure and better use of technology

- Explore clinician's skills to communicate with patients using a range of new technologies and media. This will include telephone, email and various forms of consultation, for young people the use of social media for interpersonal communication

6. On-going challenges and risks

The financial constraints and workload pressures now faced in general practice are acute. Release of staff for training is an issue for most practices as this often results in an impact on service provision or additional costs if the person goes out during working hours. Some practices still view training their workforce as a risk, that is, where they invest in skills development for individuals, neighbouring practices will 'poach' experienced and trained staff. The opportunity cost of staff development therefore needs to be recognised and supported for all practices. Evidence and experience shows where these obstacles have been overcome practices have seen the benefits of investing in training their workforce.

The emerging new MCP models of care delivery, and national directives for new roles e.g.: Nursing and Physicians Associates could be seen as a challenge as they challenge traditional professional roles and ways

of working. However, in Wolverhampton these are viewed as opportunities to increase capacity in general practices and offering new career opportunities for our staff, and not to mention better quality and appropriate care services for our local population.

6. Conclusion and next steps

In conclusion, this strategy and the attached implementation plan (appendix 4) is the initial road map for WCCG to develop and secure a workforce that is fit for purpose, able to adapt to changing demographics and the new models of care. A flexible workforce across disciplines with a breadth of skills and knowledge allows for greater adaptability and innovation and meet the scale of change in health services across Wolverhampton.
The attached Primary Care Workforce task and finish groups implementation plan outlines the tasks and actions that will need to be taken forward to meet the ambitions of the Primary Care Workforce strategy and hence the CCG Primary Health Care strategy.

References and Bibliography

Five year forward view: Department of Health 2016
https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

GP five year forward view, Department of Health 2016
https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Workforce Planning in the NHS: Kings Fund 2015

http://www.kingsfund.org.uk/publications/workforce-planning-nhs

Primary Care Health Care Strategy: WCCG 2016-2020

Road Map 2016/17 – 2019/20: WCCG 2016

Attachments:

Appendix 1: Report: Outcomes of the Consultation with General Practice on Workforce Planning and Development March – June 2016

Appendix 2: General Practice Data – results from data to HSCIC published September 2015

Appendix 3: General Practice – new Primary Care Models – Workforce data mapped (HSCIC Sept 2016)

Appendix 4: WCCG Primary Care Workforce Implementation Plan September 2016

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Report: Outcomes of the Consultation with General Practice on Workforce Planning and Development March – June 2016

1.0 Background – Policy

The government policy of shifting more health services into primary care outlined in the *Five Year Forward View* (NHS England, 2014), is adding to the intense and growing pressure on general practice and hence the workforce. This is with a backdrop of a projected shortfall of the numbers of practice nurses and GPs with high numbers due to retire within the next 5-10 years. Wolverhampton CCGs will work with local practices to ensure the WCCG primary care strategy and new models of care that are adopted by general practice to be fit for the future are underpinned by a workforce that is fit for the future too.

1.2 The aim of the consultation with general practice was to scope:

1. General Practices/General Practitioners views on the opportunities and challenges for their practice workforce individually and as a practice within their locality
2. Which disciplines were more difficult to recruit and retain locally
3. Examples of innovative practice relating to recruitment and retention of workforce adopted by practices
4. What attracts individuals who do secure employment in local general practices and what makes them stay
5. To review general practice data submitted to the national data base via the primary care web tool for September 2015 and validate this with workforce numbers by practice currently.

1.3 Consultation with CCG members, Locality meetings, Practice Managers Forum and the Local Medical Committee (LMC)

1.3.1 Before contacting practices an informal internal consultation was undertaken with key senior members within the CCG to gather their views on workforce issues they considered as key opportunities/challenges for local general practices and the CCG. The key themes from these informal meetings were as follows and were built into the above scope:

- How to engage the general practice workforce in the delivery the CCG Primary Care Strategy 2015
- Are the local workforce challenges for recruitment and retention to general practice different to the national picture and those detailed in national reports on workforce
- Are there specific areas in Wolverhampton that have more of a challenge than other areas regards recruiting and retaining the workforce
- What attracts individuals who do secure employment in local general practices and what makes them stay

- Are there innovative recruitment/retention strategies employed by practices which could be shared across the CCG
- How to have robust workforce database which identifies gaps and oversupply of the workforce and for future planning to meet service demands and changes
- How does the CCG with other partners within Wolverhampton make Wolverhampton an attractive place to work and stay
- How best can CCG supporting the workforce to network and share skills across practices

1.3.2 Attendance at the three locality meetings, and practice managers forum was undertaken to raise the profile and reason for the consultation and encourage engagement in the process. Practice members that attended were supportive of the process however did raise the following issues and concerns. These were addressed as follows:

- **Time out to participate in this exercise would be an issue as they were already very busy, and would there be backfill funding for practices**: this was acknowledged and assurance given that the meetings would take approximately 45-60 minutes. This was their opportunity for them to engage and inform future opportunities and developments for their practice and locality. No funding was available.
- **Practices already submit data to national primary care web tool and were we duplicating**: in September 2015, 9 out of the 46 practices had not submitted workforce data. This data exercise would be high level and would help the CCG to validate local numbers, and inform a baseline. For the future CCGs and other bodies will be relying on the national database for general practice workforce to inform future policy direction hence the need for all practices to engage.
- **How would this consultation inform future support to practices and their workforce:** members were informed this was the initial process of the wider piece of work that the CCG will be doing on informing and developing a primary care workforce strategy for WCCG. The role of the CCG is changing and the responsibility of commissioning services from general practice will be devolved from NHSE to CCGs. The CCG will need to have a view and a plan for this, however, at present this was not in the scope of this exercise.

1.3.3 The LMC members were also consulted, the groups feedback was positive and encouraged positive working with the CCG to support and enable practices to deliver high quality care. They provided general feedback on the support they saw that practices required to enable positive development of the workforce. Key areas raised were:

- Supportive of CCG role in supporting practice nursing revalidation

- Team W – was positive however the cover provided while GPs attend the sessions was seen as insufficient as GP would have to deal with the calls on return to their practices
- Ideas included:
    - Enabling GPs and PNs to do sessions in Acute settings to build up their skills – some GPs already do this
    - Joint training for Health Care Assistants with Acute provider to support standardization and increase workforce supply
    - Sharing the workload of CQC visits – distracting clinicians from direct patient care
    - Standardisation of training for staff clinical and non clinical and mandatory training too
    - 'Cost Model' for general practice needs reviewing to reduce workload creep into general practice (eg following up of what once was secondary care service provision)
    - Building on the GP with special interest across Wolverhampton

1.4 Consultation with practices and individuals involved

All practices within the CCG were sent a brief detailing the reason and scope of the consultation to raise their awareness. A following email was sent to individually to practice managers and lead GP inviting them to arrange a meeting with the Workforce (WF) Consultant. Representatives from each discipline were encouraged to attend the meeting eg General Practitioner, Practice Manager, Practice Nurse.

Due to challenges faced by practice managers to arrange a meeting with key members of the team within the timescale, practices were given the flexibility that the WF consultant would meet with at least one member as long as they had consulted and got views from their colleagues. In some practices Practice Manager, GP and Practice Nurse were seen separately due to their practice commitments.

21 practices were visited up to 3rd June 2016. Representation at the meetings was as follows:

- 7 meetings with Practice Manager (PM) only
- 4 meetings with GP only
- 2 meetings with Practice Nurse (PN) only
- 5 meetings with PM and GP
- 1 meeting with PM and PN
- 1 meeting with GP and PN
- 5 meetings with GP PM PN Receptionists

All practices participating in the Vertical Integration model, one practice from the Primary Care Model were visited.

1.5 The key challenges so far to participation of practices in the consultation have been:

- Restrictions of availability of WF consultant time (available in general three days a week)
- High workload in practices and unable to get GP PM and PN available at one meeting within timescales (months of April, May and June 2016)
- Practices undergoing CQC visits
- Practices requiring 'backfill' to attend meeting with WF consultant
- Key staff members on holiday
- Practices not forth coming with appointments have all been emailed four times for with no success

1.6 Key themes for each area of scope identified in point 1.2

1. General Practices/General Practitioners views on the opportunities and challenges for their practice workforce individually and as a practice within their locality

Opportunities

The question for this section was posed as key opportunities for the practice. This appeared to challenge practices as the default position members would site the challenges they were facing. On further prompting the two themes that was apparent was that practices saw themselves as:

- providing the fundamentals of general practice for their local populations
- single unit providing care, they had their own values and these did not always match their neighboring practices

Both these themes seemed to restricted thoughts on how they would work in partnership with other practices within the localities or to innovate as they had to still provide the core general practice services.

With further prompting the following thoughts for opportunities were shared:

- Share back office functions/skills – this has been muted by the CCG
- Pool resources – finance and skills for employing staff jointly to cover practices with specialists skills eg Web designers, HR specialists, Managing CQC visits
- Share experience from other practices and ways of working reduce the 'reinventing the wheel'
- Potential working with like-minded practices to deliver new ways of working
- Develop patient skills for 'self limiting illness' so not reliant on GP time
- Use of pharmacist skills in general practice – repeat prescriptions, medicines management etc.,
- Practices to work together to keep their workforce rather than poach good staff of each other
- New models for general practice where business element is removed from GP role
- Opportunity for nurses to extend skills, advanced practice, prescribing, wound management
- Increase/expand HCA skill set – some practices had joint role of part time receptionist and part time HCA

- Use of apprenticeships in practice for all job roles and not just reception roles
- Better use of skill mix within disciplines and across professions
- Opportunities to bring in Mental Health, Podiatry, Physiotherapy, Social workers, Holistic therapies
- Improved IT systems hence increasing capacity of clinicians
- Manage residential and nursing home cover differently – reduce burden on practice

Vertical Integration model practices:

- Opportunity to share resources with Acute provider eg: HR, Training ,Specialists Skills, Workforce cover

Primary Care Model practice:

- Focus on locality workforce capacity and how skills are used more effectively – early stages

Challenges:

This question provoked intense discussion and a level of dissatisfaction on how little practices felt they were supported regards their workforce by the CCG. There was frequent reference to lack of specific courses for their staff. The key challenges were identified as:

- Lack of support to train new practice nurses and their updates
- Lack of updates for HCAs
- Reduced pool of individuals to recruit from with skills of working in general practice
- Practice manager work increasing in workload and complexity
- For those practices that had recruited GP within last 12 months it has been difficult to recruit due to:
    - low level of interest
    - GP not wanting a partnership – Locum option more attractive
    - lack of GP trainees in the system to choose from
- For practices that have recruited a PN within past 12 months experience has varied at practice level
    - generally low level of interest
    - lack of practice working skills
- Workload for GPs viewed as a big issue – some practices having up to 90 appointments on a Monday morning when they have only 60 slots
- Due to reduction in practice funding there is less funding to buy in additional workforce to manage demand
- High demand and expectations from patients
- Newly qualified GPs and some of those in practice
    - not keen on responsibility of a business/partnership
    - want to work set hours with less responsibility
    - locum seen as a more attractive proposition

- Buildings are a challenge - lease options need to be more attractive, need more space if offering more services or training for undergraduate clinicians
- Use of Locums a challenge too as they are dictating terms of contracts eg
    - High fees
    - Length of sessions
    - Not doing follow ups from hospitals
    - Not doing administration work
    - Asking patients to come back and see own GP and not dealing with issue or referring appropriately
- Constant need for nurses to be signed off for specific areas eg Smoking cessation training,
- CQC visits are a big burden in collating policies and paperwork. It is not as easy as taking another practices policies – the practice still needs to understand and apply the policies in practice
- Training of other disciplines – need time to do it properly and space to accommodate additional trainees/students

2. Which disciplines were more difficult to recruit and retain

No specific discipline was identified as difficult to recruit, other than the general medical and nursing disciplines**.**

3. Examples of innovative practice relating to recruitment and retention of workforce

Majority of practices tended to recruit like for like when vacancies came up. Some practice however did take time out to evaluate roles within teams before replacing. Key themes that supported good recruitment and retention of staff were as follows:

- Word of mouth that practice is a good place to work
- Using training and other networks to recruit especially GPs and PNs
- Practice meetings and consultation with staff teams that could be effected with any change
- Taking time out to evaluate roles with the teams before replacing and offering opportunity to staff to try new roles
- Giving teams the option of working differently and letting them come up with ideas
- Rotating roles and sharing skills especially for reception and administration staff as this also support cover when staff are on holiday or off sick
- Having regular conversations with staff to get their views on if they are thinking of leaving/ retiring/ want to work differently
- Practice staff having regular 1:1 to review performance and opportunities for development and not waiting for annual appraisals to do this
- Offering training opportunities for staff to develop

4. What attracts individuals who do secure employment in local general practices and what makes them stay

It was reported that staff stay because:

- there is good team working in practices, staff support each other
- work environment good
- working as a team
- good communication with team members
- good employment relationships (with GPs)
- practice manager gets involved with team and is hands on when needed
- everyone helping each other
- knowing patients by name
- live locally so little travel and work around family commitments
- good career progression options for those that want them

5. To review general practice data submitted to the national data base via the primary care web tool for September 2015 and validate these with workforce numbers by practice currently.

Tables 1- 4: Showing Comparison Workforce Data for each discipline from local scoping (April - June 16) with WCCG Practice MDS returns to HSCIC and NHS Midlands and East (West Midlands) (September 2015)

Table 1 : General Practitioners	**WCCG Practices (17 practices) June 16**	**Total %**	**WCCG HSCIC* (37 practices) Sept 15**	**Total %**	**NHSE M+E (West Midlands) Sept 15**	**Total %**
All GPs of which:			***181***		***3229***	
GP Partners	36	69%	97	64%	1,891	69%
Salaried GPs	16	31%	54	36%	859	31%
All GPs (excluding retainers, registrars and locums)	**52**		**150**	**83%**	**2,740**	**84%**
of which						
Male	29	55%	61	40%	1,179	43%
Female	23	45%	41	27%	1,112	41%
Not Stated gender			48	33%	450	16%
% GPs (excluding retainers, registrars and locums) aged 55 and over *of those recorded		**30%**		***20%**		***22%**

5.1 General Practitioner Workforce Key Messages:

- % of GP partners in comparison to Salaried GPs is similar across WCCG and West Midlands and when locally scoped (June 16)
- % Male / female split for WCCG in comparison to West Midlands shows a lower proportion of females to males ie 27% females(WCCG) to 41% females (WM)

- However, the local scoping (June 16) shows there are high proportion of females (45%) in WCCG
- % of GPs aged 55 and over is at 30% in the local scoping(June16) compared to 20% (WCCG) and 22% (WM) - *note* - WCCG and WM figures are of those recorded only so could be higher/lower

Table 2: Practice Nurses	**WCCG Practices** (17 practices) June 16	**Total %**	**WCCG HSCIC** (37 practices) Sept 15	**Total %**	**NHSE M+E (West Midlands)** Sept 15	**Total %**
Practice Nurse HC	37		108		1778	
Practice FTE	23		68		1185	
Of which:						
Advanced Nurse Practitioner (HC)	10	27%	24	22%	288	16%
Male	0	0	2	2%	17	1%
Female	37	100%	75	69%	1481	83%
Not Stated gender	0		31	29%	280	16%
% aged 55 and over *of those recorded	14	**38%**		***23%**		***30%**

5.2 Practice Nurse Workforce Key Messages:

- There is a higher proportion of ANP reported within the local scoping (June 16) and the WCCG return compared to WM
- Local scoping reports a higher proportion of nurses aged 55 and over compared (38%) to WCCG and WM reports *note* - WCCG and WM figures are of those recorded only so could be higher/lower
- Percentage of male nurses very low but not unusual

Table 3: Direct Patient Care (DPC)	**WCCG Practices** (17 practices) June 16	**Total %**	**WCCG HSCIC** (37 practices) Sept 15	**Total %**	**NHSE M+E (West Midlands)** Sept 15	**Total %**
Total DPC	16		51		1029	
Health Care Assistant HC	16		39		694	
Health Care Assistant FTE	11		28		468	
Dispensers HC	0		3		169	
Dispensers FTE	0		2		122	
Phlebotomists HC	***a***		4		96	
Phlebotomists FTE			1		41	
Pharmacists HC	***b***		1		22	
Pharmacists FTE			0		10	
Of which:						
Male	0		0		25	2%
Female	16	100%	31	61%	814	80%
Not Stated gender	0		20	39%	190	18%

% aged 55 and over *of those recorded	3	**19%**		***21%**		***23%**

5.3 Direct Patient Care Workforce Key Messages:

- Direct Patient Care this grouped is identified as those providing direct care to patients other than General Practitioner or Nurse
- a - local scoping included phlebotomy as part of role of HCA no practice had identified specific individual role
- b - pharmacist not recorded as role not employed by practices

Table 4: All admin and non-clinical roles	**WCCG Practices (17 practices) June 16**	**Total %**	**WCCG HSCIC (37 practices) Sept 15**	**Total %**	**NHSE M+E (West Midlands) Sept 15**	**Total %**
Total Admin and non-clinical roles (HC)	147		457		7186	
Practice Managers HC	19		63		916	
Practice Manager FTE	18.5		52		808	
Receptionist HC	128		308		4785	
Receptionists FTE	82.4		201		3171	
Of which:						
Male	2	**1%**	18	**4%**	297	**4%**
Female	145	**99%**	305	**67%**	5692	**79%**
Not Stated gender	0		134	**29%**	1197	**17%**
% aged 55 and over *of those recorded	37	**25%**		***33.2**		***30.4**

5.4 All admin and non-clinical Workforce Key Messages:

- For the local scoping and collating of this data administration staff includes secretaries and other administration staff

1.7 Conclusion and next steps

It was originally planned that all practices would be visited over a 4-5 month period. However, it has been decided due to the commonality of the messages and themes that were being reported it would be wise to stock take and re-evaluated our approach.

The data validation has proved useful for it shows that there is high proportion of clinicians aged 55 and over than what the regionally figures show. This is important to note for planning now and in the future as 30% GPs and 38%PNs in the practices visited are due to retire in the next ten years.

Following internal discussions it has been decided that:

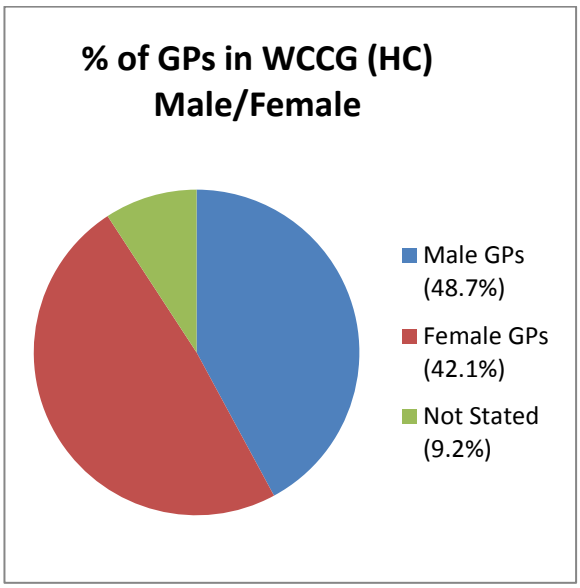
- Individual consultations have provided valuable insight to the views and thoughts of general practice and their staff. The messages/themes will inform the work primary care undertake as to how they support practices to deliver different ways of working within general practices, localities and across WCCG.
- Scoping skills and workload demand needs to be done either individually with each practice or within a locality, this will then help inform new models of care and service delivery. To do this effectively joint working is needed with primary care, public health and workforce.
- The need to do some quick scoping of skills and training needs for practice nurse and health care assistants can be done more effectively done via emails. This can then support joint working with the Community Education Practice Networks across Black Country.

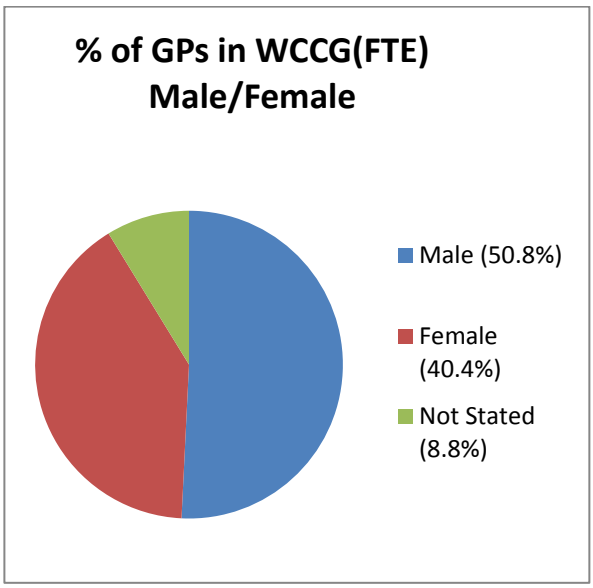
In conclusion, this has been an interesting and worthwhile exercise. The CCG needs to take the outcomes of this report to support how they work with primary care and inform the development of their Primary Care Workforce Strategy and Implementation plan.

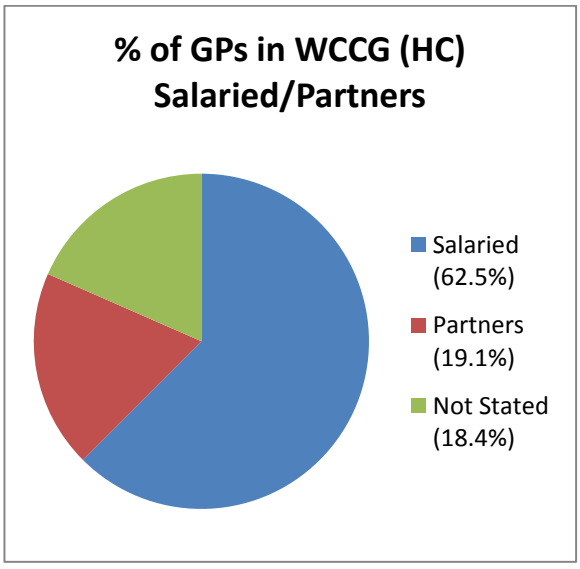
Appendix 2: WCCG GP workforce data September 2015 (source HSCIC)

NB:

1. The data used for GP numbers excludes – registrars, retainers and locums
2. There are inconsistencies when looking at total numbers and totalling up age band numbers due to incomplete returns
3. There are anomalies due to incomplete returns and in consistencies in data provided from those that have returned data
4. HSCIC – recognises data has not been fully validated at present.







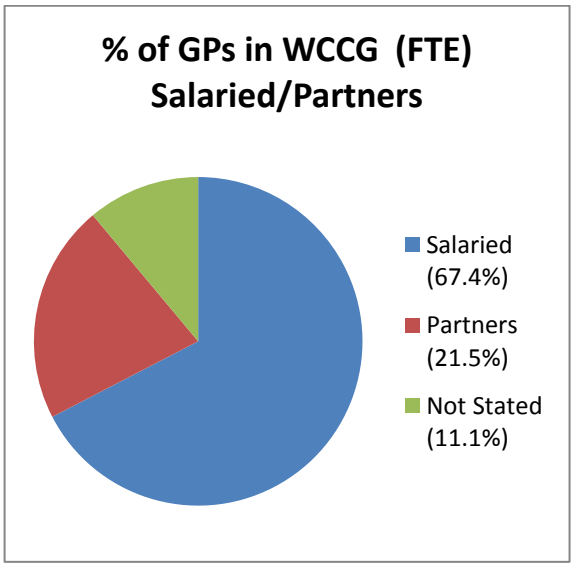


Table 1: Age Profile of GPs /Gender (WCCG)

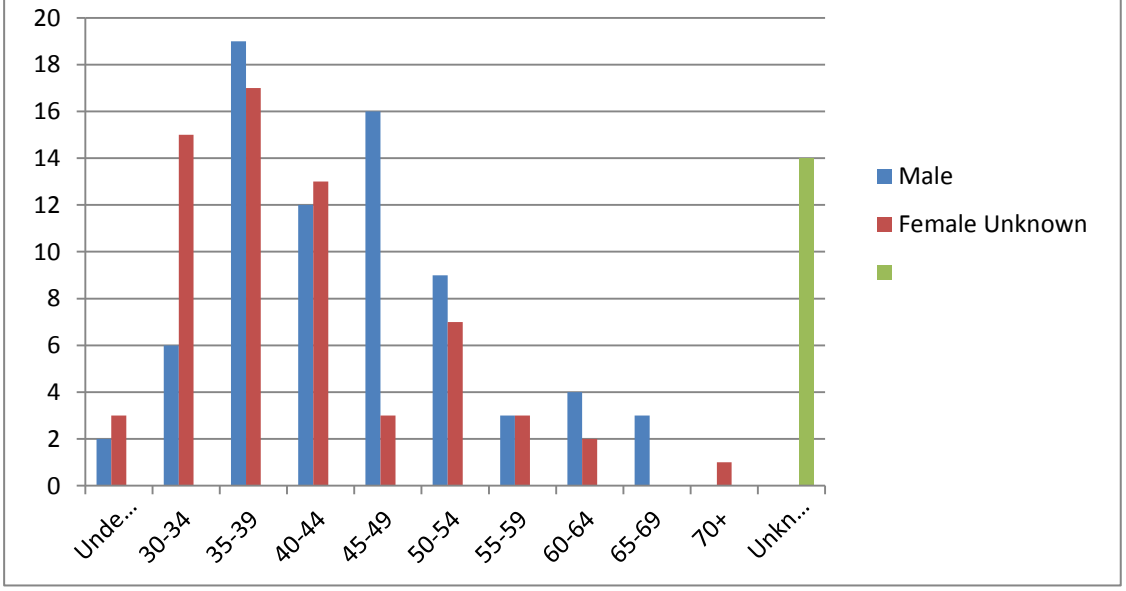


Table 2: Age profile of Nurses /Gender (WCCG)

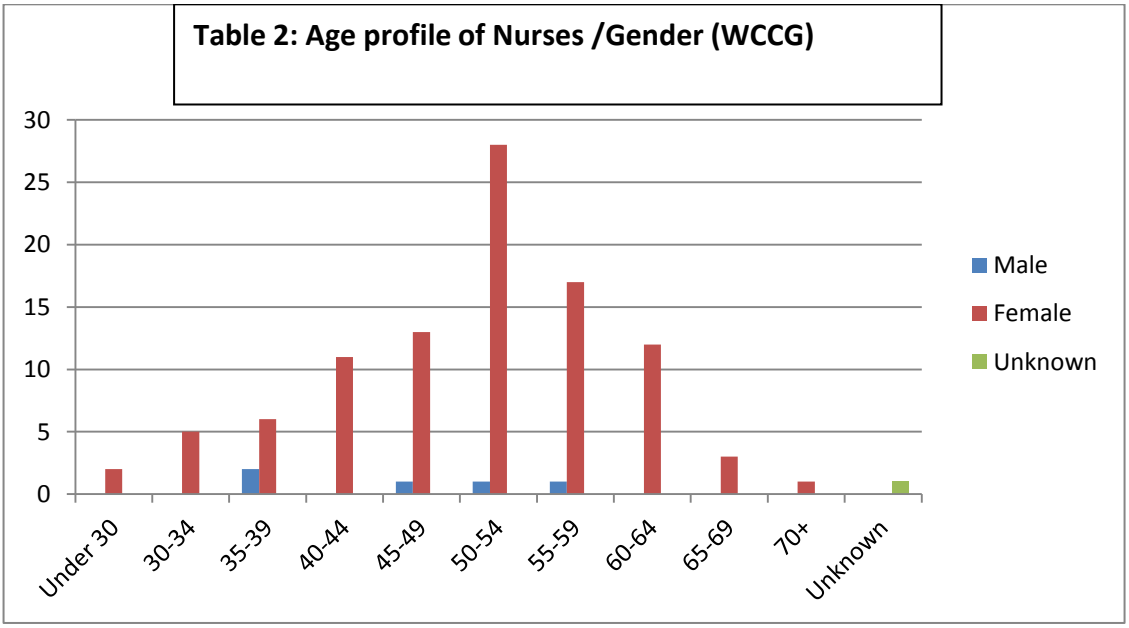


Table 3: Age Profile of HCAs/Gender

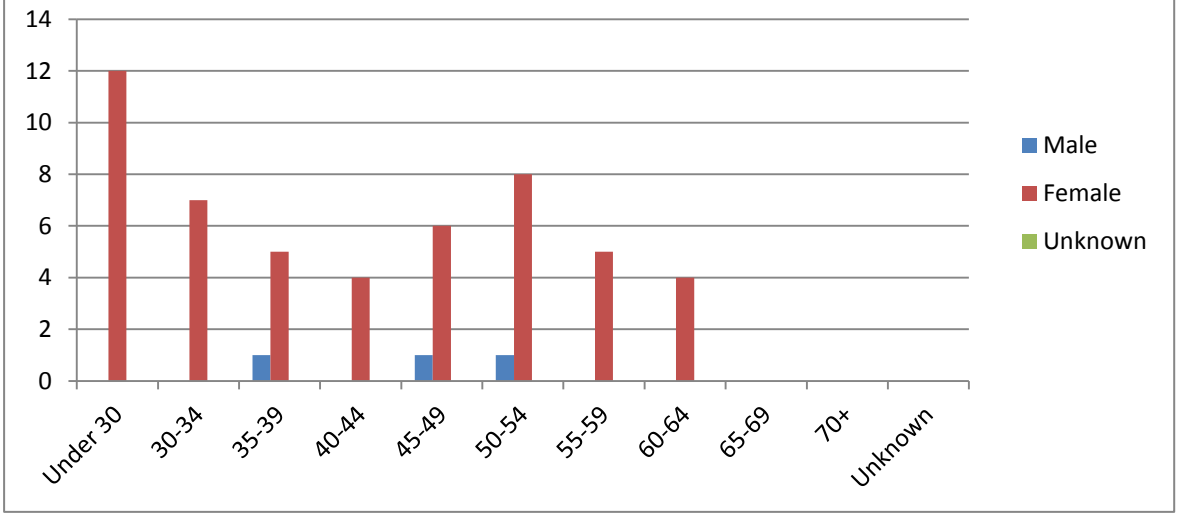
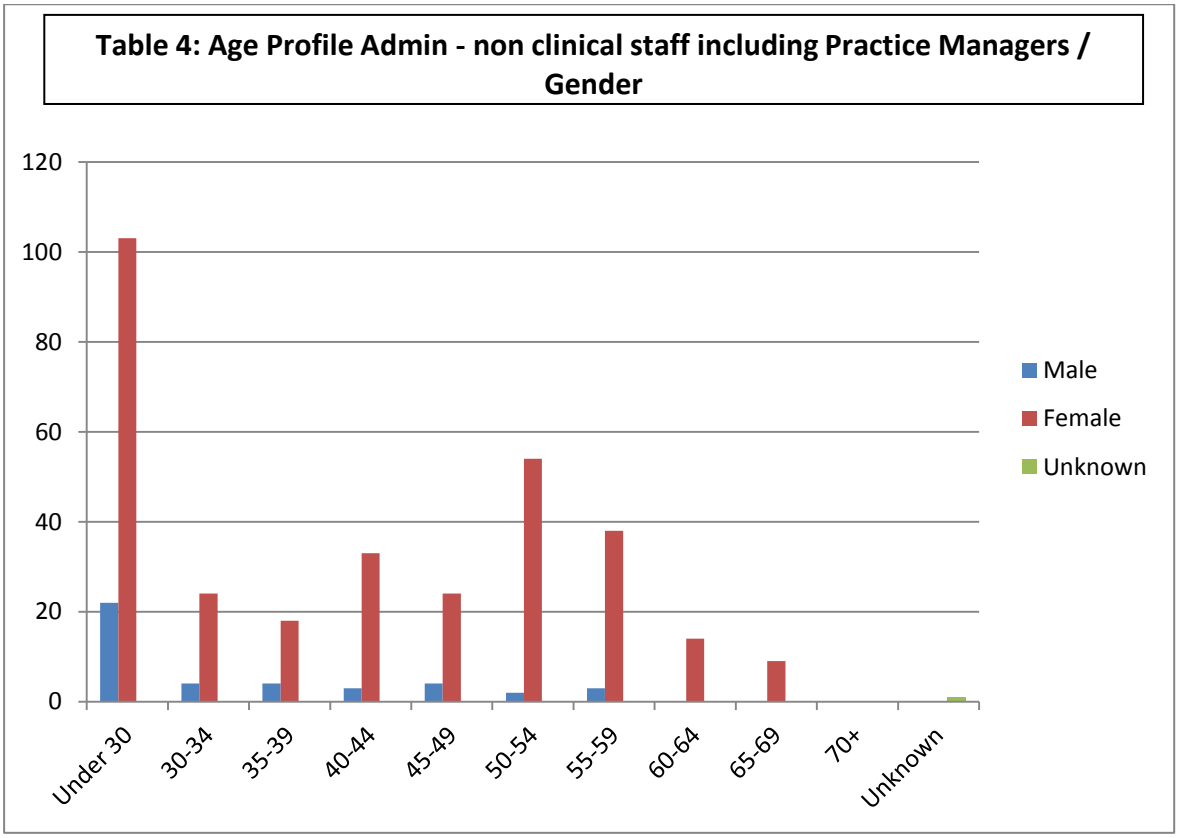


Table 4: Age Profile Admin - non clinical staff including Practice Managers / Gender



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22%		Locality		Clinical Networks & Alignment with New Models of Care Row Labels	Contract type	Registered Population April 2015	Carr Hill weighted population April 2015	No Data Return to HSCIC in Sept 15	GPs HC	GP FTEs	GP HC	GP FTE	Practice Manager HC	PM FTE	ANP HC	ANP FTE	PN HC	PN FTE	HCA HC	HCA FTE	Admin and non-clincal staff - HC	Admin and non-clincal staff - FTE
									inc registrars, locums and retianers		exc registrars, locums and retianers										including PM	
	PCH 1 Wolverhampton Total Health																					
1	1	NE	PCH 1	M92016 - TUDOR MEDICAL CENTRE	GMS	6471	7038		4	3.73	4	3.73	1.00	0.48	0	0	2	0.99	1	0.8	11	5.51
2	2	NE	PCH 2	M92629 - DRS KHARWADKAR & MAJI	GMS	3332	3720		1	1.87	1	1.6	2.00	1.53	0	0	1	0.16	1	0.48	8	4.55
3	3	NE	PCH 3	M92019 - KEATS GROVE SURGERY	GMS	6387	6305		5	3.70	2	2.59	2.00	1.72	0	0	2	1.24	0	0	10	7.87
4	4	SE	PCH 4	M92027 - CAERLEON SURGERY	still PMS	3319	4247		2	2.00	2	2	1.00	0.85	0	0	1	0.8	0	0	7	4.05
5	5	SE	PCH 5	M92030 - CHURCH STREET SURGERY	GMS	5414	5669		2	2.00	2	2.72	1.00	0.93	0	0	2	1.07	0	0	6	4
6	6	SE	PCH 6	M92630 - EAST PARK MEDICAL PRACTICE	ex PMS	4884	4991		5	4.19	3	2.4	4.00	2.80	1	1.01	3	2.31	0	0	8	4.21
7	7	SW	PCH 7	M92029 - NEWBRIDGE SURGERY	GMS	4449	4701		4	3.22	3	2.15	1.00	0.99	0	0	1	0.69	1	0.41	11	5.96
8	8	SW	PCH 8	M92607 - WHITMORE REANS MEDICAL PRACTICE	GMS	12325	12253	NR	5	4.53												
9	3	NE	NE3	M92643 - DR CHRISTOPHER	GMS	2474	2241		1	0.69	1	0.69	1.00	0.91	0	0	0	0	0	0	4	3.28
						49055	**51164.31**		**29**	**26**	**18**	**17.88**	**13**	**10**	**1**	**1.01**	**12**	**7.26**	**3**	**1.69**	**65**	**39.43**
	PCH2 Wolverhampton Care Collaborative																					
10	12	SE	SE	M92612 - GROVE MEDICAL CENTRE	GMS	3319	3284		2	1.55	2	1.55	1.00	0.53	0	0	2	0.88	0	0	5	3.63
11	5	NE	NE2	Y02736 - SHOWELL PARK HEALTH & WALK IN CE	APMS	4811	4675		4	2.48	4	2.48	NR	NR	3	1.19	4	1.79	4	2.29	NR	NR
12	5	SE	SE	M92035 - ALL SAINTS AND ROSEVILLAS MEDICAL	GMS	5611	3189		4	2.80	4	2.8	1.00	0.80	0	0	1	0.24	0	0	6	4.35
13	7	SE	SE	M92647 - BRADLEY MEDICAL CENTRE	GMS	3010	3554	NR	2	2.00												
14	6	NE	NE2	M92609 - ASHFIELD ROAD SURGERY	GMS	4930	4540		2	1.97	2	1.97	2.00	1.60	0	0	1	0.75	0	0	6	4.35
15	2	NE	NE3	M92039 - DR ST PIERRE-LIBBERTON	GMS	6574	2839		3	2.52	3	2.52	1.00	1.00	0	0	2	0.33	2	0.85	11	8.05
16	1	NE	NE3	M92009 - PRESTBURY MEDICAL PRACTICE	GMS	13763	15451		12	10.01	8	6.64	1.00	0.99	1	0.75	5	3.72	3	1.57	32	19.65
					0	**42018**	**37532**		**29**	**23**	**23**	**17.96**	**6**	**5**	**4**	**1.94**	**15**	**7.71**	**9**	**4.71**	**60**	**40.03**
	Emerging PCH 3																					
17	2	SW	SW3	M92044 - DRS DE ROSA & WILLIAMS	GMS	4248	4477		3	2.93	3	2.93	1.00	0.85	0	0	1	0.67	1	0.27	7	4.07
18	2	SW	SW3	M92043 - PENN SURGERY	GMS	4956	5061		4	2.56	4	2.56	1.00	1.00	0	0	1	1	2	1.59	9	6.5
19	4	SW	SW3	M92011 - PENN MANOR MEDICAL PRACTICE	ex PMS	11478	11799	NR	9	8.46												
20	4	SW	SW2	Y02636 - INTRA HEALTH LIMITED	APMS	3211	2571		5	1.77	5	1.77	1.00	1.00	4	1.64	6	2.51	1	0.2	8	5.85
21	8	SE	SE	Y02757 - BILSTON URBAN VILLAGE MEDICAL CE	APMS	5542	4806		6	3.21	5	2.21	1.00	1.00	4	1.79	6	2.89	1	0.8	12	8.6
22	4	SE	SE	M92015 - DRS PAHWA	GMS	3865	4182	NR	2	2.00												
23	1	SE	SE	M92024 - PARKFIELD MEDICAL CENTRE	GMS	12858	13345		10	8.48	8	6.48	1.00	0.80	2	2	4	3.91	3	2.37	19	14.15
24	9	SE	SE	Y02735 - ETTINGSHALL MEDICAL CENTRE	APMS	3374	3392		6	4.93	6	4.93	1.00	0.91	2	1.35	4	1.76	1	0.64	9	5.45
25	11	SE	SE	M92012 - DUNCAN STREET PRIMARY CARE PART	ex PMS	9491	10050	NR	10	9.38												
26	3	SE	SE	M92627 - DR SHARMA	GMS	3178	3720		3	2.39	3	2.39	2.00	0.99	0	0	1	0.72	0	0	6	3.76
27	3	SW	SW2	M92028 - THORNLEY STREET MEDICAL CENTRE	ex PMS	9683	9516		7	7.27	7	7.29	2.00	2.00	1	0.8	3	1.84	1	0.67	16	11.47
28	10	SE	SE	M92003 - DR SURYANI	GMS	1733	1960		2	1.43	2	1.43	2.00	1.35	0	0	1	0.69	1	0.69	5	5.83
29	1	SW	SW3	M92006 - COALWAY ROAD MEDICAL PRACTICE	ex PMS	5255	5397	NR	4	3.50												
30	1	SW	SW1	M92010 - LOWER GREEN HC- TETTENHALL	GMS	11681	12359	NR	5	5.00												
31	1	NE	NE1	M92022 - DR RAJCHOLAN & DR GEORGE	GMS	3787	3943		2	1.97	2	1.97	1.00	0.85	0	0	1	0.85	1	0.59	5	3.73
32	3	SW	SW1	M92008 - CASTLECROFT MEDICAL PRACTICE	ex PMS	12128	12764		7	6.00	1	1	2.00	1.79	0	0	5	3.27	1	0.53	17	11.29
						73617	**109340**		**85**	**71**	**46**	**34.96**	**15**	**13**	**13**	**7.58**	**33**	**20.11**	**13**	**8.35**	**113**	**80.7**
	PCH 4/Alliance																					
33	6	SE	SE	M92040 - MAYFIELD MEDICAL CENTRE	ex PMS	6348	6650		4	3.55	4	3.55	3.00	3.25	2	1.16	4	3.55	1	1	10	8.53
34	2	NE	NE2	M92001 - POPLARS MEDICAL CENTRE	GMS	3320	3125	NR	1	0.56												
35	4	NE	NE2	M92004 - PRIMROSE LANE PRACTICE	GMS	2885	3290		1	0.48	1	0.48	1.00	0.80	0	0	1	0.64	0	0	5	2.89
36	2	NE	NE1	M92041 - PROBERT ROAD SURGERY	still PMS	4626	4418		1	0.99	1	0.99	2.00	1.20	0	0	2	1.33	0	0	8	4.59
37	3	NE	NE2	M92026 - DR BILAS - Ashmore Road	GMS	3866	3949		2	2.51	2	2.51	1.00	0.43	0	0	2	1.33	0	0	12	5.74
38	2	SE	SE	M92649 - DR MUDIGONDA	ex PMS	3605	3889	NR	3	3.00												
39	2	SW	SW2	M92031 - DRS PASSI & HANDA	GMS	6527	6728	NR	2	2.00												
	1	NE	NE1	M92022 - DR RAJCHOLAN & DR GEORGE	GMS																	
	1	SW	SW3	M92006 - COALWAY ROAD MEDICAL PRACTICE	ex PMS																	
	1	SW	SW1	M92010 - LOWER GREEN HC- TETTENHALL	GMS																	
	3	SW	SW1	M92008 - CASTLECROFT MEDICAL PRACTICE	ex PMS																	
						31177	**32049**		**14**	**13.09**	**8**	**7.53**	**7.00**	**5.68**	**2**	**1.16**	**9**	**6.85**	**1**	**1**	**35**	**21.75**
	Vertical Integration RWT																					
40	3	SW	SW3/VI	M92007 - LEA ROAD MEDICAL PRACTICE	GMS	6467	6624		8	5.25	4	2.93	2.00	2.03	1	0.99	3	2.05	3	2.29	11	8.05
41	4	NE	NE1/VI	M92002 - THE GROUP PRACTICE ALFRED SQUIRE	GMS	8415	9641		5	5.00	5	5	1.00	1.00	0	0	4	3.01	2	2	18	13.09
43	13	SE	SE/ V1	M92654 - BRADLEY CLINIC PRACTICE	ex PMS	7494	4840		3	2.53	2	2	NR		1	0.91	1	0.91	NR	NR	NR	
44		NE	NE1	M92013 - WODEN ROAD SURGERY	GMS	6852	7474		11	9.07	6	4.53	1.00	0.80	0	0	2	1.28	1	0.8	11	6.31
45	1	SW	SW2	M92640 - TETTENHALL ROAD MEDICAL PRACTICE	GMS	2242	2110		1	1.20	1	1.2	1.00	0.72	0	0	1	0.43	0	0	5	2.52
						31470	**30689**		**28**	**23.05**	**18**	**15.66**	**5.00**	**4.55**	**2**	**1.9**	**11**	**7.68**	**6**	**5.09**	**45**	**29.97**

WF numbers by discipline per otetnial PC model																		
	PCH1	49055	51164	**29**	**25.93**	**18**	**17.88**	**13**	**10.21**	**1**	**1.01**	**12**	**7.26**	**3**	**1.69**	**65**	**39.43**
	PCH2	42018	37532	**29**	**23.33**	**23**	**17.96**	**6**	**4.92**	**4**	**1.94**	**15**	**7.71**	**9**	**4.71**	**60**	**40.03**
	PCH3	73617	109340	**85**	**71.28**	**46**	**34.96**	**15**	**12.54**	**13**	**7.58**	**33**	**20.11**	**13**	**8.35**	**113**	**80.7**
	PCH4	31177	32049	**14**	**13.09**	**8**	**7.53**	**7**	**5.68**	**2**	**1.16**	**9**	**6.85**	**1**	**1**	**35**	**21.75**
	VI	31470	30689	**28**	**23.05**	**18**	**15.66**	**5**	**4.55**	**2**	**1.9**	**11**	**7.68**	**6**	**5.09**	**45**	**29.97**
	Total	227337	260774	**185**	**156.68**	**113**	**93.99**	**46**	**37.9**	**22**	**13.59**	**80**	**49.61**	**32**	**20.84**	**318**	**211.88**

- Source of data – HSCIC September publication of GP data returns for WCCG
- NB: this data had not been validated by HSCIC hence some anomalies
- There were several practices that had not done full returns

* Those practices that had nil returns - GP numbers have been used from CCG data sources

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Implementation Plan for PC WF task and Finish group

Ref	Milestone Action	Owner	Week Start Date	Duration of Milestone	Milestone Action Completed - YES NO Future Not Required
					07 March 2016
					14 March 2016
					21 March 2016
					28 March 2016
					04 April 2016
					11 April 2016
					18 April 2016
					25 April 2016
					02 May 2016
					09 May 2016
					16 May 2016
					23 May 2016
					30 May 2016
					06 June 2016
					13 June 2016
					20 June 2016
					27 June 2016
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1. Workforce Scoping and Planning					
	General practice workforce scoping • Workforce data validation • Key issues for practices higlighted • Opportunities for development				yes
	Analysis and report on findings of workforce mapping exercise				YES
	Report to Task and Finish Group				YES
	Report to Primary Care Programme Board				YES
	Review WF returns to HSCIC – completion of returns	LC			Future
	Status report of WF numbers for CCG at with HSCIC returns	LC			Future
	WF HSCIC Reports to WF T & F group	LC			Future
	Maintain links with HEWM re - new policy changes for PC workforce - national funding for primary care workforce investments	LC			Future
2. Pilot mapping Skills for new PC Service Provision model					
	Identifya locality	BW			
	Map PH data – GP data – WF numbers	BW			
	Workshops with identified teams	BW			
	Secure resources and tools for scoping skills and workload	BW			
	Scope skills for disease areas / teams	BW			
	Monthly progress reports to group	BW			
3. Pilot new roles/New Ways of working					
	Identify locality / vanguard site/practice	RK			
	Identify new role to be adopted and resouces neededeg Care Navigator, Clinical Pharmacist, Mental Health Workker Nursing Assocate	RK			
	Scope new skills needed	RK			
	Identify learning methodologies for new role	RK			
	Monthly progress reports to group	RK			
4. Developing a leadership culture within primary care					
	Scope leadership skills withi GP teams **(Helen Ryan)**	LC			
	Identify leadership courses and resouces to support them	LC			
	Increase uptake of leadership courses/programmes by teams	LC			
	Identify evidence to be collected for evaluation	LC			
	Monthly progress reports to group	LC			
5. Wolverhampton a place to work					
	Development of a promotional campaign in partnership with partners (Acute LA private sector)	LC			
	Ensure recruitment and retention strategy/policies in place in practices	TBC			
	Work with HEWM re recriutment and retention of GP trainees **(Dr Agarwal)**	LC			
	Work with partners for opportunties for cross organisational careers eg Primary/Acute	LC			
	Monthly reports to group	LC			
6. Career development for clinical and non clinical staff					
	Support implementation of career pathways in general practice and new models of care for:	LC			
	Apprenticeships **(Helen Ryan)**	LC			
	Assistant/ associate roles	LC			
	Advanced clinical practice (Masters)	LC			
	Non academic development opportunities **(Helen Ryan)**	LC			
	Working across organisational boundaries **(RWHT)**	LC			
7. Improving and improving standards of practice					
	Professional accreditation /validation - for all clinicians	LC			
	Standardise practice – for non clinical workforce **(Helen Ryan**)	LC			
8. Increase training capacity in primary care					
	Work with Wton Uni and Walsall CEPN to increase clinical placements in primary care and ensure payment structures are in place	LC			
	Ensure clinical placement models in primary care are sustainable	LC			
	Work with HEWM and Deanery to ensure GP trainees allocations are spread across all areas with WCCG footprint	LC			
	Explore incentives for GP trainee recruitment in Wolverhampton	LC			
9. Recruitment and Retention					
	Ensure retetion strategies are in place that support innovative ways of retaining the workforce				
	Work with neighbouring employers to standardise employment practice and opportunities				
10. Budget					
	HEWM- CPENS	LC			
	HEWM	SS/LC			
	NHS E	SS/LC			
KEY					
	LC - Liz Corrigan **BW - Barry White** **RK - Ranjit Kular** **SS - Sarah Southall**				

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