NHS
Wolverhampton
Clinical Commissioning Group

Meeting of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 2nd October 2018 at 2.00pm
PC108, Creative Industries Building, Wolverhampton Science Park

A G E N D A

1	Welcome and Introductions	All	Verbal
2	Apologies	Chair	Verbal
3	Declarations of Interest	All	Verbal
4	Minutes of the meeting held on 4th September 2018	Chair	1 - 6
5	Matters Arising from the Minutes	Chair	Verbal
6	Committee Action Points	Chair	7 - 8
7	Primary Care Quality Report	Liz Corrigan	9 - 28
8	Primary Care Operational Management Group Update	Mike Hastings	To follow
9	Home Visiting Service	Sarah Southall	29 - 48
10	Primary Care Workforce - New Roles & GP Retention	Sarah Southall	49 - 80
11	Any Other Business	All	Verbal
12	Date of Next Meeting		

Tuesday 6th November 2018, at 2.00pm in the Stephenson Room, Technology Centre, Wolverhampton Science Park

NHS
Wolverhampton
Clinical Commissioning Group

For further information on this agenda or about the meeting generally, or to submit apologies for absence, please contact Laura Russell on 01902 444613 or email laura.russell4@nhs.net

MEMBERSHIP	
Wolverhampton CCG	Ms S McKie (Chair) Dr D Bush Gaytten Dr H Hibbs Dr Mr S Marshall Reehana Roberts Les Trigg
NHS England	Mr B Dhami
Patient Representatives	Ms S Gaytten
Invitees (Non-Voting)	Ms T Cresswell (Healthwatch) Mr J Denley (Health and Wellbeing Board)

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 4th September 2018 at 2.00pm
Stephenson Room, Technology Centre, Wolverhampton Science Park

MEMBERS ~
Wolverhampton CCG ~

		Present
Sue McKie	Chair	Yes
Dr David Bush	Locality Chair / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	Yes
Dr Salma Reehana	Clinical Chair of the Governing Body	Yes
Steven Marshall	Director of Strategy & Transformation	Yes
Sally Roberts	Chief Nurse	No
Les Trigg	Lay Member (Vice Chair)	Yes

NHS England ~

Bal Dhami	Contract Manager	No

Independent Patient Representatives ~

Sarah Gaytten	Independent Patient Representative	No

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	No
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	No

In attendance ~

Mike Hastings	Director of Operations (WCCG)	Yes
Dr Helen Hibbs	Chief Officer (WCCG)	Yes
Tony Gallagher	Chief Finance Officer	No
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	No
John Denley	Director of Public Health (WCCG)	Yes
Liz Corrigan	Primary Care Quality Assurance Coordinator (WCCG)	Yes
Hemant Patel	Head of Medicines Optimisation (WCCG)	Yes
Laura Russell	Primary Care PMO Administrator (WCCG – minutes)	Yes

Welcome and Introductions

WPCC336 Ms McKie welcomed attendees to the meeting and Introductions took place.

Apologies

WPCC337 Apologies were submitted on behalf of Sarah Gaytten, Jeff Blankley, Tracy Cresswell, Sally Roberts, Sarah Southall and Peter McKenzie.

Declarations of Interest

WPCC338 Dr Bush, Dr Kainth and Dr Reehana declared that, as GPs they have a standing interest in all items relating to Primary Care.

Ms McKie declared that in her role for Walsall and Wolverhampton on the Child Death Overview Panel, she has a standing interest in all items related to Primary Care

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

Minutes of the Meeting held on the 7th August 2018

WPCC339 The minutes from the meeting held on the 7th August were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from the Minutes

WPCC340 There were no matters arising from the minutes.

RESOLVED: That the above was noted.

Committee Action Points

WPCC341 **Minute Number WPCC117 - Provision of Services post Dr Mudigonda retirement from a partnership to a single hander**
The update is on the agenda, agreed to close the action.

Minute Number WPCC186 - Pharmacy First Scheme for all patients
The report is included on the agenda, agreed to close the action.

Minute Number WPCC215 - QOF+ Scheme 2018/19
The signed DPIA for QOF+ is covered on the agenda, agreed to close the action.

Minute Number WPCC318 – Primary Care Quality Report
Ms Corrigan noted the influenza vaccination programme data had been amended. Agreed to close the action.

Minute Number WPCC319 – Domestic Violence Coding Update

A meeting will be taking place to discuss the coding, agreed to close the action.

Minute Number WPCC320 – Primary Care Assurance Report
It was noted the next Primary Care Assurance Report is not due until November and the amendments will be made to the report.

Minute Number WPCC321 –Primary Care Counselling Service
The signed EIA is covered on the agenda, agreed to close the action.

Pharmacy First Scheme or all Patients progress Report

WPCC342 Mr Patel provided the Committee with a six monthly update on the progress made to date against the Minor Ailment Scheme.

Mr Patel noted that the Primary Care Trust transferred funds for the minor ailment service to NHS England in 2013. In 2017 the over 16s service was decommissioned by NHS England and taken over by the CCG. In May 2018 NHS England de-commissioned the under 16's service. In response the CCG decided that a service covering all ages should be continued and commissioned locally as agreed by the Committee on the 6th February 2018.

The CCG commissioned Pharmacy First Scheme went live on 1st June 2018 and to date 47 of the 66 pharmacies have expressed an interest in providing this service across Wolverhampton. Latest data suggest only 29 pharmacies have provided this service/sent claims to date. Mr Patel noted the usage is lower than previous years and could be due the new contract sign up process or misinformation regarding commissioning.

The CCG intent to launch a communication campaign to raise awareness of the scheme via a newsletter and campaign posters and leaflets will be sent to practices to raise awareness with patients.

The Committee noted the reports assurance of the Pharmacy First Scheme for all patients.

RESOLVED: That the above was noted.

Mr Patel left the meeting

Primary Care Quality Report

WPCC343 Ms Corrigan presented to the Committee the monthly Primary Care Quality Report which provides an overview of activity in primary care. The following key points were raised:

- No new infection prevention audits have taken place during the month of August, an update on current actions plans have been requested.
- The flu vaccine ordering uptake continues to be monitored and the primary care flu vaccine task group continues to explore ways to engage with traditionally hard to reach groups.
- There are 7 quality matters open and overdue incidents are currently being chased. The highest category of reporting was to do with information governance breaches, this is being addressed with the

practices.

- There have been slight improvements in none submissions again with the overall repose rate being 1.7%, which is still significantly better than both the regional and national averages.
- In relation to workforce, the Practice Nurse Strategy is currently being worked upon in correlation with the training hub and will be shared with the Committee once finalised.

Dr Hibbs asked in response to the highest number of complaints relating to staff attitude, which was highlighted under section 3.1, is there any opportunity to arrange conflict and resolution training for admin/reception staff. It was agreed that Ms Corrigan would discuss and explore with Ms Reynolds and the training hub.

RESOLUTION: Ms Corrigan to explore opportunities of conflict resolution training with the training hub and Ms Reynolds for reception/admin staff.

Update Report following the retirement of Dr Mudigonda

WPCC344 Ms Shelley informed the Committee since the retirement of Dr N Mudigonda last year, Dr V Mudigonda still remains as single hander with 3,700 patients. The practice employs a salaried GP for two days a week and also has a clinical pharmacist. The practice does take on GP registrars, one has commenced in August 2018 for 18 months and another has just been confirmed to start on an 18 month contract. Ms Shelley noted that the practice is performing well and there is no comprise to the quality of services.

Dr Reehana asked if the existing Dr Mudigonda worked full time. It was noted that Dr Mudigonda works full time and they a have a salaried GP for two days a week. The practice also takes on locum cover as and when necessary, it was confirmed that the practice are also part of Primary Care Home 1, which mitigates the isolation of being a single hander.

The Committee asked if Ms Shelley could confirm the process on the training supervision of the GP registrars, as the committee were concerned if there is only one full time GP and the salaried GP only works 2 days a week, what provision was in place, as they cannot be left unsupervised.

RESOLUTION: Ms Shelley to confirm the supervision process of the GP registrars.

Primary Care Operational Management Group

WPCC345 Mr Hastings advised the Committee of the discussions that have taken place at the Primary Care Operational Management Group, which took place on the 1st August 2018. Mr Hastings highlighted the following points:

- The MGS Medical Practice transition meetings continue to take place on a fortnightly basis with the contract holders.
- Everything is on track as work continues on the APMS re-procurement.
- There is now a dedicated team for estates across the Black Country.

Primary Care Counselling Service (EIA) For Information

WPCC346 The Equality Impact Assessment for the Primary Care Counselling service was shared with the Committee for their information and approval. The report, Quality Impact Assessment and Data Impact Assessment had been agreed at the August 2018 Committee Meeting.

The Committee reviewed and approved the Equality Impact Assessment.

RESOLVED: That the above is noted.

QOF+ Scheme (DPIA) For Information

WPCC347 The Data Protection Assessment for the QOF+ scheme was shared with the Committee for their information and approval. The report, Business Case, Quality Impact Assessment and Equality Impact Assessment had been agreed at the May 2018 Committee Meeting.

The Committee reviewed and approved the Data Protection Assessment.

RESOLVED: That the above is noted.

Any Other Business

WPCC348 Amended Delegation Agreement

Mr Hastings presented the above report on behalf of Mr McKenzie which advises the Committee of a revised version of the Delegated Agreement between the CCG and NHS England. The revised agreement has been updated to take into account the changes of the Data Protection Legislation. NHS England have requested that the CCG return a signed copy of the agreement by the 21st September 2018.

The Committee reviewed the document and noted the changes to the Delegation Agreement.

RESOLUTION: The Amended Delegation Agreement was approved by the Committee.

Influenza Vaccination Programme

Mr Denley stated an update report on flu vaccinations should be brought the next meeting for the Committees discussion and review.

RESOLUTION: Mr Denley to provide an update report on flu vaccinations for the next Committee meeting.

Date of Next Meeting

WPCC349 Tuesday 2nd October 2018 at 2.00pm in PC108, Creative Industries Building, Wolverhampton Science Park

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Primary Care Commissioning Committee Actions Log (public) Open Items

Action No	Date of meeting	Minute Number	Item	By When	By Whom	Action Update
17	**07.08.18**	**WPCC320**	**Primary Care Assurance Report** The graphs in the report need to be amended to reflect/interpret by practice size.	November 2018	Sarah Southall	04.09.018 - Primary Care Assurance Report is not due until November and the amendments will be made to the report.
19	**04.09.18**	**WPCC343**	**Primary Care Quality Report** Ms Corrigan to explore opportunities of conflict resolution training with the training hub and Ms Reynolds for reception/admin staff.	October 2018	Liz Corrigan	
20	**04.09.18**	**WPCC344**	**Update Report following the retirement of Dr Mudigonda** Ms Shelley to confirm the supervision process of the GP registrars.	October 2018	Gill Shelley	
21	**04.09.18**	**WPCC348**	**Influenza Vaccination Programme** Mr Denley to provide an update report on flu vaccinations for the next Committee meeting.	October 2018	John Denley	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE COMMISSIONING COMMITTEE
2ND OCTOBER 2018

TITLE OF REPORT:	Primary Care Report
AUTHOR(s) OF REPORT:	Liz Corrigan
MANAGEMENT LEAD:	Yvonne Higgins
PURPOSE OF REPORT:	To provide an overview of activity in primary care, and assurances around mitigation and actions taken where issues have arisen.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain OR This report is confidential for the following reasons
KEY POINTS:	Overview of Primary Care Activity
RECOMMENDATION:	Assurance only
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Providing information around activity in primary care and highlighting actions taken around management and mitigation of risks
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	

Wolverhampton Clinical Commissioning Group

PRIMARY CARE QUALITY DASHBOARD

RAG Ratings: 1a Business as usual; 1b Monitoring; 2 Recovery Action Plan in place; 3 RAP and escalation

Data for April 2018		
Issue	**Concern**	**RAG rating**
Infection Prevention	Two new IP audits in September, both gold – update on action plans requested. All practices have now reported on aTIV flu vaccine ordering –6 practices have no aTIV stock on order an action plan has been formulated with Public Health and NHSE. aTIV flu vaccine ordering/availability issues – action plan in place verified by NHSE	2
MHRA	Since 1st April 2018 • 24 weekly field safety bulletins with all medical device information included. • 4 device alerts/recalls • 9 drug alerts/recalls	1a
Serious Incidents	None to report at present	1a
Quality Matters	Currently up to date: 7 open 3 overdue 3 closed	1b
Escalation to NHSE	On-going process	1a
Complaints	Details of 36 complaints received since 1st November 2017 28 now closed 8 still under investigation	1a
FFT	In June 2018 • 4 practice submitted no data • 1 zero submission • 2 submitted fewer than 5 responses (supressed data)	1b
NICE Assurance	NICE assurance is now linked to GP Peer Review system – last meeting on 12th September	1a
CQC	2 Practices currently have a Requires Improvement rating and are being supported with their action plan.	1b
Workforce Activity	Work around recruitment and development for all staff groups including new roles continue.	1b
Training and Development	A training business was presented to Workforce Task and Finish Group – for further discussion. Work continues on Practice Nurse Strategy and documents.	1a
Training Hub Update	TBC	1a

1. BACKGROUND AND CURRENT SITUATION

This report provides an overview of primary care activity in Wolverhampton and related narrative. This aims to provide an assurance of monitoring of key areas of activity and mitigation where risks are identified.

2. PATIENT SAFETY

2.1. Infection Prevention

Infection prevention is provided by Royal Wolverhampton Hospitals with a dedicated link nurse for primary care. Information for the most recent visits and audits are shown below.

IP Audit Ratings: Gold 97-100%; Silver 91-96%; Bronze 85-90%; No rating ≤84%

Figure 1: Infection Prevention Audits April 2018

Infection Prevention Audits 2018/19		
Rating	**Number**	**Percentage**
Gold	3	21.4%
Silver	7	50.0%
Bronze	2	14.3%
No rating	2	14.3%

Ratings overview and issues identified within primary care:	Exceptions and assurance:
• Ensure audits are being undertaken • Cleaning schedules needed • Bins need replacing • Clinical wipe holders needed • Damage to plaster and décor • Sinks need replacing • Wipeable notice boards needed • Wipeable blinds needed • Couches must be moveable • Paper roll holder position	Support will be provided for practices where appropriate via liaison with IP and CCG Operations Team. Monitoring of IP audits is undertaken by the Primary Care Quality Assurance Coordinator in conjunction with the IP team and by the Primary Care Team, a new audit cycle has now commenced.

• Ensure air vents are cleaned • Ensure soap dispensers are cleaned • Legionella risk assessment needed	

MRSA Bacteraemia:
None to report this month.

Influenza vaccination programme:

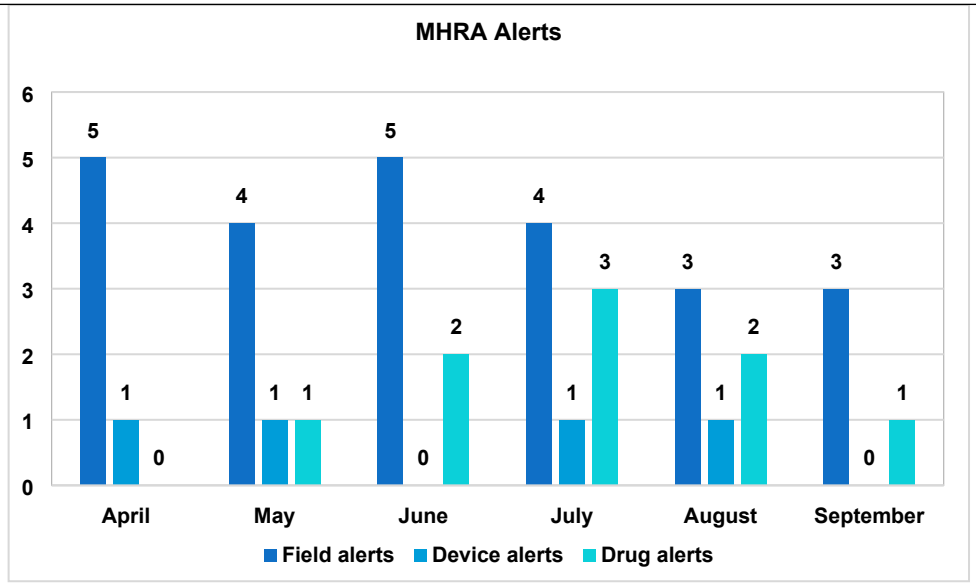
Figure 2: 2017/18 Influenza Vaccine Programme activity

Exceptions and assurances:
Continued monitoring of flu vaccine ordering and uptake is being undertaken by Public Health and NHSE. The primary care flu vaccine task group has met three times and is due to meet again on 3rd October. The group continues to explore ways to engage with traditionally hard to reach groups through working at scale.

12. MHRA Alerts

Figure 3: MHRA Alerts from April 1st 2018

Alert Type	Number	Exceptions and assurances
Field Safety Bulletin	24	There are currently no direct actions required by CCG. Healthcare professionals are informed about the alerts via a monthly newsletter (Tablet Bytes). In addition, ScriptSwitch messages and/or PMR searches are used to inform healthcare professionals where appropriate. The management of alerts is part of both the GP contract and a requirement under CQC registration. Practices are required to keep a record of alerts and actions taken for scrutiny. At present this is monitored by the CCG via collaborative contracting visits. Suspected adverse drug reactions should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) through the Yellow
Device alerts/recalls	4	
Drug alerts/recalls	9	



Card Scheme (www.mhra.gov.uk/yellowcard).

Drug, device and Field Safety Notices to date links are below – these are managed centrally by the government and forwarded directly to practices by NHS England: https://www.gov.uk/drug-device-alerts

2.3. Serious Incidents

There are currently no serious incidents being investigated in primary care. All serious incidents are reviewed by internal serious incident scrutiny group and reported to NHS England PPIGG group for logging and appropriate escalation and feedback is provided to the CCG.

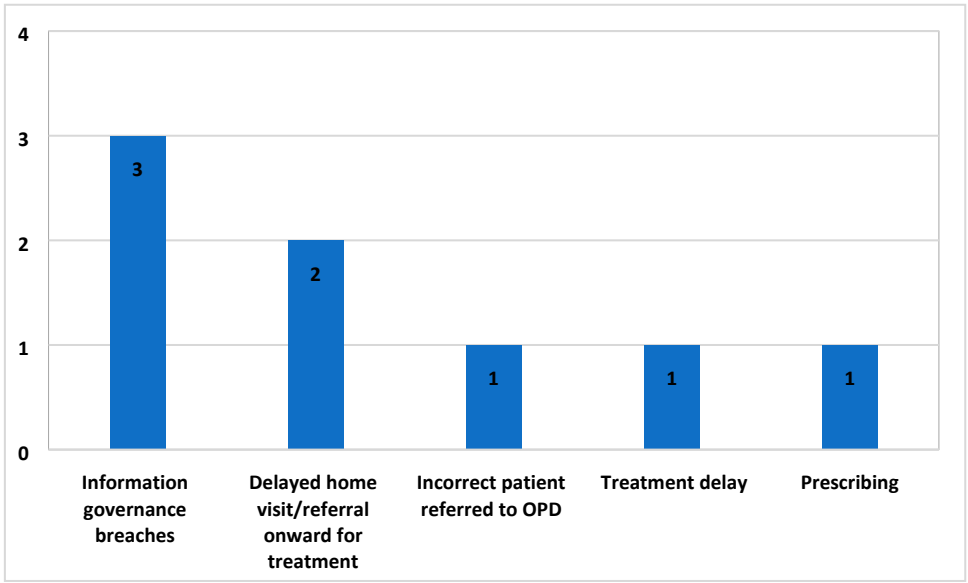
2.3. Quality Matters

Figure 4: Quality Matters Status 2018/19 and Variance

Status in September 2018	Number (running total)	Exceptions and assurances:
Open	7	Overdue QMs are currently being chased.

Overdue	3
Closed	2

Quality Matters Themes:



- Information governance breaches – incorrect blood forms given to patients
- Delayed home visit/referral onward for treatment
- Incorrect patient referred to OPD (2 patients with same name)
- Treatment delays

Closed QMs:
No QMs were closed in September.

Quality Matters continue to be monitored, and all Primary Care incidents have been forwarded to the relevant practices and to NHSE where appropriate. Practices are asked to provide evidence of investigation and learning from these incidents and this is provided to NHSE who will then escalate accordingly and feedback to the CCG or to the Serious Incident Scrutiny Group for further consideration. The Quality Team plan to share lessons learned from Quality Matters in primary care as part of an on-going programme.

2.4. Escalation to NHS England

Figure 5: Escalation to Practice and Performance Information Gathering Group (PPIGG) NHSE

Exceptions and assurances:
One issue was referred to PPIGG recently relating to a complaint . Assurances around NHSE escalation are provided by bi-weekly feedback from action logs from PPIGG meetings and quarterly reports relating to complaints raised and their outcomes. Any action from escalation is shared via PPIGG and reports, however comprehensive information is not always available. PPIGG outcomes are shared with Primary Care Contract Manager and Primary Care Liaison Manager and practice visits set up if necessary. Data is triangulated with other information i.e. Quality Matters, FFT, IP audits and complaints.

3. PATIENT EXPERIENCE

3.1. Complaints

Figure 6: Complaints Data 2018/19

	April	May	June	July	August	September	Exceptions and assurances:
Number	2	2	3	13	3	0	• Actions and lessons learned identified are: • Reflection • Sharing of pathways and treatment plans – revision of current processes • Audit • Review of records • Discussion at practice meetings • Review of telephone calls and processes The CCG does not have oversight of GP complaints dealt with within the surgery. NHSE is now sharing complaints data and this can be triangulated with other data e.g. SIs and Quality Matters. All complaints reported to NHSE are logged via PPIGG for appropriate escalation; this includes local actions e.g. additional training or serious incident reporting. Practices must provide evidence of their complaints

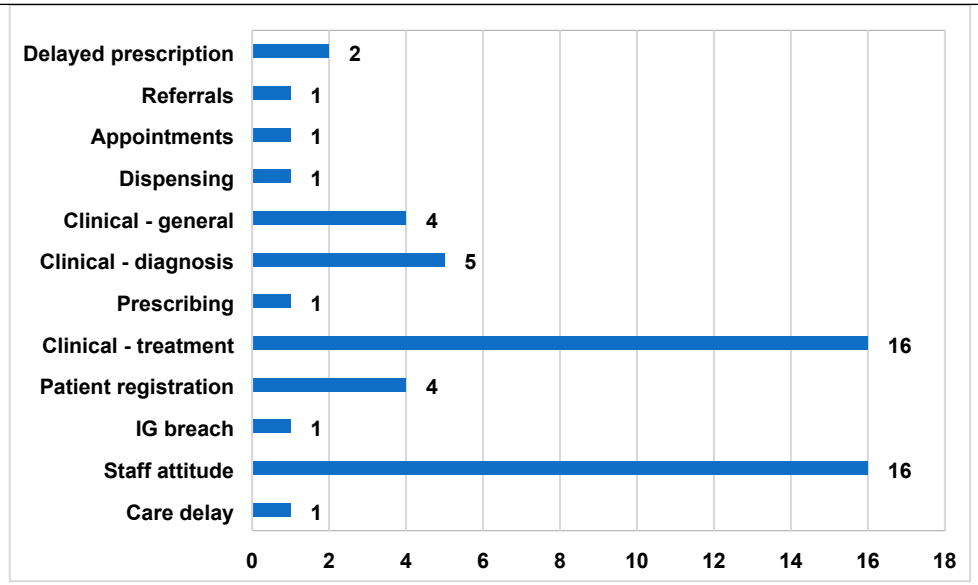
Complaints Numbers and Themes:

Quarterly figures for complaints show that 21 complaints were received between 1st April and 30th June 2018.

- 7 complaints were fully upheld (33.3%)
- 7 complaints were not upheld (33.3%)
- 3 complaints were partially upheld (14.3%)
- 4 were still pending response (19.0%)

Where complaints have been upheld these have predominantly involved clinical issues such as treatment, delayed diagnosis or refusal to refer. There have also been issues around confidentiality breaches and staff attitude.

36 complaints have been received from NHSE since the new process began on 1st November 2017. Themes for complaints are all shown below, please note that each complaint may have more than one theme.



procedure and handling, including action plans and lessons learned for CQC and for the CCG Collaborative Contracting team.

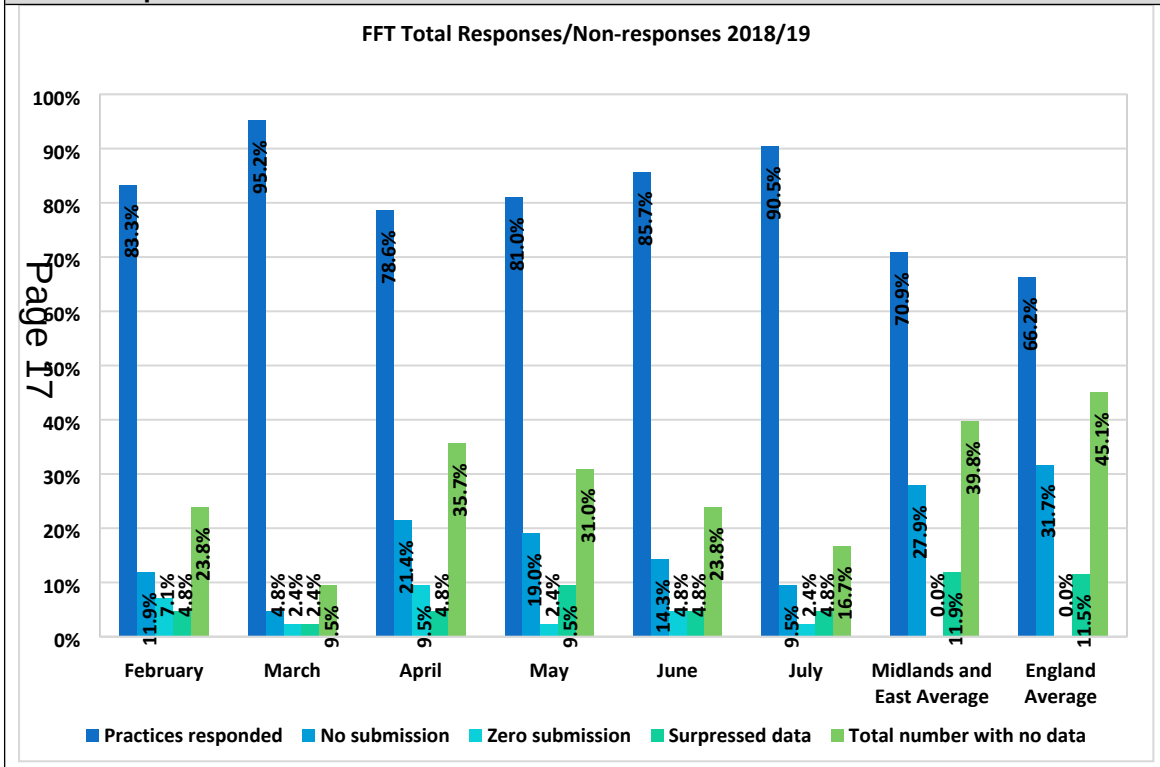
3.2. Friends and Family Test

Figure 7: Friends and Family Test Data Overview 2018/19

Percentage	March	April	May	June	July	West Midlands	England
Total number of practices	42	42	42	42	42	2154	7222
Practices responded	95.2%⇧	78.6%⇩	81% ⇧	86%⇧	90.5% ⇧		
	40/42	33/42	34/42	36/42	38/42	70.9%	66.2%
No submission	4.8% ⇩	21.4%⇧	19% ⇩	14.3%⇩	9.4% ⇩		
	2/42	9/42	8/42	6/42	4/42	27.9%	31.7%
Zero submission (zero value submitted)	2.4% ⇩	9.5%⇧	2.4%⇩	4.8%⇧	2.4% ⇩	N/A	N/A
	1/42	4/42	1/42	2/42	1/42		

Suppressed data (1-4 responses submitted)	2.4% ⇩	4.8% ⇧	9.5% ⇧	4.8%⇩	4.8% ⇔		
	4/42	*15/42*	4/42	2/42	2/42	11.9%	11.5%
Total number with no data	9.5% ⇩	33.3%⇧	31% ⇩	23.8%⇩	16.7% ⇩		
	4/42	15/42	13/42	10/42	7/42	39.8%	45.1%
Response rate	1.8% ⇧	1.4%⇩	1.7% ⇧	1.7%⇔	1.8% ⇧	0.6%	0.5%

Data Comparison



Exceptions and assurances:

There were improvements in all areas of submission again this month, overall response rate increased slightly at 1.8%, still significantly better than both the regional and national averages.

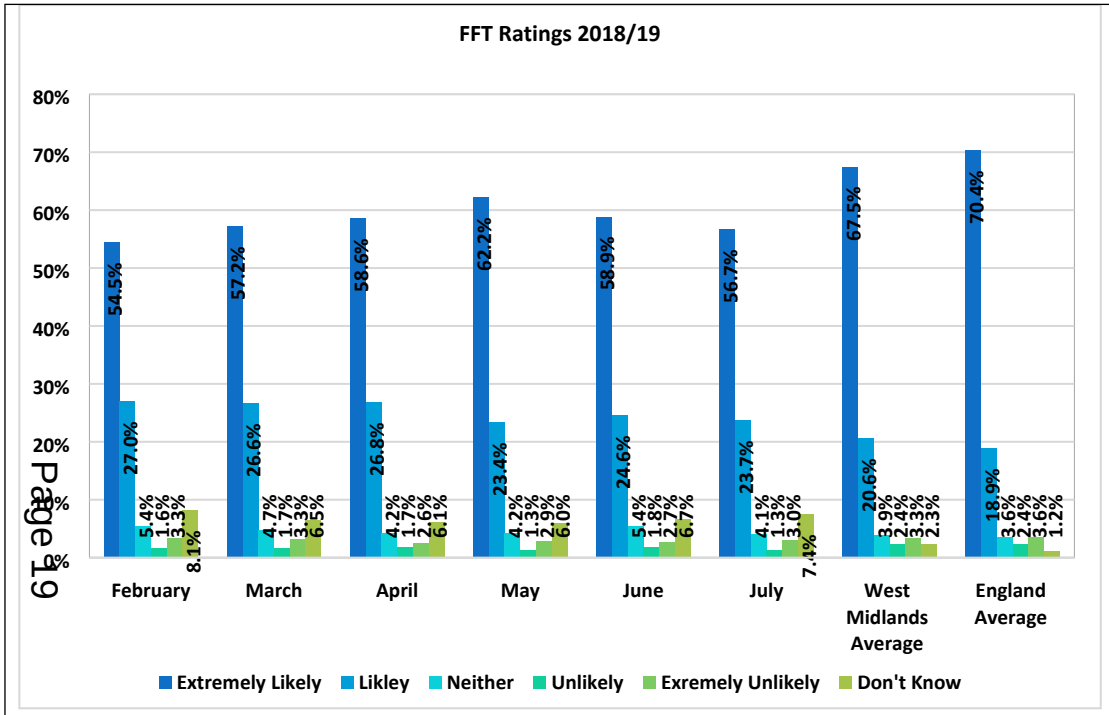
Submissions are now being monitored as per FFT Policy and practices have been contacted.

Figure 8: FFT Highest Uptake July 2018

Identifier	Practice	Uptake	Exceptions and assurance:
M92002	The Group Practice Alfred Squire Road	3.0%	Eleven practices had above average uptake. All practices have been contacted by Locality Managers to share their data.
M92004	Primrose Lane Practice	1.9%	
M92009	Prestbury Medical Practice	2.6%	
M92010	Tettenhall Medical Practice	4.0%	
M92011	Penn Manor Medical Practice	2.8%	
M92012	Duncan Street Primary Care Partnership	9.1%	
M92040	Mayfield Medical Centre	2.2%	
M92041	Probert Road Surgery	7.6%	
M92609	Ashfield Road Surgery	9.8%	
M92612	Health And Beyond	3.4%	
Y02736	Showell Park Health & Walk In Centre	2.8%	

Figure 9: FFT Ratings and Method of Response 2018/19

Ratings Data Comparison	Exceptions and assurance:

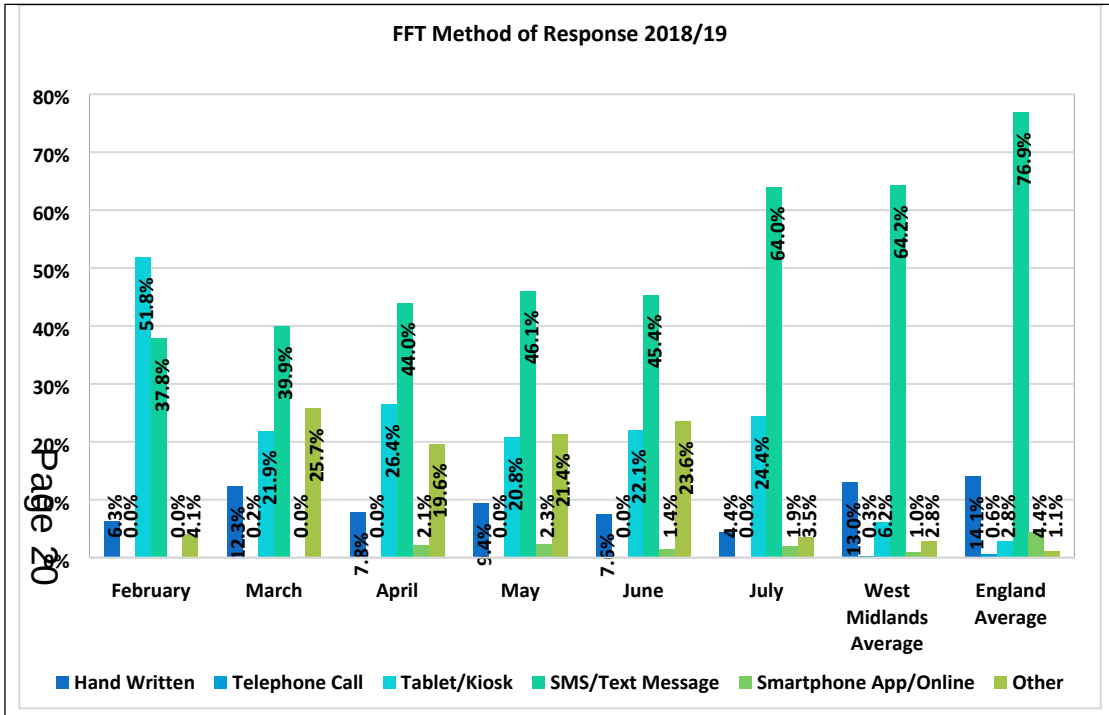


Overall 84% would recommend their practice, 4% would not with ratings similar to last month, and lower than regional and national (88%/90% would recommend and 5%/6% would not) averages. This month 11.5% gave either a "don't know" or "neither" answer compared to 6.2% regionally and 4.8% nationally and this has reduced slightly. There is still a strong correlation between these responses and submission via practice check in screens and SMS text as previously discussed.

11 practices had higher than average not recommended ratings, and 9 practices lower than average would recommend ratings (with some correlation between the two) – these have been discussed with Locality Managers in relation to the recently released patient survey data. Figures may be skewed as response numbers were low in some of these practices.

FFT activity continues to be monitored on a monthly basis by the Operational Management Group, and via the NHSE Primary Care Dashboard. Non responders, suppressed and zero data is monitored monthly, practices that do not submit are contacted by the Primary Care Contract Manager or locality managers and appropriate advice and support offered to facilitate compliance. Those that fail to submit on a regular basis may receive a contract breach notice, and a number of sites are being monitored closely. Wolverhampton LMC have offered to support the process to avoid the need for breach notices to be applied. Information from FFT is also triangulated with NHSE Dashboard and GP Patient Survey data when available and with Quality Matters, SIs and complaints.

Method of response	
Methods Data Comparison	**Exceptions and assurance**



This month the majority of responses have again come via electronic media, SMS text 9on a par with national and regional averages) and Tablet/Kiosk, with an increase in use of website/app and a decrease in written responses. Please note that some practices do not record the method of collection.

4. CLINICAL EFFECTIVENESS

4.1. NICE Assurance

Guideline	Ref	Linked to Peer Review
Neuropad for detecting preclinical diabetic peripheral neuropathy	MTG38	Yes
Pancreatitis	NG104	Yes
Preventing suicide in community and custodial settings	NG105	

Chronic heart failure in adults: diagnosis and management	NG106	Yes
Emergency and acute medical care in over 16s	QS174	
Community pharmacies: promoting health and wellbeing	NG102	
Flu vaccination: increasing uptake	NG103	
Endometriosis	QS172	Yes
Intermediate care including reablement	QS173	
Rheumatoid arthritis in adults: management	NG100	Yes
Early and locally advanced breast cancer: diagnosis and management	NG101	
Brain tumours (primary) and brain metastases in adults	NG99	
Medicines management for people receiving social care in the community	QS171	
Dementia: assessment, management and support for people living with dementia and their carers	NG97	
Hearing loss in adults: assessment and management	NG98	Yes
Spondyloarthritis	QS170	Yes
Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over	NG36	Yes
Rheumatoid arthritis in over 16s	QS33	Yes
Chronic heart failure in adults	QS9	Yes
Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease	TA217	

Exceptions and assurances:

The NICE meeting was held on 12th September 2018. The assurance framework around NICE guidance is applied in line with the peer review system for GPs, the following clinical areas are part of the peer review process and relevant guidance will be discussed in line with these areas:

- Urology
- Trauma & Orthopaedics
- ENT
- Opthalmology
- Pain Management
- Gastroenterology
- Haematology
- Cardiology

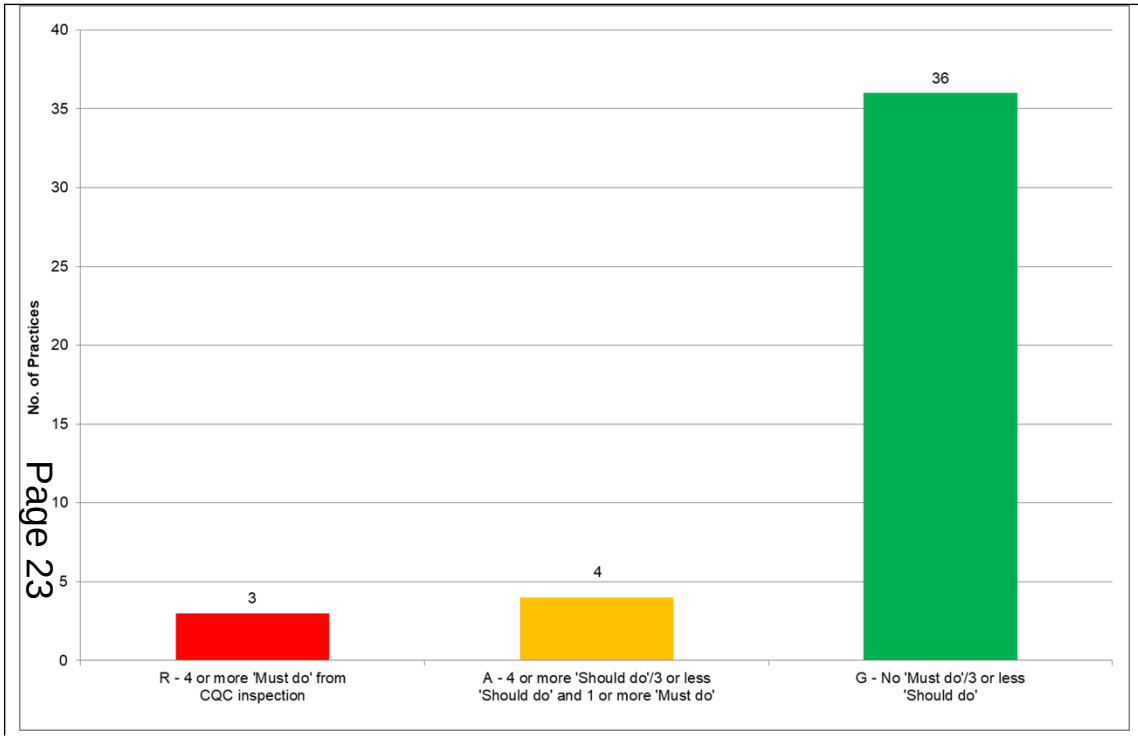
- Dermatology
- Rheumatology
- Gynaecology

5. REGULATORY ACTIVITY

5.1. CQC Inspections and Ratings

Figure 10: CQC Inspections and Ratings to date 2018/19

CQC Ratings by Domain	Overall	Safe	Effective	Caring	Responsive	Well-led	Families, children and young people	Older people	People experiencing poor mental health (including people with dementia)	People whose circumstances may make them vulnerable	People with long term conditions	Working age people (including those recently retired and students)
Outstanding	0	0	0	0	0	0	0	0	0	0	0	0
Good	33	31	34	35	35	33	33	33	33	35	35	35
Requires Improvement	3	5	2	1	1	2	3	3	3	3	3	3
Inadequate	0	0	0	0	0	1	0	0	0	0	0	0
RAG Ratings – actions from CQC inspections:							**Exceptions and assurances**					



There are currently two practices with a Requires Improvement rating (the third practice is now under different registration and has not yet been inspected, the practice manager is due to be interviewed by CQC on 25/9/18) and are being monitored by the Primary Care and contracting team with input from the Quality Team, face to face support has been offered to both practice teams.

Collaborative contracting visits are carried out where appropriate and CQC actions plans reviewed.

Themes for improvement identified within the CQC reports are as follows: • Ensuring safe recruitment of locums. • Ensure complaints are investigated fully in a timely manner. • Providing assurances around responses to safety alerts. • Ensuring systems for good governance. • Ensuring appropriate responses to best practice guidance. • Engaging in service improvement audit. • Improvement around communication with staff within the practice around performance. • Ensuring equipment is safely managed. • Performing health and safety audits and ensuring they are updated. • Providing evidence of sepsis management as per NICE guidance. • Improve the number of carers registered.	

Figure 11: Collaborative Contracting Visit Schedule 2018/19

Identifier	Practice	Date of visit	Action plan status
Y02736	Showell Park Health Centre	30/4/2018	Signed off
M92042	West Park Surgery	30/5/2018	Signed off
M92004	Primrose Lane Health Centre	2/7/2018	Outstanding
M92015	IH Medical Bilston	28/8/2018	Outstanding
M92044	Warstones Health Centre	26/9/2018	
M92001	Poplars Medical Practice	16/10/2018	
Collaborative contracting visit activity		**Exceptions and assurances**	
21/42 50% practices have been visited in total (an average of one per month) since the programme started in October 2016. Themes from visits identified are: • Policies needing updating or amending e.g. version control, update date or author • Missing policies. • Mandatory training gaps – particularly safeguarding training.		Members of the contracting, Primary Care and Quality Teams and Public Health attend the visits. An action plan is formulated where necessary which needs to be addressed and returned to the Primary Care Liaison Manager within a month. Support is offered where necessary to address actions.	

6. WORKFORCE DEVELOPMENT

6.1. Workforce Activity

	Activity		Exceptions and assurance
Recruitment and retention	A GP retention scheme has been agreed across the Black Country with a co-design event planned at Bescot Stadium on 25th September 2018, this will look at ways to maintain GPs in post but increase options to work across primary and secondary care or take up leadership roles. A Physicians Associate internship programme is due to commence with 3 practices expressing an interest. There is a HEE incentive of £5000 per PA to participate in this with the CCG matching the funding if the practice offers the PA a substantive post. Work continues to promote the Nursing Associate apprenticeship programme with plans to target HCAs as well as practice managers for expressions of interest. There are plans to develop and promote a "job of the month" feature that will include the personal, practice, patient and financial benefits of a range of roles e.g.: • Nursing Associate • Physicians Associate • ANP • Clinical Pharmacist		No exceptions noted.
Workforce Numbers	**Group**	**WTE**	Figures taken from NHS Digital data – some practices have not agreed to share their information and there may be higher numbers of staff than shown here. Locality Managers are encouraging practices to tick the data sharing agreement to allow CCG to view data.
	Nurses (all levels)	58.5	
	Health Care Assistants	22.3	
	Junior doctors (inc registrars)	25.1	
	Locum GPs	2.1	
	Salaried GPs	35.5	
	GP partners	73.4	
	Administration/Receptionists	244.3	

	Practice Managers	42.2	
	Apprentices	8.7	
GPN 10 Point Action Plan	Action 1: To continue work with university and Training Hub around mentorship. Action 2: Continue to promote RCN, NHSE and QNI leadership programmes, this is also being further developed by NHSE as part of the national 10 Point Action Plan programme. Action 3: To continue promoting mentorship training until new NMC standards are fully implemented working with Training Hub. Action 4: To develop induction and preceptorship programme in conjunction with Black Country GPN strategy and Training Hub workplan. Action 5: Continue to promote RtP in line with Training Hub and through HCA links, scoping those with lapsed registration – Wolverhampton University will be providing this as a rolling programme. Action 6: to work with local school and Training Hub to develop Work Experience pilot. Action 7: Ensure oversight of those that have applied for sponsored programmes particularly where backfill is provided. Action 8: Training Hub to explore why nurses are not accessing ACP programmes as numbers have dropped. Action 9: To assist with development of HCA training programme funded by LWAB. Action 10: To develop a local GPN programme in line with STP GP programme. To await further information from NHSE and link to NHSE resilience programme.		Monthly returns are provided to NHSE on behalf of the Black Country, collated by Wolverhampton CCG. The steering group meets on a monthly basis and includes members from all 4 CCGs and the Black Country Training Hub. Liz Corrigan took part in a regional 10 Point Action Plan led by NHSE/HEE on 20th September which discussed the actions as left in more detail,

6.2. Training and Development

	Activity	Exceptions and assurance
Nurse Training	• Business case covering a range of training options discussed at Workforce Task and Finish Group – for further discussion due to delay in spirometry specification for Black Country. • Bid/EOI submitted to take part in Digital Nurse Champion's pilot. • Wolverhampton CCG to meet with NHSE regarding Clinical Supervision Digital Tool pilot.	Business case to be reviewed by T&F group and forwarded to relevant boards/committees for consideration.

	• Practice Makes Perfect continues on a monthly basis with CCG staff due to meet with sponsors to arrange the 2019 programme. • Additional training sessions are being provided by the Black Country Training Hub.	
Non-clinical staff	Training continues in the following areas: • Care navigation • Dementia friends The practice manager support offer is under development, looking at peer support. PMs have developed a skills mix matrix and identified where they have skills they can support with. A TNA has been undertaken with gaps in training identified. PMs have undergone coaching and mentoring training with more planned. Training on bid and business case writing has been identified as a need. NHSE will fund one place per PM on the diploma programme (Wolverhampton has also funded places)	No exceptions.

8. Training Hub update

		Exceptions and assurance
Black Country Training Hub	Update to follow	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
PRIMARY CARE COMMISSIONING COMMITTEE
OCTOBER 2018

TITLE OF REPORT:	Home Visiting Service- update
AUTHOR(s) OF REPORT:	Ranjit Khular, Primary Care Transformation Manager
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To request additional funding for the appointment of a Healthcare Assistant to support the GP Home Visiting service project.
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• A business case for a GP Home Visiting service project was approved by the Primary Care Commissioning Committee in February 2018. Following the appointment of practitioners this service is currently in mobilisation and is due to commence in December 2018. • Following discussion with the practices and the provider (RWT) the business case has been updated to request funding for a Healthcare Assistant to undertake some of the routine activity as set out in the service model.
RECOMMENDATION:	• For the Primary Care Commissioning Committee to approve funding for the Healthcare Assistant for the six month period of the pilot project at an additional cost of £13,094.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	[Outline how the report is relevant to the Strategic Aims and objectives in the Board Assurance Framework – See Notes for Further information]
1. Reducing Health Inequalities in Wolverhampton	<u>Improve and develop primary care in Wolverhampton</u> – Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this <u>Deliver new models of care that support care closer to home and improve management of Long Term Conditions</u> Supporting the development of Multi-Speciality Community Provider and Primary and Acute Care Systems to deliver more integrated services in Primary Care and Community settings

1. BACKGROUND AND CURRENT SITUATION

1.1. A business case for a six month project to deliver a Home Visiting service for a group of Wolverhampton practices was approved by the Primary Care Commissioning Committee in February 2018. This business case proposed the appointment of 2 x wte Advanced Nurse Practitioners at Band 8a to deliver the service.

1.2. The project is currently in mobilisation following the appointment of practitioners to the roles, and is due to commence on 1 December 2018 for a six month period. Project mobilisation meetings with the provider (RWT) and the practices involved have started to take place.

2. NEXT HEADING

2.1 As part of the mobilisation meetings it was recommended that the service is supported by a 1.wte Healthcare Assistant at Band 3 to undertake some of the routine clinical procedures, and to this end the business case has been updated to include the cost of a Healthcare Assistant at a total cost of £13,094 for the duration of the pilot scheme.

3. CLINICAL VIEW

3.1. The recommendation to appoint a Healthcare Assistant was endorsed by the GPs who will be involved in the pilot scheme.

4. PATIENT AND PUBLIC VIEW

4.1. N/A

5. KEY RISKS AND MITIGATIONS

5.1. Key risks relating to the scheme are highlighted within section 7 of the business case.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. These are highlighted in section 10 of the business case.

Quality and Safety Implications

6.2. Please refer to the completed QIA.

Equality Implications

6.3. Please refer to the completed EIA.

Legal and Policy Implications

6.4. N/A

Other Implications

6.5. N/A

Name	**Ranjit Khular**
Job Title	**Primary Care Transformation Manager**
Date:	**28/09/18**

ATTACHED:

(Attached items:) GP Home Visiting service Business Case version 0.4

RELEVANT BACKGROUND PAPERS

(Including national/CCG policies and frameworks)

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	**Date**
Clinical View		
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
Other Implications (Medicines management, estates, HR, IM&T etc.)		
Any relevant data requirements discussed with CSU Business Intelligence		
Signed off by Report Owner (Must be completed)	**Ranjit Khular**	**28/09/18**

BUSINESS CASE

Project:	**Home Visiting Service Pilot Project**
Release:	
Date:	28.09.18
Author:	Ranjit Khular
Owner:	Ranjit Khular
Client:	Primary Care Programme Board
Document Ref:	
Version No:	V0.4

1 Business Case History

Template Revision History

Date of this revision: 17/03/2017
Date of Next revision:

Revision date	Previous revision date	Summary of Changes	Changes marked
08/2013		Preliminary Equality Analysis added	1.1
		First issue	
12/2014		Quality Impact Analysis added	1.2
18/06/15		Document Review	1.3
02/03/16		Addition of Task and Finish Section	1.4
17/03/2017		New CCG Logo and document formatting	2.0

Task and Finish Group Views

Please include the initial comments from each of the Task and Finish group leads, on the proposed project Business Case, before submission to the Programme Board:

Area	Lead Name	Date	Comments
Clinical			
Public/ Patient			
Finance			
Quality			
Medicines Management			
Equality			
Information Governance			
Legal/ Policy (Corporate Operations Manager)			

Report Distribution

This document/report has been distributed to:

Name	Title	Date of Issue	Version

2 Table of Contents

Page

Business Case

3 Purpose

Improving access to general practice and other primary care services is a priority for reforming the NHS. The national driver of seeking accessible Primary Care services 8am to 8pm, seven days a week is one of the underlying policy drivers behind this proposed scheme.

Home visits are a significant call on GP's time, and there is a view that in many cases the patients can be seen by a health professional other than the GP.

Currently patients or patients representatives requesting a home visit are offered the following service :

- Patients request a home visit and depending on the initial triage are given an estimated time of visit. Requests for home visits depend on the immediate availability of a GP who may be otherwise engaged with surgery duties or carrying out other home visits. Therefore the timeliness of the visit is not always achieved.

- Patients are often advised by the practice if their condition deteriorates before the visit has occurred to dial 999. In addition due to the complexity of general practice, as patients are not always visited immediately, some patients panic and do ring 999.

An audit of Home Visit requests completed by practices indicated:

> Around 40% of the requests for Home Visits could be diverted to the Rapid Response Service. A number of those requests could not be completed by the Rapid Response Team due to capacity issues, however with the recent recruitment that has taken place this situation has improved.

Under this proposed initiative primary Care access will be extended by virtue of a home visiting service delivered by appropriately trained clinicians.

The service would seek to enable Practices to offer more or longer GP sessions which in effect offers an extended primary service to improve overall patient access to primary services. The additional capacity would also be used to drive new models of care.

There is real opportunity to redesign services and develop integrated working across the health and social care landscape. The time saved for GPs will ensure they are able to address local priorities such as local QOF, Complex Care management, MDT working and enhanced services, for example. A commitment to these schemes could be agreed as a requisite.

It is proposed that this service is initially introduced as a pilot scheme which would be closely monitored and evaluated.

Implementing an extension of available primary care access will give patients local access and support, reducing the need to attend other services e.g. A&E, Minor Injuries Units or GP OOH services.

It will also test the proof of concept of providing extra capacity within primary care services during core primary care hours and the impact on patients' need to seek alternative services elsewhere whilst reducing the burden of visits for practices.

There is a consensus that given societal changes, with more elderly patients living independently, the demand for home visits is likely to increase over time.

Expressions of Interest were invited from GP practices across the city, from practices aligned with all New Models of Care practice groups, to take part in a pilot Home Visiting scheme. The following practices responded to this exercise:

Practice	**Practice List Size**
Newbridge Surgery	4603
Parkfields Surgery	13952
Grove Surgery	3576
Caerleon Surgery	3182
All Saints and Rosevillas Surgery	5976
Pennfields Surgery	4513
Warstones surgery	4264

Table 1 Practices expressing an interest to take part in the pilot scheme

An audit of Home Visit requests undertaken across these practices indicated the following:

4 Reasons

The Home Visiting service is aligned with the 10 High Impact Actions to release time for care in General practice as follows:

High Impact Action

Productive work flows

Introduce new ways of working which enable staff to work smarter, not just harder. These can reduce wasted time, reduce queues, ensure more problems are dealt with first time and that uncomplicated follow-ups are less reliant on GPs consultations.

Develop the team

Consider broadening the workforce to reduce demand for GP time and connect the patient more directly with the most appropriate professional.

Increasing access to primary care which would be realised through a Home Visiting service delivered by clinicians other than GPs could achieve a variety of attractive outcomes for Wolverhampton Clinical Commissioning Group and the NHS; these are:

- Provide the right care, at the right time, in the right place
- Improve patient primary care access experience
- Support the reduction of A&E attendances as a number of patients would default to accessing Urgent care services if they are not able to secure a home visit
- Responsiveness – ability to respond to patient led demand for same day access to primary care.
- Relieve pressure on practices – help by relieving some of the workload burden on primary care with respect to same day appointment requests
- Coordination – between the external delivered home visiting service and a patients registered practice
- Improves equity of access for patients who are housebound

The service will:

- Provide a comprehensive, responsive and appropriate assessment, examination and treatment for patients requiring urgent and routine healthcare in their own home.
- Identify and communicate the agreed access points to the service with other providers.
- Ensure good communications with all practices and integrated care team in place to ensure continued care for patients.

- Formulate service protocol with practices.
- To promote education for patients around local services.
- Work to agreed clinical governance policies.
- Be required to collect and provide agreed monitoring information to Wolverhampton CCG.
- Provide management information to Commissioners regarding the demand for and usage of the service

The aims and objectives of the proposed service would be as follows:

- To deliver a Home Visiting service targeting patients living at home who ring their own registered practice requesting a home visit
- Reduce inappropriate emergency admissions through timely health care intervention
- Reduce inappropriate A&E attendances
- Improve the quality of care received by patients by practices having the ability to proactively respond when an acute medical problem occurs (during office hours)
- Improve sign posting to the appropriate clinical pathway reducing replication and waiting for patients

Each of the above will be measured through Key Performance Indicators agreed with the provider to monitor the impact and effectiveness of the service.

The pilot would recruit appropriately trained clinicians to work with a specified number of practices covering 40,000 patients with a nominated GP lead providing support to the service. In preparing this business case a number of Home Visiting service models operating in different Health economies have been explored.

A number of options are presented within this business case.

The patients registered GP will maintain clinical responsibility for the patient. Ideally staff delivering the service will be a prescriber at Advanced Nurse Practitioner (ANP) level. Non-prescribing clinicians/students could also be included to test different levels of care within a controlled pilot environment.

The patients registered practice will be responsible for triaging and identifying when a patient requires a home visit. Appropriateness will be monitored and communicated by the GP lead supporting the service. Staff delivering the service will be aligned to practice

hubs where a set number of daily appointment slots are available. Each practice will be able to book a patient in to the available slots electronically, providing:

- Patient information
- GP and contact details for support if required
- Reason for the visit

Options

There are a number of different options that can be considered on how the pilot scheme can be delivered. A number of different options have been considered.

Option 1

2 x 0.8 wte practitioners to deliver a Home Visiting Service the practices identified in Table 1.

Staff Cost:

Option 1 ANP led Home Visiting Service- 2 x AfC band 7 Advanced Nurse Practitioners working 30 hours per week costed in accordance with the CCG costing template equates to:

6 month Pilot 2 x ANPs at Band 7	**Recurrent £**	**Non Recurrent £**
Pay:	38,621	
Non Pay:		
Travel	2000	
Mobile Phone	240	1,170
Sub Total	40,861	1,170
OH 20%		8,406
Total Cost home Service		50,437

The total cost of the service would be £50,437 over a 6 month period. This equates to a running cost of £1940 per week during the duration the pilot.

Option 2 Paramedic and Pharmacist led service- 1 xAfC band 8a practitioner (Clinical Pharmacist) and 1 x AfC Band 6 practitioner (Paramedic) working 30 hours per week costed in accordance with the CCG costing template equates to:

6 month Pilot Pharmacist (Band 8a) and Paramedic (Band 6)	**Recurrent £**	**Non Recurrent £**
Pay:	40,420.22	
Non Pay:		
Travel	2000	
Mobile Phone	240	1,170
Laptops		
Sub Total	42,660	1,170
OH 20%		8,766
Total Cost home Service		52,596

The total cost of the service would be £52,596 for a 6 month period. This equates to a running cost of £2023 per week during the duration the pilot.
Whilst there are clear benefits of having a Paramedic lead service, it is noted that the recruitment of practitioners to a fixed term post, in particular during Winter pressures will prove challenging
Features of a Home Visiting Service where practitioners are employed by General Practice.
Practitioners working within this service can:

- Prescribe any medicine for any condition within their competence (including some controlled medicines) provided they have completed an Independent Prescribing qualification.
- See patients with undiagnosed, undifferentiated medical conditions and make treatment decisions, including ordering necessary investigations.
- Refer patients to secondary care, although this varies on a local basis.
- Practitioners will be working with a defined cohort of patients (registered patient list for the specific practices)
- The impact of the service will be demonstrable in terms of time released in those practices

However a number of practical issues have been raised with this option such as:

- Employment of practitioners: If this was the preferred option it would be likely that the practitioners are employed by one of the practices and then work across the practice groups. Initially they would be employed on a fixed term basis for the duration of the pilot project. However this will present some technical questions about access to other practice systems that would need to be addressed.

Option 3

To build additional capacity within the Rapid Response service (RWT) to undertake Home Visits to this cohort of patients. This would involve employing an Advanced Nurse Practitioner and a Healthcare Assistant to undertake Home Visits

Staff cost

2 x Band 8a Advanced Nurse Practitioners (ANPs) and 1 x Band 3 HCA working 37.5 hours per week.

6 month Pilot 2 x Band 8a ANPs	Recurrent £	Non Recurrent £
Pay:	57,579	
On costs	11752	
Travel	2000	
Mobile Phone	240	300
Sub Total	71,571	300
Total Cost		**71,871**

6 month Pilot 1 x Band 3 HCA

Pay:	**9,561**	
On costs	**2113**	
Travel	**1000**	
Mobile Phone	**120**	**300**
Sub Total	**12,794**	**300**
Total Cost		**13,094**

The total cost of the service would be £84,956 for a 6 month period. This equates to a running cost of £3268 per week during the duration the pilot.

Features of building additional capacity to the Rapid Response Service:

- Practitioners will be part of a larger team providing a responsive service for people with exacerbations of their conditions
- This will allow for joint working with other practitioners

- Feedback from the RIT service indicates that there are a number of requests that are currently made to the RIT service that could be facilitated through a GP Home Visit.
- The practices taking part in the pilot scheme would be responsible for taking any requests for Home Visits for their registered patients. The practices would also be responsible for undertaking a triage process to ensure that only those patients where the presenting symptoms would warrant a Home Visit are booked for a Home Visit. The practice would be responsible for liaising with the RIT service.
- Practices would not assume any additional responsibilities for employing or supervising staff delivering the Home Visiting service.

The Rapid Response Service is a service that the CCG commissions from the Royal Wolverhampton NHS Trust and discussions would need to take place with regards to the feasibility of the Trust employing additional practitioners within this service, should this option be pursued. The Rapid Response Service is commissioned on the basis of outputs/patient contacts which would need to be adjusted to recognise the additional practitioners.

Given that this is to be introduced as a pilot project, the preferred option is Option 3. This option allows for the service to be delivered within an existing organisational and governance infrastructure. This will also allow for the practitioners to work across both services wherever practical, although a clear audit trail will be maintained to disaggregate total activity.

A robust set of Key Performance Indicators will need to be established against which delivery of the service would be measured.

6 Benefits Expected

There are a number of benefits that can be realised from this approach:

Benefits expected for patients
"Provide right care, at the right time, in the right place".

Patients with minor ailments who are housebound will receive clinical assessment and intervention in a timely manner. It will prevent some patients from attending the Urgent Care Centre. It will also mean timely referral to services when needed. Under the proposed model patients will be allocated an indicative time for the home visit

Benefits expected for practices
"Release time to care"

There is a growing consensus that in some cases the standard 10 minute appointment slot is not adequate for a GP to make a comprehensive assessment and recommendation for patients with more complex needs. The Home Visiting service pilot

will enable practices some scope to be flexible in their use of time and allocation of appointments for patients with more complex needs.

7 Risks

There are a number of risks associated with this type of service.

Risk	Actions proposed to mitigate the risk
Reduced access to GP for patient cohort. There may be a perception amongst patients using the service that they are receiving a suboptimal service from an ANP as whereas they would have previously had a visit from a GP	The benefits of an ANP led service will be clearly communicated to the public and member practices as part of the service mobilisation process. All patients requesting a Home Visit will be triaged so that only those patients whose symptoms indicate that ANP intervention is appropriate will be offered a home visit. The patient's GP will retain overall clinical responsibility for the patient at all times.
Service will not manage some complex cases – E.g. patients with End of life care needs	The referral criteria will be clearly defined and agreed with primary care clinicians via the Clinical Reference Group.
Potential challenges integrating across Primary and Community providers	Access to the scheme by patients from individual practices will be monitored
Requires financial investment	The business case for the service will be presented to the relevant Programme Board and Commissioning Committee. The business case includes an Investment appraisal which demonstrates the savings that would be generated as a consequence of the financial investment made.
Services clinical capability does not align with clinical need	The scope of the service could be further refined following the evaluation of the pilot
Employment risks associated with pilot	The employment risks and potential difficulty in recruiting appropriately qualified and skilled practitioners have been recognised. A number of different options for therefore presented which include different professional groups.
Potential varied uptake across Primary Care	Uptake from practices will be closely monitored to promote fair access to the service during the pilot. This will form part of the monitoring and evaluation process.
Practices reluctance for practitioners to	Process for access to be agreed with each

access / update their clinical systems	individual practice as part of the project implementation process.

To mitigate these risks we are proposing a pilot responsible for the delivery of a defined capacity of primary care home visits across a small number of carefully identified practices, to deliver a pilot that will help inform future commissioning. Practices included within the pilot will be from Unity, PCH1, PCH2 and VI practices who will contribute to continuous improvements with the service and a final evaluation.

Given the ambitions at national level to introduce new models of care requiring large scale change, not implementing a home visiting service will likely impede progress whilst the current significant pressures on general practice remain. The consequences are far reaching and are already apparent with practices struggling to engage and some being 'at risk'. Having a home visiting service is considered one of the single best ways to reduce GP workload thereby freeing up capacity to support other initiatives.

8 Cost

Option 1: Weekly cost for ANP equates to £1939.88

Option 2: Weekly cost for Paramedic/Pharmacist equates to £2023

Option 3: Weekly cost for Rapid Response(RWT) equates to £3268

The pilot project will be funded from the PMS Premium monies held by the CCG.

9 Timescales

The milestone plan below details the timescales for implementation of the pilot project:

Milestone	To be completed by
Agreement of referral criteria for the service	December 2017
Finalisation of service specification	December 2017
Appointment of practitioners	**By September 2018**
Development of referral forms, data collection tools and identification of READ codes	**October 2018**
Pilot goes live	**December 2018**

10 Investment Appraisal

Based on the assumption that each Home Visit carried out by the service would have previously been undertaken by a GP, this model enables the release of 75 GP hours per week to improve access to primary care services and to drive new models of care.

If all the released capacity was allocated to delivering practice appointments, this would represent an additional 450 10 minute appointments per week across the practices taking part in the pilot scheme.

In accordance with the CCG costing template this represents £6680 per week against a cost of £3268 per week. The net saving in GP time equates to £3412. per week

Over a six month period this would equate to a net saving in GP time of £88,712

11 Equality – Appraisal

Complete

12 Quality Impact Analysis (QIA)

Complete

13 Privacy Impact Assessment (PIA)

Complete

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Commissioning Committee
2 October 2018

TITLE OF REPORT:	Spotlight on GP Workforce Initiatives
AUTHOR(s) OF REPORT:	Sarah Southall, Joint Head of Primary Care
MANAGEMENT LEAD:	Sarah Southall, GPFV Programme Director (Black Country STP)
PURPOSE OF REPORT:	Provide an overview of the GP workforce position & projects underway locally and across the STP footprint to combat recruitment & retention of GPs.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• The Black Country is an Intensive Support Site for GP Retention • Based on available data the age profile of Wolverhampton GPs confirms where potential gaps will be in the next 2-3 years if GPs retire or choose to leave the profession • There a number of projects underway locally & at STP level that seek to mitigate the potential GP shortfall
RECOMMENDATION:	The committee are required to consider the content of this report. The committee are encouraged to acknowledge the assurance detailed within the report & confirm their support for the work of the Intensive Support Site..
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1 Improving the quality and safety of the services we commission 3 System effectiveness delivered within our financial envelope

1. Background & Current Situation

1.1. The General Practice Forward View (GPFV) provides a vision for workforce that will be required for the future of general practice. In order to achieve this there is a strong commitment at national level for NHS England and Health Education England to work in partnership with the Royal College of General Practitioners (RCGP) and British Medical Association to deliver an extra 10,000 staff to strengthen primary care by 2020/21.

In order to do this there will be an increase in GP training places to 3,250 per year to support the overall net growth leading to 5,000 extra doctors by 2020. Funding has also been allocated for 500 overseas doctors who are trained & qualified work in General Practice. Other measures include supported recruitment in areas who have traditionally found it hard to recruit to GP vacancies.

1.2. The committee will be aware of the challenges faced in Wolverhampton to recruit and retain GPs in Primary Care. Whilst there are programmes of work already underway as a measure to tackle the problem this report seeks to confirm the extent of progress made to date and provides an insight into some of the projects that are beginning to mitigate the risk of a growing gap in GP numbers.

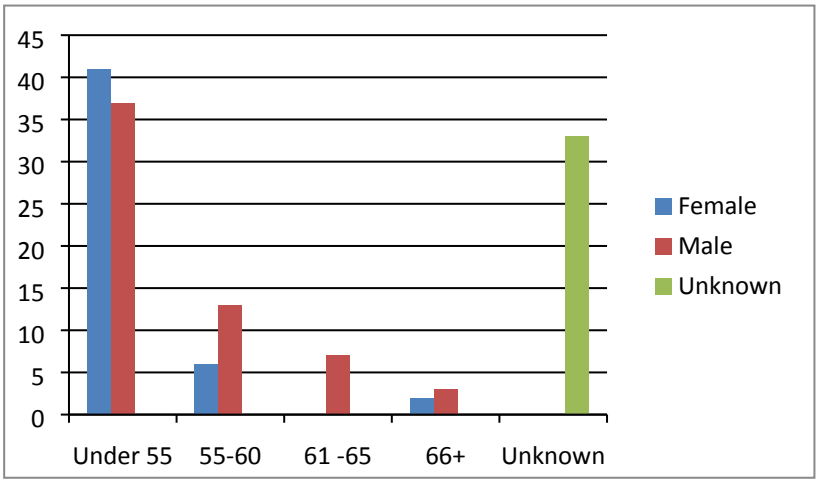
2. GP Workforce in Wolverhampton

2.1. Based on available data from NHS Digital there are currently 142 GPs (FTEs) working across 42 practices in Wolverhampton who are either employed as partners or salaried GPs. The demographics are currently unknown for 33 GPs (FTEs) due to data quality issues, Group Managers are working with their respective practice groups to refine the quality of data from this a small cohort of practices as part of our ongoing development of a primary care workforce dashboard.

2.2. Importantly, the age profile of our GPs demonstrates that 21% of GPs are of an age where they may choose to retire with a minority 3% who are over the age of 66:-

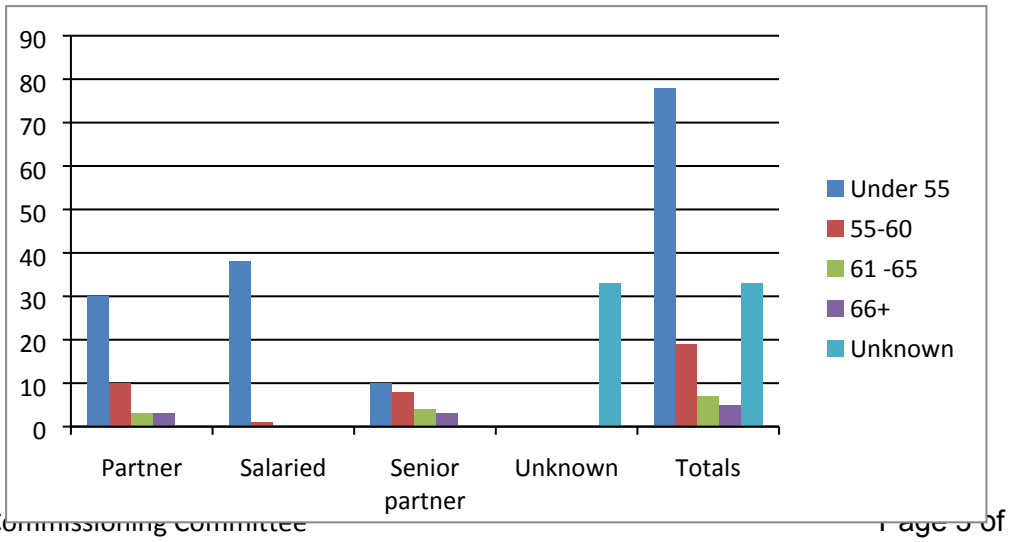
Column1	Under 55	55-60	61 -65	66+	Unknown
Female	41	6		2	
Male	37	13	7	3	
Unknown					33
Totals	78	19	7	5	33

During the latest data validation exercise we are able to evidence that there are more male GPs who are of an age where they may choose to retire or continue working in general practice.



It is encouraging to note that there are more female GPs under the age of 55 this demonstrates that the gap is closing as more females are choosing to work in Wolverhampton although little over half of all GPs under 55 are partners confirming that partnerships are less attractive to the under 55s & salaried employment is more favourable.

Column1	Under 55	55-60	61 -65	66+	Unknown
Partner	30	10	3	3	
Salaried	38	1			
Senior partner	10	8	4	3	
Unknown					33
Totals	78	19	7	5	33



2.3. Local Initiatives & Priorities

The Workforce Task & Finish Group have placed strong emphasis on supporting practices to recruit to GP vacancies introducing funded advertising via the RCGP website and also developed a Primary Care Vacancy webpage for general practice vacancies that is shared with practices and an extensive list of stakeholders to broaden the reach to different audiences. Videos have been produced to attract GPs to work in Wolverhampton these are available via the CCGs website and are available to use in training and other promotional material. Training placements continue to be popular in Wolverhampton however, the retention of trainees is traditionally quite poor and requires further attention.

An extensive training programme spanning the wider workforce in general practice is well underway, as part of the CCGs Primary Care Strategy Programme of Work & GPFV. The introduction of new roles including Clinical Pharmacists, Nurse Mentors, Nursing Associates & Physicians associates has been met with varying levels of interest. The extensive provision of training for administrative staff has resulted in 234 care navigators working across our practices to support patients to be fielded to an appointment with the right team member of the practice team and/or signposted to support from other provisions outside of the practice. There are currently 10 pathways that Care Navigators are able to read code activity to demonstrate the impact care navigation is having to improve patient experience & reduce demand on GP time through fielding patients to other professionals. The Primary Care Assurance Pack (GPFV & Primary Care Strategy) will provide further detail in November.

In addition the Workforce Task and Finish Group Critical Path includes a plethora of training and development opportunities as well as peer support for practice nurses & HCAs. The 10 point action plan places emphasis on increasing nurse training, including nurse mentors and more students being placed in Wolverhampton practices. The plan extends to more robust induction made up of consistent content for nurses working in any care group – a basket of recommended training for registered nurses and health care assistants. This offering is being developed further in response to a new Practice Nurse Strategy that will span the STP, this is currently being finalised & is envisaged will further strengthen work already underway.

2.4. STP Initiatives & Priorities

The Black Country STP has in place a Primary Care Workforce Strategy that has been partially assured by NHS England. The strategy acknowledges that there are many challenges affecting the footprint including:-

- 15% of practices with one GP aged 55 and 8% are 60 and over - GP retirements to 2020 critical factor
- 28% of practices have 1.5 FTE GPs or fewer, 16% (n=38) have at least one GP aged 55 and over
- Attraction & retention of trainees historically low in parts

- Recruitment of GPs is often unsuccessful & results in gaps for practices

Based on NHS Digital data the GP headcount for the Black Country is 762 (FTEs) currently. In the region of 26% of GPs across the Black Country are aged 55 and over, this presents a greater risk to the sustainability of primary care. Therefore, in addition to a range of local measures already underway at CCG level a robust work programme is being constructed to capture a series of projects that will build on local activities and enable a collaborative approach to tackling the potential shortfall of GPs.

Therefore, in order to create a resilient care system, training & education of new and existing staff is a shared priority in order to support retention and transformation in primary care. Recruitment to vacancies and the introduction of new roles is also a priority recommendation from the GPFV and recognition is given to the importance of encouraging flexibility and avoiding historic rigidity in GP employment. A combined programme of work is currently under construction specifically focussing on the GPFV recommendations and vision for primary for the future and will be designed to capture progress that has been made to date whilst confirming where additional support & attention will be required in the coming year to respond more fully to the recommendations spanning all chapters of the GPFV.

Intensive Support Site – The Black Country has been identified as an Intensive Support Site (ISS) for GP Retention. There are seven sites that have been selected across the country by NHS England (one per 'new' region) in areas that are struggling most with retention. ISS status is coupled with dedicated funding to invest in a series of projects over a time limited period to March 2019. The ISS has access to a range of additional resources, tools and change management expertise – to apply a range of support from the GPFV 'toolkit' – specific focus is placed on improving retention of GPs.

There are three levels of intervention:-

- **Person** - individual support specifically for GPs
- **Practice** - organisational support (e.g. 10 High Impact Actions)
- **System** - system wide interventions (e.g. primary / secondary care interface)

To date, a Project Team has been formed to support the Black Country STP this comprises of a GP Clinical Lead, Project Manager and Change Facilitator in support of primary care teams in each part of the STP. The STP have also been successful in appointing GPFV Programme Director and Programme Manager on a time limited basis who are also heavily involved in the success of the ISS.

Initial priorities have been to focus on data validation & scoping a series of projects, this has required significant discussion with practice level personnel and LMCs to

ensure their thoughts & suggestions particularly from GPs influence the content of the overall scheme.

The timeline defined by NHS England regional & national team(s) is as follows:-

Proposal Submission to Local Area Team	End of June 2018
Approval & feedback to STP	July 2018
Confirm Schemes	July 2018
Diagnostic Assessment & Scheme Development	July – August 2018
Mobilise Schemes	By end of October 2018
Evaluation & Closure	April 2019

To date, of the ISS is progressing well, this has been endorsed by feedback from NHS England teams who we maintain close liaison with, not only locally but regionally & nationally too.

There are 4 schemes that have been co-produced with GPs across the STP, LMCs have also been encouraged to be part of the design and to that are due to be launched in October for GPs from across the Black Country to consider/access if they wish:-

- Incentivising Portfolio Careers
- Retention of Newly Qualified & GP Trainees
- Peer Mentoring Network
- Pre-retirement Coaching

Further detail can be found in Appendix 1, this presentation will be used to introduce the final schemes to GPs over the coming weeks. Target audiences include Group/Locality Meetings, LMC Meetings, Members Meetings etc. All 4 projects combined seek to afford support to more than 100 GPs across the Black Country this targeted support will be beneficial early, mid and late career GPs. An evaluation report will be available in April 2019, periodic updates will be shared in the meantime via the Primary Care Assurance Pack (quarterly intervals).

Post CCT Fellowships

Health Education England is funding a national programme of Post-CCT GP Fellowships in 2018-19. The new posts are intended to meet current and future primary care workforce needs. The programme provides additional support and development for newly qualified GPs or those in their first 2 years of practice. The fellowship programme directly contributes to the transformation of the primary care workforce by supporting both the acquisition of clinical maturity in general practice and extended development in specific clinical or professional areas, furthering both local workforce capability and the career aspirations of the GP fellows themselves.

The Black Country have agreed an intake of 11 CCT Fellows, round 1 of recruitment for this region has secured 4 candidates who have chosen placements in the Black Country, a second round of recruitment is due to commence shortly and plans for them to be in post by February 2019. Three candidates have taken up part of their fellowship with Royal Wolverhampton Trust, each fellow has chosen a general practice of choice, 2 of which are in Wolverhampton, one in Dudley and another in Sandwell.

Discussions are underway with both acute trusts and local mental health trusts about the feasibility of incorporating their organisations into an enhanced Black Country offer for cohort 2 recruitment.

The fellowship programme is an excellent opportunity for the Black Country to attract and retain doctors of a high calibre who may not have been attracted to the area. They will be able to put their new found skills and experience into practice as practice teams develop and clinical pathways are continuously improved with their valuable contributions to helping to meet the health needs of our population.

International GP Recruitment **-** Nationally NHS England is working towards recruiting 2000 IGPR doctors by March 2020. Recruitment has commenced and we are likely to know in the next few months the potential to recruit such numbers of doctors from Europe. The Midlands and East region has been allocated funding for the recruitment of 624 doctors out of the national total of 2000. The Black Country STP has been allocated 57 in this initial phase of the scheme which is equal to that identified in our workforce planning assumptions.

Earlier in the summer the committee supported an application for this project, the STP application is currently being updated and due to resubmitted by the end of October. All practices and LMCs have been approached to reaffirm their level of interest in the employment of GPs sourced from overseas as recruitment is due to commence by early 2019. The process is lead nationally ie recruitment, relocation and educational support & salaries of the doctors. In addition, the STP will receive further funding to support their retention & integration into the local community, further details will be confirmed in due course but funding in likely to be released on a quarterly basis.

3. CLINICAL VIEW

3.1. The CCGs clinical chair is an active member of the Workforce Task and Finish Group, there is also close liaison maintained with LMC so that the views of GPs are influencing the co-design of projects. There is also a GP Clinical Lead for GP Retention who is championing each of the Intensive Support Site projects.

4. PATIENT AND PUBLIC VIEW

4.1. Practices are beginning to introduce new roles within their teams these have been met with positive response from patients ie Clinical Pharmacists. There are also regular updates and discussions taking place at meetings with patients and the public at events run by the CCG and/or practices, particularly Patient Participation Group Chairs Meetings.

5. KEY RISKS AND MITIGATIONS

5.1. Risks attached to primary care workforce are captured on the CCGs Risk Register and also within individual project plans for each strand of work references in this report. At STP level the GPFV risk register is begin refreshed also.

5.2. Both the CCGs Primary Care Team and the STP resource has been assigned to support the implementation of all of the projects referenced in this report however the success of these projects is based on the willingness and reception of practices who are required to participate in the projects detailed.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. Wolverhampton CCG has been nominated as the recipient of funding for all GPFV allocations on behalf of the STP. To date, funding has been confirmed for the Intensive Support Site Projects and Practice Manager Training at this stage, the Finance Team have been briefed and await the receipt of funds.

Quality and Safety Implications

6.2. Existing programmes of work have been developed with quality in mind, both the safety of service provision and the wellbeing of our primary care workforce as well as the experiences patients have of care in general practice. The effectiveness of changes in clinical practice will be evidenced as part of the evaluation process for each project and in where necessary in discussion with patients and stakeholders.

Equality Implications

6.3. There are no foreseen equality implications arising from the detail within this report.

Legal and Policy Implications

6.4. There are no legal and policy implications foreseen at this stage, individual project plans are developed in conjunction with NHS England and Health Education England to ensure all appropriate processes are duly followed.

Name: Sarah Southall
Job Title: Joint Head of Primary Care (Wolverhampton) / GPFV Programme Director (Black Country STP)
Date: 26 September 2018

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**Dr S Reehana**	**27.9.18**
Public/ Patient View	**NA**	
Finance Implications discussed with Finance Team	**NA**	
Quality Implications discussed with Quality and Risk Team	**NA**	
Equality Implications discussed with CSU Equality and Inclusion Service	**NA**	
Information Governance implications discussed with IG Support Officer	**NA**	
Legal/ Policy implications discussed with Corporate Operations Manager	**NA**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**NA**	
Any relevant data requirements discussed with CSU Business Intelligence	**NA**	
Signed off by Report Owner	**Sarah Southall**	**27.9.18**

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The Black Country

Sustainability & Transformation Partnership (STP)

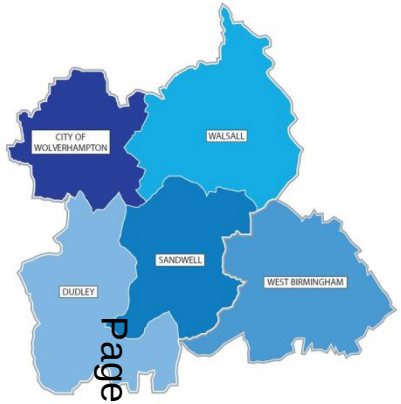
GP Retention Intensive Support Site

Co-design workshop
25 Sept 2018


WELCOME

Fire

The Black Country



- 1.4m Population
- 233 Practices
- 4 CCGs / 5 places / 1 system
- Significant workforce challenges
- Shared vision for achieving a sustainable Primary Care
- Established collaborative approach GPFV recommendations

- Tackling GP gap -39 underpinned by range of initiatives (814/852)
- 15% of practices with one GP aged 55 and 8% are 60 and over - GP retirements to 2020 critical factor
- 28% of practices have 1.5 FTE GPs or fewer, 16% (n=38) have at least one GP aged 55 and over
- Attraction & retention of trainees historically low
- Recruitment generally challenging – local initiatives underway

- Resilient care system, wrapped around the whole of general practice
- Training & education of new and existing staff to support retention and transformation
- Recruitment to existing and new roles, encouraging flexibility
- Retaining the skilled people we have, along with managing demand and embracing a culture fit for the future.

Full Time Equivalent:	All Practitioners	GP Providers	Salaried/Other GPs	GP Retainers	GP Registrars	GP Locums
NHS Dudley CCG	178	122	37	1	15	4
NHS Sandwell and West Birmingham CCG	302	160	94	0	25	23
NHS Walsall CCG	141	96	30	1	7	8
NHS Wolverhampton CCG	140	93	37	-	9	2
Black Country STP	762	469	198	2	55	37

Pressures on general practice

↑ **population**

↑ **consultations**

↑ **complexity**

↑ **costs**

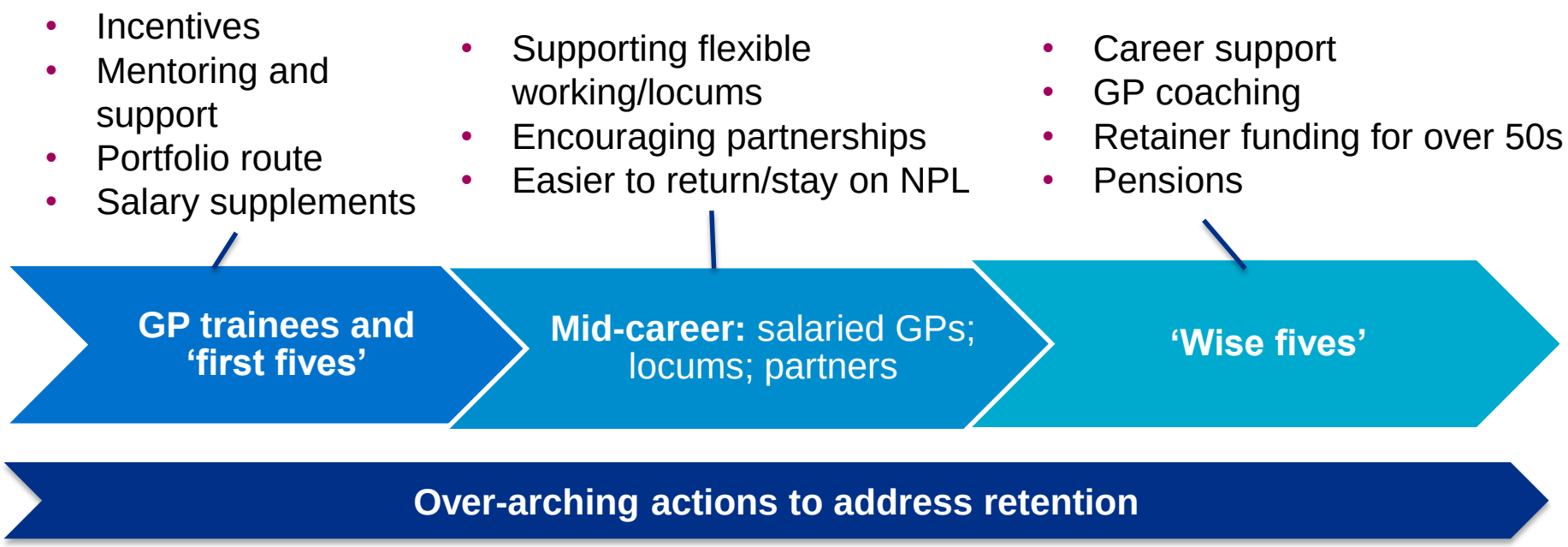
↓ relative funding

↓ relative workforce


Why?
Pressure
Opportunity

National perspective -Future agenda

- Increasing focus on retaining the GP workforce that we already have – alongside other major programmes of work (e.g. international recruitment).



- Rebuilding the reputation of general practice
- Focus on benefits of growing the wider general practice workforce
- Workload
- Professional development (including education of other professionals)
- Indemnity

7 Intensive Support Sites

- The seven sites have been selected across the country (one per 'new' region) in areas that are struggling most with retention.
- Will benefit from additional resources, tools and change management expertise – to apply range of support from GPFV 'toolkit' with a specific focus on improving retention of GPs - geared at maximising impact as a proof of concept.
- Three levels of intervention:
  - **Person** - individual support specifically for GPs
  - **Practice** - organisational support (e.g. 10 High Impact Actions)
  - **System** - system wide interventions (e.g. primary / secondary care interface)

GP Retention Intensive Support Site

Project Team Formed July 2018
- GP Clinical Lead (STP)
- Project Manager (NHS England)
- Change Facilitator (NHS Improvement)
- Programme Director & Manager (STP)
- 4 Primary Care Leads (CCG reps.)

Diagnostic Assessment July-August 2018
- Data validation and scoping
- Delivery Plan
- Logic Model
- Critical Path
- Cost Benefit Analysis

Mobilise Schemes Sept-Oct 2018
- Launch schemes across STP
- Scheme level reporting CCG/STP/NHSE
- Engagement Event (25-09-2018)
- Active project monitoring and control

Schemes Confirmed £415k July 2018
- Incentivising Portfolio Careers
- Retention of Newly Qualified and GP Trainees
- Peer Mentoring Network
- Pre-retirement Coaching

Achieved in August 2018
- Liaison with LMCs, Practice Group Leads, Providers etc.
- Early, mid & late career confirmed/prioritised
- Project planning, inc comms and engagement
- Attained NHSE assurance

Evaluation and Closure April 2019
- Anticipate 78 WTEs will benefit
- Viability for future
- Measure impact vs Cost Benefit Analysis
- Sustainability for April 2019 →

The Schemes

- **Incentivising Portfolio Careers:**
- **Retention of Newly Qualified GPs and GP Trainees**
- **Peer Mentoring Network**
- **Pre-retirement Coaching Forum**

National Offers

- 1-1 Coaching
- Primary-Secondary Care Toolkit
- PGP Quick Start
- Learning in Action
- Team-based Coaching

Key opportunities

Link to wider GPFV work in the Black Country:

- PCN
- Care redesign
- Delivery of care using digital technology

Introduction of new roles, flexibility and skillset in General Practice

Complement wider GP recruitment initiatives. E.g. IGPR, post CCT fellowships, PA internships, etc.

STP transition to ICS

Key issues and challenges

- Tight timescales
- Engagement with wider stakeholders
- Project planning during August
- Limited resources and time
- Workload versus small teams
- Sustainability of schemes – post March 2019?
- Reduction in headcount (FTE)
- Natural attrition – a level of acceptance

Evidence

Evidence of Retention - Total sessions/week retained = 20

Dr A:
Issue – no confidence to return to work after significant illness
Support given – monthly sessions to listen/encourage/build confidence
Outcome – returned successfully and negotiated a 2 session reduction to 4 sessions a week
Sessions/week retained - 4

Dr B:
Issue – intended leaving GP due to work stress and issues within partnership
Support given – met every 2 months - listened, encouraged to deal with conflicts, some IT support (manage inbox/consultation shortcuts)
Outcome – continues in post on 7 sessions a week
Sessions/week retained - 7

Dr C:
Issue – new partner, high achieving at massive cost to own health, wanted to leave medicine completely
Support given – met every 6 weeks - listened, encouraged to deal with issues, learn to delegate, encouraged self-referral to GP Health Service
Outcome – remained in post for the year, did contact GP Health Service (despite massive reluctance to) who were prompt and effective. Has decided to remain in GP but relocate outside of UK GP for a year.
Sessions/week retained - 9

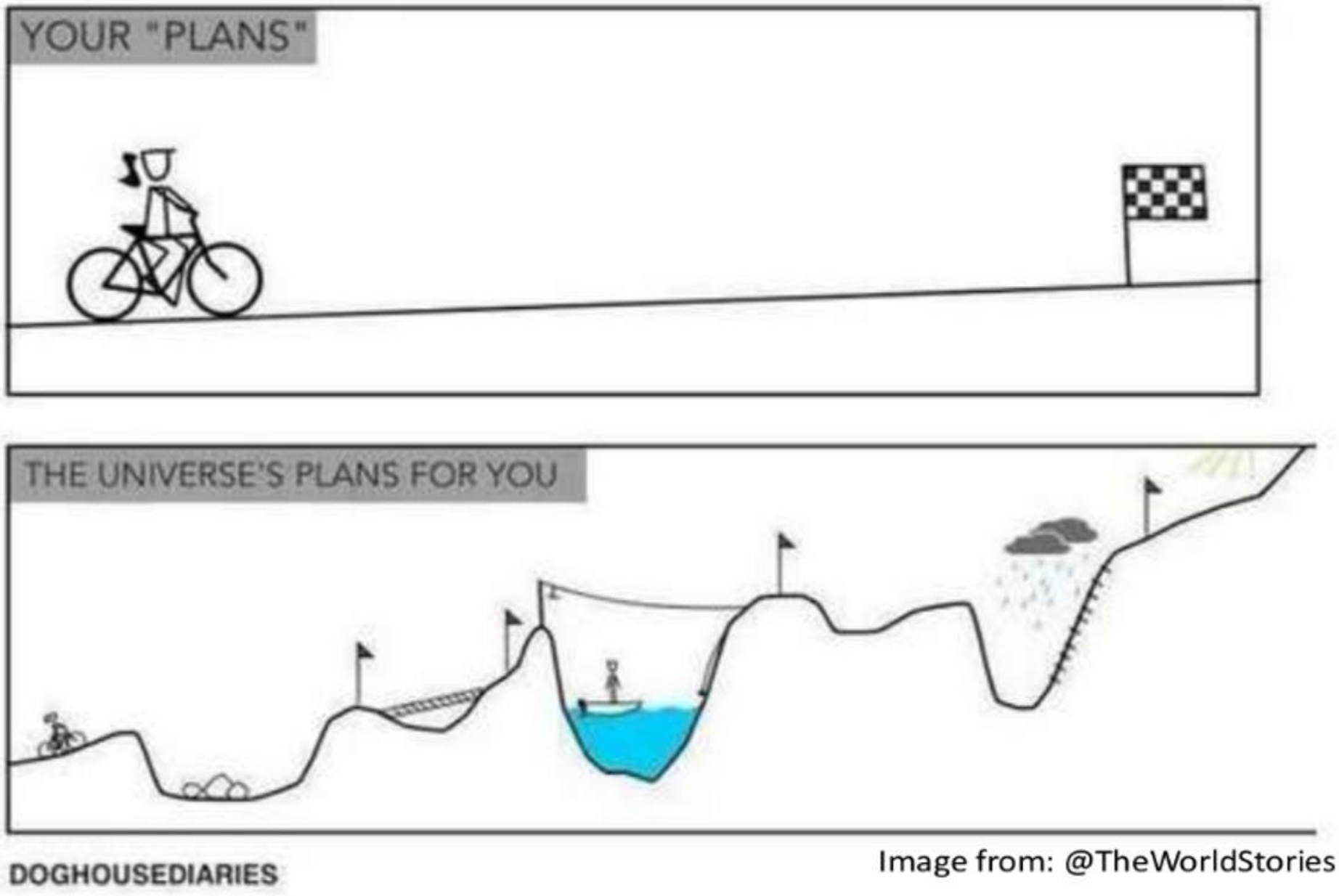


Image from: @TheWorldStories

Incentivising Portfolio Careers

The Idea

- Develop flexible career opportunities for GPs – Portfolio Career
- Enhance skills and knowledge in area(s) of interest
- Encourages flexibility whilst retaining GPs
- Strengthen speciality level exposure, experience and flexibility in employment

What will it include ?

- Work alongside colleagues in a different setting/ area of interest
- Expression of interest form
- Confirm the broad area of interest, skills and knowledge development
- Financial support up to £10k per portfolio career/person available until March 2019
- Mutually agreed period of time for development into additional role

Who can access this support ?

- Available to all GPs on the performers list employed in the Black Country
- GPs willing to remain in general practice & keen to explore a blended career path

What is the time commitment?

- Tailored to individual preference
- Reduction in GP clinical sessions / additional sessions in an alternative setting ie education, leadership, hospital, community etc.
- Preparation of joint development plan (portfolio match)
- Training, education needs may be identified

How long is the offer available

- Offer is open to application till 1 March 2019
- Support will run to March 2019
- If successful the project is likely to continue as part of our sustainability plan.

How do I find out more?

- Complete expression of interest form & hand to a facilitator or email Sarah Southall sarah.southall@nhs.net for further information

Retention of Newly Qualified GPs and GP Trainees

The Idea

- The aim is to support newly qualified GPs and GP trainees transition into General Practice as a salaried or partner GP in the Black Country.
- Encourage networking and exploring the range of possible career opportunities in the Black Country

What will it include ?

- Four networking and development events to provide opportunities to meet peers; induction to the area; meet recruiting practices; link with senior GPs from the area;
- Learn practical advice on pension/tax;
- Plan and develop career opportunities within the area;
- Support CPD through small group sessions.

Who can access this support ?

Newly qualified GPs, First5 and GP Trainees within the Black Country STP.

What is the time commitment?

Series of Four events (monthly) to run across the Black Country STP

How long is the offer available

This scheme will run from November 2018 to March 2019

How do I find out more?

For further information and/or complete an expression of interest form please contact Sherry Samaan s.samaan@nhs.net

Peer Mentoring Scheme

The Idea

Creating a peer career planning service for GPs in their early, mid or late career Peer mentoring offered to GPs to explore ways to develop themselves and their career within General Practice. This could be personally and professionally. Delivered by GPs

What will it include ?

- One to one peer mentoring support, initially for 3 sessions, fully funded. These sessions will be 2 hours, face to face, provided by a GP.

Who can access this support ?

Those GPs in mid career, and late career, and those who understand the local issues and opportunities for development .

working 9-10 sessions per week.in the Black Country STP

What is the time commitment?

Up to 3 sessions of 2 hours, face to face, mentoring. GP required to complete questionnaire pre and post the mentoring session(s).

How long is the offer available

This offer is available between 1st October 2018 and 31st March 2019.

How do I find out more?

A more detailed **draft** service description is available on the tables.

- Would you add anything to the what is offered
- Do you agree with the way with the way in which GPs will be identified?
- For further information and/or complete an expression of interest form contact Daniel King
  email: daniel.king@nhs.net

Pre-retirement Coaching Forum

The Idea

Helping retain GPs considering retirement, and return recently retired GPs to clinical practice

The offer is support through pensions and estates advice, and indemnity costs support to a cohort of these GPs

What is the time commitment?

1 evening, 2-3 hours

What will it include ?

- A facilitated forum to explore options
- Support for indemnity costs for up top £2000

For how long is the offer available?

2 sessions, provisionally November and January (participants would only attend a single session**)**

Who can access this support ?

GPs working in the Black Country STP who are contemplating retirement in the near-future and recently retired GPs interested in returning to practice for a few sessions per week

How do I find out more?

For further information and/or complete an expression of interest form contact Leon Mallett
email: leonmallett@nhs.net

System support: Productive General Practice Quick Start Learning In Action - Coaching – Implementation toolkit

The Idea:

Accessing national offers of support which will help redesign general practice releasing time to care through teams delivering quality improvement efficiency though use of tool and tools and developing collaboration and partnership across system.

Supported GPs development through national coaching session

Toolkit to support develop improved secondary /primary Care systems

What will it include ?:

Learning in Action programme (LIA) – groups of 10 practices working through series of facilitated 3.5 hour work shops x 6

Productive General Practice Quick Start (PGP) – groups of 10 -12 practices working with lean tools and external support, receiving intensive hand on support over 8 weeks.

National Coaching for GPs – 3 x1.5 hour session across 3-4 months

Implementation Toolkit- Tool sharing practical ways in which organisations can collaborate locally to improve the delivery of care across the primary and secondary care interface.

What is the time commitment?

- LIA – 3hour workshops across 5- 6 months
- PGP – 8 weeks (majority of support session in practice)
- Coaching 1.5 hours x 3
- Toolkit – workshop

Who can access this support ?

- Learning in action / PGP / Toolkit – practice teams
- National coaching offer – General Country STP Practitioners in Black

For how long is the offer available?

Support available across programme – March 2019

How do I find out more?

To discus these options and how they may support you and your teams please contact alice.o'neill@nhs.net

Theory of Change for GP Retention Intensive Support Sites: The Black Country

1) The issues

- The Black Country STP workforce issues and challenges include:- An aging workforce with 15% (n=36) of practices with one GPs aged 55 and 8% (n=18) are 60 and over
- -28% (n=65) of practices have 1.5 FTE GPs or fewer, 16% (n=38) have at least one GP aged 55 and over
- An aging workforce across the whole system - a significant proportion of the workforce is aged 55 or over
- Gaps across STP in range of specialisms as demand on secondary care has increased due to gaps in GP knowledge
- Trainees and newly qualified GPs not retained in the area they trained leaving to work elsewhere
- GPs leaving employment as a result of the lack of flexibility.

2) Activities

Scope plan and implement four schemes to support GP retention (16 GPs):

1. **Incentivising Portfolio Careers**: GPs develop flexible portfolio comprising clinical session in both General Practice and secondary care/mental health. Enhancing skills and knowledge

2. **Retention of Newly Qualified GPs and GP Trainees (10 GPs):** scope and target GP trainees and newly qualified GPs (First 5) to remain practicing in Black Country post qualification. Recruit onto specially designed transition support programme.

3. **Peer Mentoring Network (32 GPs)**) creating a peer career planning service for GPs in their early, mid or late career PMN offered to GPs to explore ways to develop themselves and their career within General Practice. This could be personally and professionally.

4. **Pre-retirement Coaching Forum (20 GPs):** Utilising the information gained from scheme 3 and local intelligence .Group coaching forum for *Wise 5* GPs . Exploring and planning options to retain their skill and knowledge

System wide support :

- **Productive General Practice Quick Start** 8 weeks Programme specialist hands on support to practices
- **Learning In Action –** collaborative of practices redesigning their care and manage demand more sustainably
- **Coaching**:1:1 National offer

3) Outcomes

Timescale		
16 GPs developing portfolio career Clinical skill development in related STP priority with Accredited schedule of placement	GPs Expanded career possibilities Consistent support for development	GP trainees able to find suitable employment within the STP as a newly qualified GP
10 trainees and newly qualified GPs join scheme	Manage transition to GP role and 1st 5 career positively	Further GPs attracted to portfolio role and enhanced skills
4 GPs trained to provide peer mentorship across STP	Support 32 GPs through PMN	Build GP resilience
20 Wise 5 GPs identified for coaching support	Late career GPs offered a range of targeted advice and guidance	Retain skills and knowledge and experience within general practice
55 practices enrolled PGP QS	At scale delivery PGP Coaching 107 places	Improve efficiency & release GP time for care

GOAL: We have made, and will continue to make, a difference to GP retention by making sure General Practice in the Black Country feels like a good place to work, understanding what makes the difference and building momentum for change

Any questions?