1.0 Introduction

1.1 A third of babies born this year will see their 100th birthday in contrast to 1948 when 50% died before age 45. This evidences the significant improvements seen in healthcare over the last 60 years however it poses a significant risk to our workforce in managing this increased demand. We are ‘promised’ nationally, an additional 5000 GPs to support these workforce issues however the reality is that less trainees are choosing general practices when they qualify and more GPs are choosing to retire earlier than normal retirement age. The gender balance between male and female doctors is also changing which is also impacting on workforce availability as traditionally female GPs in Rotherham choose to work part-time.

1.2 NHS England has produced a 10 point action plan – Building the workforce, a new deal for GPs to support addressing these workforce issues however, as this is a national document and targeted at the most under-doctored areas first, it is essential that Rotherham CCG has its own strategy which is compliant with the national action plan.

1.3 The current silo working of practices is also unsustainable as we move more and more to delivery of equitable services and increased services closer to home. Significant progress is now being

2.0 Current position

2.1 Rotherham currently has 36 general practices which consist of 24 PMS, 4 APMS and 8 GMS practices. Rotherham CCG has been encouraging practices during 2014/15 to utilise the Yorkshire & Humber Health Education England workforce tool to enable a broader understanding of workforce issues and to date 31 practices are utilising the tool. For the purposes of this plan therefore we have to assume the picture across Rotherham is consistent with the data we have and extrapolate.

2.2 From current data 45 GPs in Rotherham are over 55 and 27 GPs are over 50, whilst small numbers are continuing to practice way beyond 65, with changes to pension taxation, there is high potential of GPs choosing to retire or reduce working hours much earlier than originally planned. At present, we intake on average 13 GP
trainees into Rotherham each year and approximately 50% are appointed to posts in the Rotherham area. On this basis therefore, without any intervention we currently have 8wte GP vacancies and are predicted to have a shortfall of a further 15wte by 2020 (or earlier).

Graph 1 – Age profile – GP workforce

In relation to particularly ‘under-doctored’ practices, it is of concern that over 50% of practices are below Rotherham average of 0.7wte GPs per 1000 patients. It also shows the significant differences between the staffing profile of practices. For example the Gate which is predominantly nurse led and evidenced by the way it outlies on the graph with significant more nursing workforce than any other practice. Clifton, Thorpe Hesley, Village and Woodstock Bower have a higher than average nursing workforce evidencing an increased nursing workforce to manage their overall demand. The practices of concern are where they have insufficient GP capacity and from review do not appear to be backfilling with a nursing workforce (they could however have more innovative models around therapy and pharmacy we are not aware of). This indicates disproportionate investment in workforce which must be addressed.
Graph 2 - GPs per 1000 patients in Rotherham

Please note, St Anns, Brinsworth, Broom Valley, and Surgery of Light did not submit information regarding nursing for the graph below:

Graph 3 – Nurses per 1000 patients in Rotherham

3.0 Models of workforce

3.1 Recruitment and retention issues within general practices are well understood, and many practices in Rotherham have already risen to the challenge by reviewing their skill mix and supporting the training and development of both medical and nursing disciplines. However this is not across the board and other than the social enterprise model, there are no practices sharing resources (clinical or non-clinical) to deliver their activity. Capacity planning within practices is also limited which makes the following very difficult:
Radical new models of primary care workforce are emerging, Health Education England reported recently that from data returns, they are seeing the following models emerge:

<table>
<thead>
<tr>
<th>Maximising the supply of GPs and Practice Nurses</th>
<th>Enabling Skill Mix: distributing the practice workload differently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bringing other professionals/healthcare workers into the practice</td>
<td>Developing new roles as alternatives to the existing GP workforce</td>
</tr>
</tbody>
</table>

Making it happen – the enabling works

<table>
<thead>
<tr>
<th>The conservative model (replacing like for like)</th>
<th>GP</th>
<th>Practice Nurse/Advanced Clinical Practitioner</th>
<th>Healthcare Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practices under pressure (evolutionary change)</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>The extreme scenario (workforce transformation)</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

3.2 Developing nursing

As outlined above, a number of practices are now extending their use of nurses to support practice workload however more can be achieved from the use of Band 1-4 roles within practices. Practices need to operate more clearly defined roles to ensure minutes, which add up to hours are undertaken by the most suitable post within the practice. It is acknowledged that it is difficult to ‘carve’ staff time out in this way but not unachievable. Enhanced job satisfaction is achieved by enhancing
nursing roles so long as the requisite training and education is provided to ensure the team feel sufficiently competent to undertake.

3.3 **Associate Physicians**
Rotherham CCG is supportive of Sheffield Hallam and Sheffield University who are commencing Associate Physician training in the next 12 months. This is a 2 year programme which Y & H HEE are now piloting funding a £10k bursary and provide training costs to practices who host trainees. It is hoped during this initial training period that issues relating to prescribing and imaging requesting along with regulation can be resolved. It is intended that this new role is utilised to support practices with an alternative model to advanced clinical nurse practitioners as these roles are also difficult to recruit to. They are not described in the model above as the training schemes are only just commencing in our locality.

3.4 **Practice based pharmacists**
NHS England have announced opportunities for practice based pharmacists. We are awaiting further guidance however this is already an alternative model being explored by 3 Rotherham practices. Woodstock Bower, Crown Street and Northern Road are pursuing this model and it was well supported by GPs at a recent commissioning event. GPs felt that pharmacist support in practice particularly for medication reviews, management of long-term conditions, dealing with hospital discharge letters, managing house bounds and nursing home patients, health promotion along with involvement in managerial roles eg. QOP, CQC work and clinical governance could have a positive impact on GP workload. It has been agreed that the Medicines Management Team at the CCG will provide professional leadership and mentorship to the practice based pharmacists to ensure they do not become professionally isolated and potentially lead to retention issues. There will be an opportunity to bid for central resources to non-recurrently fund Pharmacists within practices as a pilot to prove concept. It is proposed that 6wte Pharmacists are required to provide additional support into practices and to assess workload impact, training requirements and patient experience. It is proposed that if a bid for funding is not successful that we work with practices with GP vacancies to reutilise funding to employ pharmacists. Other organisations are also working in partnership with commercial pharmacies to supply pharmacist support into practices and this will also be considered.

4.0 **Rotherham workforce requirements**

4.1 The CCG has taken a simplistic approach to assessing workforce requirements for the future as this looks at Rotherham as a whole and not in silos per practice. Based on
current average information and the conservative model, Rotherham would require the following workforce:

260,000 patients – 173wte GPs, 87wte Advanced Nurse Practitioners/Associate Physicians/Pharmacist/AHPs, 43wte Healthcare/support assistants/phlebotomists, 286wte administrative support, 26wte Practice Managers, 13wte deputy practice/business managers.

4.2 Based on current average information and the evolutionary change model, Rotherham would require the following workforce:

260,000 patients - 130 wte GPs, 130wte Advanced Nurse Practitioners/Associate Physicians/Pharmacist/AHPs, 87wte Healthcare/support assistants/phlebotomists, 286wte administrative support, 26wte Practice Managers, 13wte deputy practice/business managers.

4.3 Based on current average information and the extreme change model, Rotherham would require the following workforce:

260,000 patients – 43wte GPs, 87wte Advanced Nurse Practitioners/Associate Physicians/Pharmacist/AHPs, 173wte Healthcare/support assistants/phlebotomists, 286wte administrative support, 26wte Practice Managers, 13wte deputy practice/business managers.

4.4 Our current workforce data (from data provided) is as follows

<table>
<thead>
<tr>
<th>GP HC</th>
<th>GP FTE</th>
<th>GPs per 1k PTs FTE</th>
<th>Pts Per GP FTE</th>
<th>GP Providers HC</th>
<th>GP Providers FTE</th>
<th>Practice Staff FTE</th>
<th>Practice Staff per 1k pts FTE</th>
<th>Nurse FTE</th>
<th>Nurse s Per 1k pts</th>
<th>Direct PT (HCA) Care FTE</th>
<th>Direct Pt Care (HCA) per 1k pts</th>
<th>Admin FTE</th>
<th>Admin Per 1k pts FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roth</td>
<td>5.03</td>
<td>4.94</td>
<td>0.69</td>
<td>1,453</td>
<td>4.94</td>
<td>3.26</td>
<td>12.06</td>
<td>1.68</td>
<td>2.37</td>
<td>0.33</td>
<td>1.09</td>
<td>0.15</td>
<td>8.26</td>
</tr>
<tr>
<td>Eng</td>
<td>5</td>
<td>4.69</td>
<td>0.65</td>
<td>1,530</td>
<td>3.32</td>
<td>3.02</td>
<td>11.22</td>
<td>1.57</td>
<td>1.91</td>
<td>0.27</td>
<td>1.18</td>
<td>0.16</td>
<td>7.9</td>
</tr>
</tbody>
</table>

We therefore have 179wte GPs, 85.8wte practice (qualified)staff, 32.4wte Healthcare Assistants (direct patient care) and 299wte administrative support staff. Practice management wte is not known.

The conservative model is not sustainable and it is therefore recommended that practices pursue the evolutionary model which makes much better use of the wider general practice workforce along with new roles. The extreme change model has not been evaluated and is not supported.
Rotherham is therefore severely lacking in qualified practice staff and healthcare assistants when adopting the evolutionary model this is because most practices are continuing to follow the traditional (conservative) model which will be difficult to sustain long term.

4.4 It is essential that practices start to look collaboratively rather than individually at their workforce, there are significant efficiencies which can be achieved by working across traditional practice boundaries. Closer review of how the LLP can support this collaboration is required with hopefully joint working with the CCG to agree new working arrangements which are sustainable. We have also not factored into above the impact of potential 7 day working on practices. At minimum, for our population we would require an additional 94.5 hours GP time per week (if utilising GPs) to facilitate sufficient Saturday capacity, based on a 9 session week this would equate to an additional 2.6wte to the 130wte identified. As the model evolves, review of utilising the extended workforce with GP overview will be considered.

4.5 **Locum bank**
Clearly, longer term the intention is to create models which are less reliant on qualified doctors however in the interim, practices are using expensive locum agencies for their short term requirements which are high cost and at times lower quality. The impact is felt for the CCG as from peer review visits, it has become evident that when a locum is used, referrals to secondary care increase. There was clear support for a bank arrangement from current GP registrars who indicated that they were keen not to settle down into one practice at the end of training. To support practices and improve referrals, it is proposed that the CCG supports the creation of a locum bank, hosted by a practice. The CCG is currently seeking information regarding demand for such a service to create a fully costed proposal. The intention is however for the host practice to recruit full/part-time GPs who will receive a salary rather than payment for sessions to provide employment stability with flexibility in workplace. The full cost will be recharged to the user on a monthly basis with a year end adjustment to ensure the bank is self sufficient. This proposal also provides the opportunity to work in non-training practices to aid recruitment in practices less known to GP trainees.

4.6 The key concern about moving to new models of workforce are the transitional arrangements and ensuring quality of care is not compromised. There is no single solution to address this issue as some changes will have to happen more quickly than others (due to unforeseen circumstances i.e. unexpected vacancies) however a task and finish group will be established to develop proposals for how services are sustained during transition.
5.0 Defining the required workforce

5.1 Capacity planning is an essential tool to ensure capacity is fully understood across general practice. A simple template capacity spreadsheet will be provided to practices to support them with planning. This information will then be utilised alongside our workforce data to support practices with more effective succession planning. It will also be utilised to define the impact of utilising different roles within practice e.g. using a pharmacist, associate physician, extending skills of healthcare assistants and potential impact of technology.

6.0 Technology

6.1 We have to fully exploit the technology which is available to us to free up capacity in general practice. The key systems identified from pilots as having most impact to date are telephone and self-care.

6.2 Telephone systems – evidence is now identifying that up to 50% GP time can be saved by a full telephone consultation system. In a recent engagement event, over 90% of the general public supported such a system. Concerns have been raised in relation to capacity to see if required and it is part of the system that sufficient slot capacity is carved out to see those patients who require a face to face on the same day. At present, practices are devising their own different ways of implementing telephone triage/consultation and it is recommended that an approach is agreed and implemented consistently (clearly with the ability to vary for clinical reasons).

6.3 A number of CCGs have implemented telehealth systems to support self care and reduce avoidable attendances in primary and secondary care. At a recent event, there was significant support for using telehealth from the public. These systems can be targeted towards specific long term conditions, for example patients with Hypertension. The GP would target specific suitable patients and offer them the opportunity to sign up to use the system. A set hypertension protocol (following NICE guidelines) is pre-populated, but can be amended to the specific needs of the patient. The patient is then sent text messages requesting BP levels, the patient is then sent advice based on their readings, the advice could be to take the blood pressure on the other arm or immediately make an appointment. The Clinician can review the text messages (sent & received) as well as the data submitted on a chart, an email and / or text message alert can be sent to the clinician should any abnormal readings be submitted. The clinician has the option to send a free text SMS to the patient, for example, requesting they attend an appointment that has been booked for them.

Potential areas to target:
Anti-coagulation
Hypertension
Diabetes
COPD
Heart failure

It is accepted that this is still workload for the practice but it does take less time than current monitoring arrangements. It is also feasible to consider practices collaborating to allocate a suitably qualified (Healthcare Assistant) clinician to this task for a higher population or a whole service can be ‘bought in’. There are significant patient satisfaction benefits to operating this system. It is acknowledged that current payment arrangements for monitoring would need to be reviewed to incentivise use of technology.

7.0 Developing our workforce

7.1 It costs on average £30k every time we recruit a clinician in primary care (Lost output whilst new employee gets up to speed, induction, locum for any gaps in service and cost of recruiting). Understanding this investment is crucial along with acknowledging the personal and professional needs of our workforce. We understand that continuing to develop our workforce not only retains them within their organisation but also ensures the ability to develop services using a wider workforce. Traditionally we attract new GPs from the effectiveness of training, flexibility in sessions along with out proximity to Sheffield. Our nursing workforce traditionally

7.2 We expect each practice to ensure each member of staff receives mandatory training as required along with ensuring there is an annual development plan as part of a structured appraisal process. 37.5 hours structured training per wte each year which includes PLT attendance, robust mentoring/coaching and internal training.