NHS
Castle Point and Rochford
Clinical Commissioning Group

Castle Point & Rochford Workforce Strategy

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1 Executive Summary

Castle Point & Rochford CCG (CP&R CCG) was awarded “CCG of the Year” in the Primary Care Today Awards in October 2015. It is the only CCG in the East of England to have secured support from GPs who voted for it to become the co-commissioners. With this clear mandate it now has a unique opportunity to continue the journey, started last year, and set out a vision of the workforce required for the future, working closely with our GP colleagues to deliver this.

CP&R CCG has developed strong partnership working with GPs, Essex County Council and other stakeholders. The first stage of assessing the development of an integrated health and social care has been undertaken. Detailed analysis and research has been completed with a forward looking focus on creating and developing new roles to deliver services across historic boundaries.

This strategy seeks to continue our workforce transformation journey in considering the current key workforce issues. It is important to consider how these may need to be addressed, highlight the developments achieved to date, and identify what potential new roles may be needed as part of integration aligned with the Neighbourhood Team Service model in development.

Equally important is the role of this work in relation to the ‘programme to sustain services and improve care’ of the Mid and South Essex Success Regime of which CP&R CCG is a member organisation. The Success Regime has identified workforce and talent gaps as a key challenge and this strategy is part of the work that CP&R CCG will use to address that challenge.

2 Vision

Our vision is to create a healthier and more sustainable future for people in Castle Point and Rochford through commissioning high quality care in the most appropriate place at the optimal time within the resources available.

A paradigm shift from many people being acutely unwell and requiring complex care in hospital settings, to more people taking responsibility for their own health and wellbeing, with more care being delivered in the community and closer to patients’ homes

3 Purpose

A focus on enhancing and developing the workforce to play their role in delivering whole person care that augments self-management, with services that are enabling as well as supporting according to need, with the CCG’s having an influence to communicate with the local population to promote roles within the NHS providers locally.

4 Aim

"By integrating teams and creating genuine partnerships between statutory and voluntary sector agencies that are closer to the community and working together in a genuinely collaborative way, an individual's experience of care will be based on their ambitions and needs rather than service boundaries and criteria. To this end, people will be equal partners in their care and feel supported to continue living in their local community and we will move away from our current over-reliance on institutional and acute care"

To aid this process, in January 2016 CP&RCCG invited NHSP Workforce Insight Service (NHSP WIS), with their specialised national knowledge, to assist in the development of a document which set out a shared understanding of CP&R CCG's vision for:

- A recruitment & retention strategy for the primary care workforce
- Potential of new worker roles
- The future internal workforce needs for CP&R CCG

Significant steps have been taken by the CP&R CCG in the creation and development of new roles to support GPs and nursing as well as creating forums to bring professional leadership to the teams.

Examples of new roles are Care Coordinators and A&E Case Managers

This is the next step on that journey for a longer term strategy to review and design the future workforce to deliver services for patients that are effective, efficient in the most optimum way with the right resources and support.

New ways of working are always a challenge to put into place and the following are key elements to delivering a supported, successful partnership process to take forward such a strategy:

- **Leadership** - a strong robust systems and clinical leadership structure for an integrated workforce approach to bring together partners and providers across all sectors to create an environment of collaboration, monitoring and continuous improvement

- **Workforce Intelligence** - accurate workforce data to inform future workforce strategy and planning

- **Job/role design** – determining responsibilities and accountabilities of roles for effective workflow and ensuring individuals have competencies and clear understanding of role expectations

- **Training** –CP&R CCG has a large number of training practices to facilitate and support the future workforce with opportunities for creative placements, new role development and support. Building on this experience and local environment, the CCG could take the lead in securing the availability of local, high quality training for all members of the primary care team. In addition, the provision of local training courses to encourage secondary care nurses make the transition to primary care

- **Capacity** – ensuring there are sufficient resources for effective delivery and performance of service needs with clear, co-joined strategies across all staff groups
- **Skills** – ensuring the right skills are available/developed to meet the changing needs of services

- **Organisational structure design –** development and implementation of an organisational structure that supports business processes, effective governance and workforce development

- **Culture change** – supporting the workforce to adopt new working practices and collaborative working and desired behaviours

5 National Context

Investment in primary care has fallen well behind investment in hospitals, despite increasing expectations of the work that should be done in primary care.

Between 2003 and 2013, the number of hospital consultants increased by 48 per cent while GP numbers increased by only 14 per cent. Indeed the number of GPs per head of population has declined since 2009, with major problems of recruitment and retention. Nursing is another area of serious concern, with an ageing workforce in General Practice Nursing (GPN) and similar problems of recruitment and retention.

Between 2001 and 2011 the number of community nurses fell by 38 per cent and there is a growing dependency on agency staff. Only in pharmacy does there appear to be a potentially adequate supply of newly trained graduates (PCWC 2015).

6 Local Context

Our catchment area is sub-divided into two district localities, namely Castle Point Borough Council area and Rochford District Council area. We serve a population of approximately 182,000 and approximately 22 -24% of our population are over 65, with over 75s amounting to just over 9%.

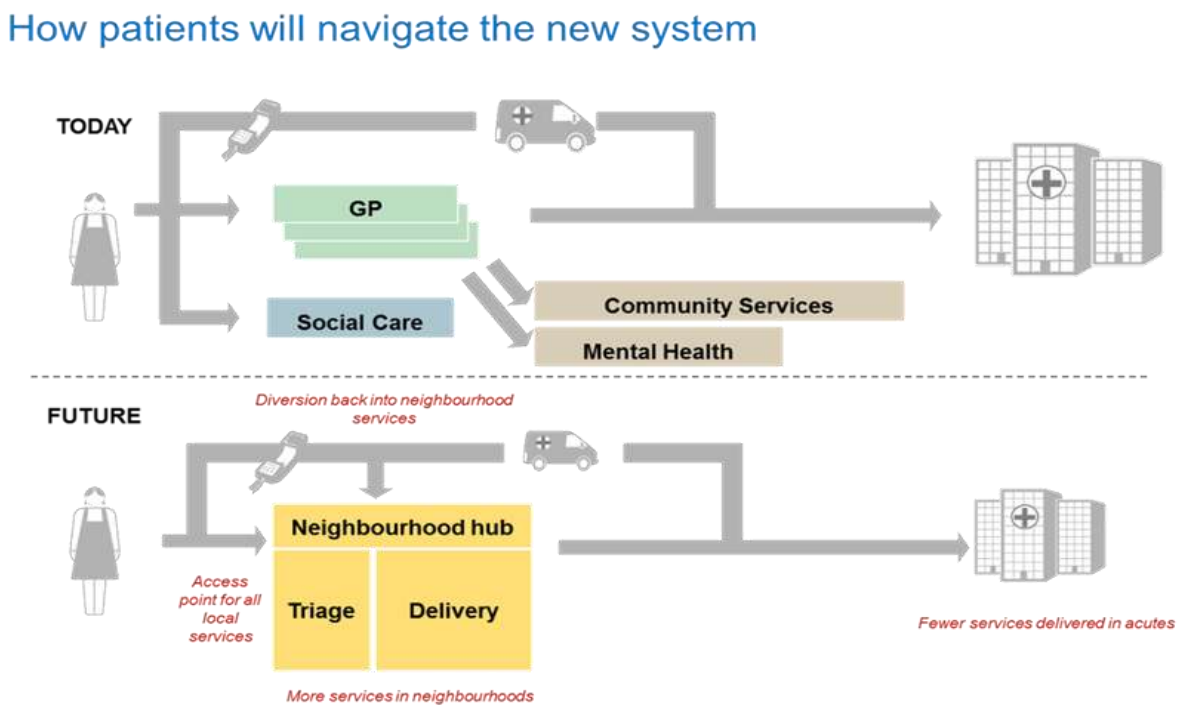
We have 25 GP Practices. Of the practices 7 are training practices which indicate both our and our partners' commitment to supporting the development and education of the workforce.

In 2015 the CCG Governing Body set out a strategic vision for developing integrated care model solutions centred around integrated commissioning, pooled budgets, population health management and multi-disciplinary teams working together to deliver an agreed set of outcomes. Part of this vision is to move towards a Hub and Spoke model of services and this strategy document encompasses this as part of the workforce transformation that may be required as a part of delivering this realigned service.

The CCG have been working with stakeholder colleagues across the County to consider the future workforce roles and structure required and the outputs of these form this outline vision for the future workforce. This document is the basis to continue to develop the debate with stakeholders and determine the work streams required to explore and take forward the strategy. The aim will be that greater integration between health and social care organisations will improve patient experience, delivering equitable provision to deliver effective, efficient and quality services in the most optimum way. The current model and

proposed future model can be seen Diagram 1:

Diagram 1 - Navigating Healthcare



7 The family experience of access to services

The CCG has a vision of how individuals and families, either moving into the catchment area or already resident here, could access our services. The aim is to provide a positive experience with ease of access to all the information they may require – a shop window to the locality with clear signposting to meet their needs.

As part of this work we will reach out into local schools to both provide the CCG vision to students but also to inspire students to consider a career in health related service. Diagram 2 below gives an idea of how this could be achieved and the kind of collaboration with stakeholders that would help achieve this vision.

Diagram 2: CPR CCG Vision for patient/family access to services

8 Function, role and management requirements for the Neighbourhood Team Service model

The key element of the Hubs for the patient to be at the centre of care for all services working together with a Care Coordinator helping the patient by coordinating the services throughout. The Buurtzorg model in the Netherlands has a nurse acting as "a navigator" for the patient and family, helping them find the most relevant and innovative solutions to receiving the care they need at home.

Consideration is being given by a number of CCGs as to whether this model could be adapted to the NHS England healthcare system. This requires a focus on patient care being delivered in the community at home.

Diagram 3 gives an overview of how a Neighbourhood Team Service Hub could be developed showing all the interlinked services, with Diagram 4 showing the patient at the centre of the services.

Diagram 3: Neighbourhood Team Service Model

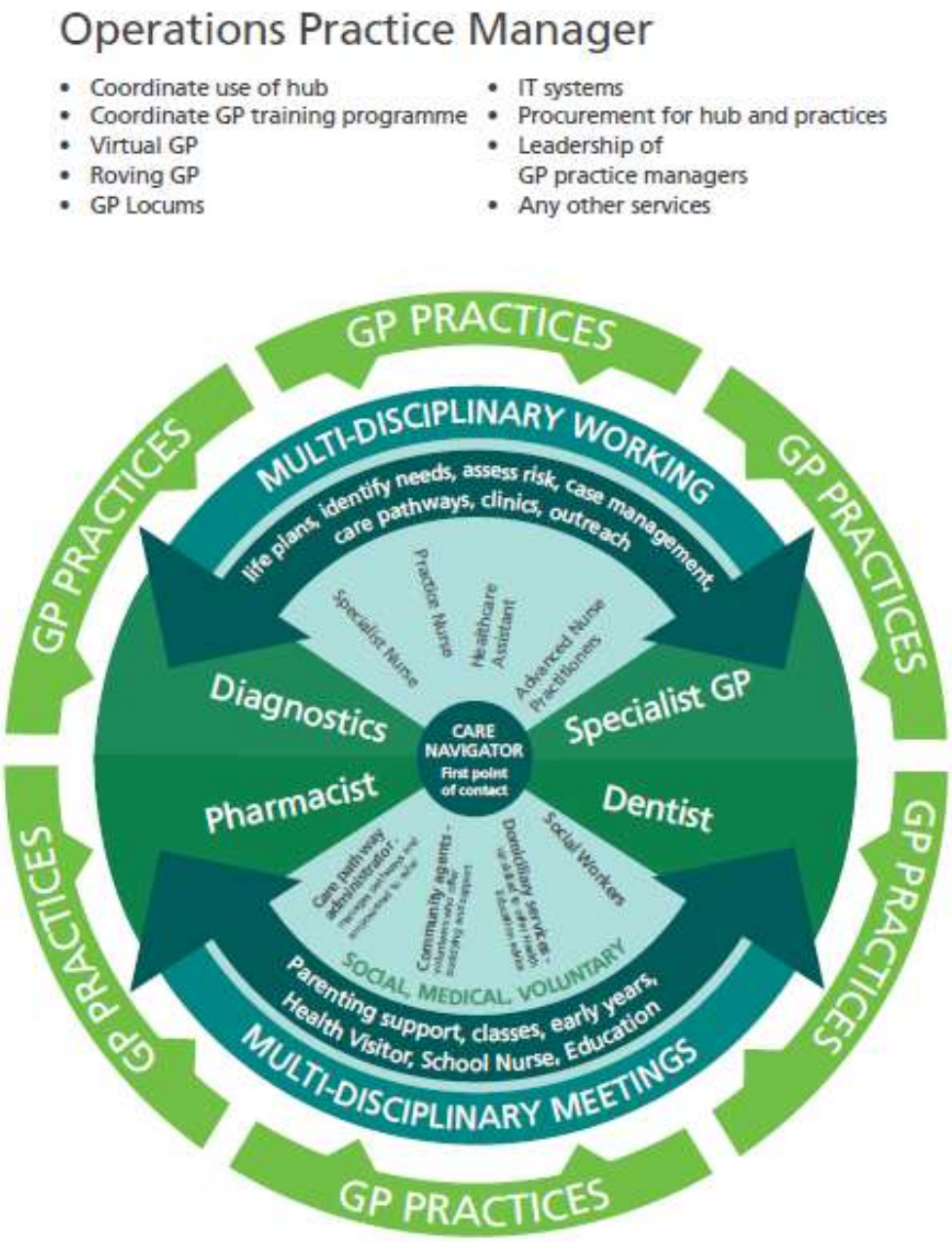


Diagram 4: Patient Focus

9 The Current Status of the Workforce for CP&R CCG

Health Education East of England (HEEE) have developed a detailed 5 year workforce strategy in conjunction with stakeholders. This describes the safe staffing levels for future provision and sets out the transformation programme required for developing the future workforce. All South Essex CCGs are engaging with HEEE to undertake this work and encouraging our providers to fully participate.

CP&R CCG's five year Strategic Plan includes detailed initiatives from the various workforce development initiatives and options that have been proposed (or are already in early stages of implementation) from HEEE, the Essex Area Team and the Essex LMC. These enable the Workforce Steering Group to evaluate and agree on the most effective and viable options for implementation within the confines of the available budget (currently £200k). Some of the workforce proposals in the document are aligned to the workforce development needs and objectives identified (CP&R CCG Commissioning Plan 2015/6).

The current status of the primary care workforce is detailed in Table 1 below:

Table 1: Issue/RAG status

ISSUE FOUND	RISK	INITIAL RAG	ACTION REQUIRED	IDEAL RAG STATUS
Ageing GP workforce	Inability to provide qualified GPs: Inability to provide mentorship to trainees; patient care will be compromised		Recruitment strategy to be given a high priority Skills retention strategies to include: flexible options for hours, days, skill updates, CPD to ensure ability to meet revalidation principles and	Skilled staff retained Trainee placements increase

ISSUE FOUND	RISK	INITIAL RAG	ACTION REQUIRED	IDEAL RAG STATUS
			encourage new ways of working	Recruitment is robust
National levels of GP Trainee Applications has reduced	The locality does not attract sufficient local trainees		Currently places are filled to capacity but this could reduce with increased competition from London/Cambridge and the limited capacity of GP Supervisor time in the Practices Rotational trainee programme to give variety of experience	All places fully subscribed
Capacity for GP Supervisor/ Trainer to increase GP trainee numbers	The locality is constrained by the number of Supervisor/Trainers currently in place and funded		Increase trainer time provision by use of retired/flexi time GPs on a flexible basis. This will also demonstrate the benefit by retention of skills and experience to provide mentoring support to trainees and also to newly qualified GPs and potential nurse prescribers.	Increased GP trainee places available Increased attraction for GP trainees and recruitment when qualified
Recruitment of GP Trainee on qualification	Inability to recruit into vacant posts, salaried or partnership		Recruitment strategy to offer flexible, salaried contracts across the whole CCG area Hub posts which highlight the flexibility, professional satisfaction and quality services values of the roles The advantages of working in Essex to be given a higher profile on website to engage prospective applicant when landing on home page CCG website to be linked to facilitate advertising all local vacancies - all stakeholders linked	Increased applications for GP roles Hubs become beacon site for trainees
GP Retainers	Inability to ensure GPs who are considering leaving the profession remain		CCG to actively promote this scheme more widely	Increased applications for retainer scheme
Ageing Nursing workforce	Inability to provide qualified nursing services; Inability to provide mentorship to student nurses; inability to supervise and mentor the HCA		Recruitment strategy to be given a high priority Skills retention strategies to include: flexible options for hours, days, skill updates, CPD to ensure ability to meet revalidation principles and encourage new ways of	Skilled staff retained Student nurse placements increase Recruitment is robust

ISSUE FOUND	RISK	INITIAL RAG	ACTION REQUIRED	IDEAL RAG STATUS
	workforce; patient care will be compromised		working Consideration of the employment model of nursing workforce to attract and retain qualified nurse workforce	
Poor recruitment levels for Qualified Staff	Inability to provide qualified nursing services; Inability to provide mentorship to student nurses; inability to supervise and mentor the HCA workforce; patient care will be compromised		The role of nurses NP and ANP need to be standardised Terms & Conditions of employment need to be standardised Evidence professional development, skills enhancement and role development opportunities	All posts filled Recruitment robust ANP roles developed to lead in specialities GP workload reduced Lack of career framework for nursing development.
HCA role, skills and competencies variable	Inequalities of standards of care; inequality in terms and conditions; Care certificate not apparent; risk in care homes also		The role of the HCA need to be standardised Care Certificate needs to be planned and work commence for HCAs to be able to achieve this minimum standard Terms & Conditions of employment need to be standardised Personal development, skills enhancement and role development, career opportunities need to be evident	Roles are standardised and recruitment is robust to meet standards Recruitment is robust Role and career development opportunities

A number of new roles/services were recently put in place to support these initiatives/proposed model and these will help the movement towards developing an integrated workforce. These are detailed in Table 2 below.

Table 2: New Services and Roles

❋ **A Care Co-ordination service:** This was launched in September 2015 providing a 7-day service across the localities which offers support to those identified as complex/at risk. Named coordinators are

allocated to patients, undertaking regular reviews to ensure outcomes are achieved and patients are managed within their own home, supporting them to stay healthy and independent as long as possible.

Alongside this new role and an integral part of the pathway is the establishment of the locality based MDT meetings which case manage patients and develop a single multi-agency care plan. These developments are still at an early stage but are critical factors in enablement of joint working and cohesive patient care management from both a health and social care perspective.

- **GP Practice – CQC Inspection/Visit Preparation Support:**

This innovative role has been created to support GP Practices be better prepared for CQC visits and helping the practice meet its CQC obligations inspections. This has been a welcome support mechanism especially with a stretched clinical workforce and clinical activity at an all-time high.

- **Lead Nurse – Revalidation Support and Development:**

This role is to help support the nursing staff in meeting the needs of Revalidation. This includes the opportunity for nurses to have a "Confirmer" who has an understanding of their role and can provide professional leadership and guidance.

The CCG has taken the initiative by using this role to establish a nurse forum to facilitate professional networking, networking and sharing of ideas/practice. This support includes support for nurses working in care homes. The forum will be an excellent place to consider development needs and help support ways of meeting those needs with HEE, ECC and other stakeholders.

- **Social Workers:**

The introduction by the healthcare provider of two social worker appointments working as part of the MDT, will be able to be engaged in the Neighbourhood Team model. These roles focus on a user/patient enablement model and would be able to provide a valuable opportunity to be a part of a signposting function to other services.

These new roles have already had some success by working closely with the nursing team, and help remove some of the role barriers to deliver the right service and facilities the patients and carer need with joint working. It is planned that evaluation of these roles will cover both the patient and carer experience and include assessing any improved quality of life criteria.

- **Apprenticeships:**

The CCG is keen to develop this scheme and has already started progress on this journey with one placement in the CCG plus a further post has been successfully completed in one of the GP practices. This success has helped to engage partners and it is an expectation that by offering a variety of experiences, this will be an attractive career option to take out to schools and colleges in the locality as well as continue to develop the course proposition with HEE. (See Diagram 4 for the career pathway envisaged)

10 Other new roles/ways of working to support the Neighbourhood Team

To deliver services optimally in this format requires a workforce strategy that covers all services including social care. There also needs to be some consistency in recruitment practices which are variable across the practices perhaps due to a lack of Human Resource expertise and input available to them. Therefore it is important to build a joint workforce strategy that is agreed across stakeholders with robust HR process in place. Diagram 2 indicates the workforce for a Hub model.

10.1 Leadership

All new workforce models will require creative, motivated and inspired leaders open to new ways of working which will need to remove some of the traditional boundaries. Member Practices will be crucial in continuing to provide excellent clinical leadership.

Senior Practice Manager/General Manager role. This role could be the professional lead for all the practice managers to link into - giving support and leadership.

The role could take on a function of potentially pulling into the Neighbourhood Team some of the back office functions such as a centralised procurement role for all the practices. This would potentially enable reduced costs improved purchasing power due to scale and would meet some of the procurement recommendations of the Carter review.

In order to achieve this we will commission a joint development programme including Social Services, Practice Managers, Acute and CCG staff. This should include validated competencies, shadowing and action learning ideally resulting in a recognised qualification. This could be commissioned from Essex University and using their current modules such as Leadership in Health and Social Care and a selection of their optional modules that best meet the needs of all participants. Exit level could be at Post Grad Certificate or Diploma with Essex University being the awarding body.

10.2 Neighbourhood Team – Core Staff

There needs to be a consideration of the general management of the “Hub” and this will need to include new combined roles, as well as potentially centralised employment of some staffing groups.

Another consideration is to move the line management/employer to change from an individual practice to a different host organisation to enable a move to team working within the Neighbourhood.

10.3 General Practitioners

The Essex Area Team’s Primary Care Strategy recognised that the County already has one of the lowest concentrations of GPs per 1,000 patients in England and needed to recruit an additional 143 WTE GPs just to reach the English average. 46% of GPs in Essex are due to retire in the next 15 years. (Source: North & South Essex LMS GP Workforce Survey, 2014). The GP Workforce survey confirmed from responders that 50+ GPs and approximately 25 nurses across the County were planning to leave within the next twelve months. The demographics of the workforce would suggest that this was a reasonable reflection.

Across CP&R CCG there are 108 GPs in 25 practices who serve a population of 182,000 and approximately 22 -24% of the population are over 65, with over 75s amounting to just

over 9%.

Nationally GP consultation rates increased by 40% in the period 2005 – 2008 and are predicted to continue to rise by a further 35% by 2035. The average member of the public now sees a GP almost six times a year, twice as often as a decade ago and the average time a GP spends with each patient is now just under 12 minutes, compared with just over eight minutes in 1993. Demand on GPs in the county will only increase as the number of patients with long term conditions increases. This particular patient group currently makes up around 50% of all GP appointments (Source: North & South Essex LMS GP Workforce Survey, 2014).

As previously mentioned the GP workforce is an ageing one with many GPs planning to retire in the next 5 years. Pension arrangements mean that early retirement is financially viable especially with the amount of locum work available.

Any future strategy needs to recognise that this deficit may not be retrievable so we need to act thinking about future recruitment and in the absence of success, how the Multi-Disciplinary Team is constructed differently.

In Essex there is full recruitment to GP training but this is because of London circuits being oversubscribed. This turns what could be an advantage into a disadvantage with trainees coming to Essex to train and then returning to London.

10.3.1 GP trainees

Although there is a high number of training practices and support already in place in the area, an increase in the number of training places gives more opportunity to recruit. If these could be further expanded, consideration of the logistical support required needs to be considered to prevent overloading the current level of trainers available. One option would be to consider the potential of GP retirees taking on training responsibilities to provide further support to the practices and how this could be funded.

To maximise opportunities for recruiting good candidates when there is not a partnership/post available, consideration of offering a GP practice placement in the doctors' first year could prove beneficial. This has proved successful in the past.

The issue of GP trainees returning to London could be mitigated by setting criteria whereby priority for training is given to those who live in the area and the development of a career pathway.

10.3.2 GPs/Practices

Increase the use of salaried GPs. These posts could be employed by a host organisation or by the CCG in a new approach to service provision. It would be a new approach but worth considering as there is evidence from the national picture that stability and certainty is becoming a more attractive proposition.

There is a need to develop different and more flexible working arrangements that allow health care professionals to use their specialist skills as noted in the North & South Essex GP Workforce Survey as an option that could encourage recruitment and retention.

Also suggested by the GP Workforce survey was a desire for more flexible contract options that allow the development of "special interests" and an improved work/life balance. Given the GP workforce demographics this should be seen as a priority.

GPwSI appointments CCG wide with a focus on Long Term Conditions, Care of the Elderly, Diabetes may assist in building the relationship and professional development across the acute/primary care sectors. Although these roles have been used with varying degrees of success, this does link with the GP Survey suggesting specialism is attractive.

By developing flexible, specialist opportunities and varied working arrangements these could be a significant aid to recruitment into primary care given the present discontent of junior and middle grade doctors in the acute sector. This could provide the work/life balance desired which is being cited as a key issue in the current dispute.

The CCG could consider having a placement for GPs to go into while they wait for a post to become available - such as a research role or community liaison role.

Roving and Virtual GP roles are being trialled in other CCG “Hub” services (West Heath Hub, Birmingham and Bradford). There could be the potential to learn and consider these in more depth by contacting/visiting one of these CCGs with a number of the GPs.

- Consideration of the Neighbourhood Team Service employing a “roving GP” to undertake emergency visits and/or care home visits in order to prevent admission to acute sector.

- Explore alternative ways of working such as SKYPE whilst being aware of the likely impact on indemnity costs.

- Potential of employment of a “virtual GP” for the Hubs to undertake skype/teleconference consultations; (this model could be used by nursing, community pharmacy as well as GPs)

To manage locum services with assured safety, quality and cost effectiveness the CCG could:

- Develop a GP bank/pool in line with the Hubs that can work across the boundaries
- Negotiated with the GP Federation to increase cross cover and reduce reliance on locums
- Introduce a locum rate cap (in line with the new GP contract) to help reduce the use of Locums, standardise the rates paid across the County. If managed centrally, there could be gains due to collective purchasing power

GPs could be offered development opportunities in the CCG to better understand commissioning.

11 General Practice Nurses and Health Care Assistants

Nationally the picture of the GPN workforce is one of an ageing workforce of whom 33.4% are due to retire by 2020 (QNI 2016) and this is consistent with the local GPN workforce.

Although there is evidence from the local HEE that Student Nurse Attrition has reduced considerably, never the less commissioning numbers are still insufficient and this is likely to become more of an issue with the removal of the bursary.

Nationally almost 90% of GPNs do not hold an NMC recordable specialist practice qualification in General Practice Nursing (QNI 2016) and it is clear that CP&R CCG member practices have widely varied approaches to GPN development.

There is evidence that Advanced Nurse Practitioners (ANP) reduce admissions, waiting times are shorter, patients have better access to services and care can be provided in the community. ANPs Practitioners score highly in patient satisfaction surveys and are shown to reduce GP workload (Pierce & Belling, 2011).

The nursing workforce locally is ageing and it is proving difficult to attract recruits. However, with limited opportunities for career development, variable salary progression, terms and conditions of employment it does not appear an attractive proposition.

Unfortunately the impression that this role could be career limiting is likely to be the overall impression with student nurses and experienced nursing who therefore opt for other more "dynamic" pathways. However, the autonomy and 1:1 patient contact that GPNs have is something that could be used as a recruitment attraction initiative.

The potential of specialising and leading in a number of long term conditions, and enhanced roles such as the ANP, could be attractive if managed differently perhaps.

11.1 For Pre-employment - Apprentice style scheme (pilot opportunity)

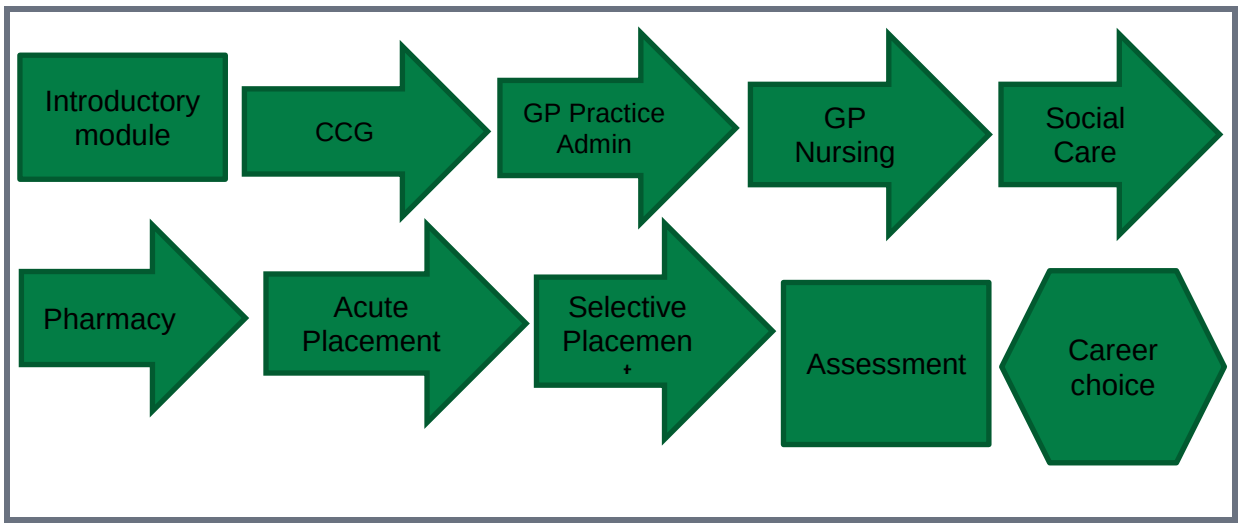
This is an opportunity to be creative in developing interest in a career in health and social care. Examples are, cadetships, apprenticeships and work experience models.

Cadetship/Apprentice schemes can work in a number of ways with introductory placements in the CCG, GP practices, working alongside nursing, pharmacy as well as in the social care environment.

A scheme covering a 2 year programme would not be unreasonable as it would give a reasonable amount of placement time in a number of areas to gain a realistic insight and determine next career steps. An example of a module pathway is shown in Diagram 5.

As stated previously, the CCG have already taken great strides forward in this area with apprentices and have planned to promote the extension of the number and variety of placements including the CCG.

Diagram 5 - Introduction into Health & Social Care Apprentice Model



11.2 For Student nurses and preceptorship

To continue to work closely with HEE to help influence an increase the numbers commissioned with the variety of placements and rotational programs offered to improve quality and placement experience.

An innovative development would be for CP&R CCG itself to become a placement for Student nurses.

Develop nurse mentors to support student nurses in CP&R CCG member practices. This may encourage students to consider GPN roles when newly qualified. This might be a role for newly retired GPNs.

Preceptorship programme for newly qualified or career change nurses. This would take approximately 12 months and be hosted by one practice with other practices supporting placements. The programme could be split so preceptees have two general practice experiences of six months' duration; additionally they would need to take part in short placements with community and secondary care team and seek opportunities to work in nursing homes, pharmacies and in third-sector organisations.

11.3 For Health Care Assistants

Care Certificate
Following the report of the Francis Inquiry in 2013 which identified serious failures in healthcare provision, Camilla Cavendish was asked by the Secretary of State to review and make recommendations on the recruitment, learning and development, management and support of healthcare assistants and social care support workers, to help ensure that this workforce provided compassionate care.

As a result the Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health. Designed with non-regulated workers in mind, the Care Certificate is a set of standards that social care and health workers stick to in their daily working life and sets out the minimum standards that should be covered as part of induction training of new care workers.
The 15 standards in the Care Certificate are:

Understand your role	Your personal development	Duty of care
Equality and diversity	Work in a person centered way	Communication
Privacy and dignity	Fluids and nutrition	Awareness of mental health, dementia & learning disability
Safeguarding adults	Safeguarding Children	Basic Life Support
Health and Safety	Handling information	Infection prevention and control

70% of assessment is knowledge based, 30% is to be assessed in practice.

The Care Certificate was launched on April 1st 2015, with organisations having until September 2015 to implement it. Whilst the Care Certificate is not mandatory providers regulated by the CQC are expected to ensure that the standards of the Care Certificate are covered in their induction of new staff.

> *"CQC expects providers to induct, support and train their staff appropriately. In our guidance for providers on how to meet the regulations, we are explicit about our expectation that those who employ health care support workers and adult social care workers should be able to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction."*

We need to consider how best we can include in contracts with Care Homes for assurance that staff have or are working towards the Care Certificate to meet the obligations outlined. This is an important quality and governance criteria to support our commissioning quality, safe services for those using these services.

The Care Certificate is itself the start of the career journey and is only one element of the training and education that will make new staff ready to practice within their specific sector. Although the Care Certificate is designed for new staff, it also offers opportunities for existing staff to refresh or improve their knowledge. Therefore, we need to consider if and how we can support current employers help their staff meet the standards and issue Care Certificates. Such a strategy would potentially help to "grow our own" nursing workforce locally.

Other considerations for the strategy for Health Care Assistants include:

- Standardised Terms and Conditions to help plan for and overcome the challenges of the implementation of the new minimum wage

- Standardised Role Descriptors to give consistency and potential to share these and the recruitment standards with Essex Council Social Care and explore the potential of a rotational placement
- Develop a standardised development programme for gaining additional competencies and a route to Associate Practitioner roles, entry into nursing, if desired

The Practices and CCG have embraced the HCA role and the development opportunities. The key now is to set the standards and competencies to ensure clarity about the role and its responsibilities, as well as provide professional support and development opportunities.

11.4 A new role: Associate Practitioner

This is a new development which would give a development programme for the current HCA workforce.

It gives an opportunity for HCA's to be recognised for their advanced skills therefore there is a need to work with HEE to enable a conversion-style programme which will recognise current skills, competencies and experience.

The role has potential to attract new applicants to work in the community due to the career pathway it offers. It is within this role that there is potential to consider different ways of working by these being joint roles with Social Care. The Associate Practitioner role could certainly be a role that could be utilised for domiciliary care; it could be a gateway to a social work career pathway as well as into nursing.

It would be strategically very innovative to take the opportunity to take a broader approach to the Associate Practitioner role than just a gateway into nursing. There is no reason why this role should not include a navigator role of some kind.

Nationally there is a consultation around the Nursing Associate role which would give the Associate Practitioner the opportunity to have a recordable qualification.

11.5 For General Practice Nurses

There is a need to utilise GPNs to give better quality care to long term conditions such as one stop shop QOF clinics.

This will include the increased use of Patient Group Directives to help give increased autonomy to nurses and balance the workload for the GPs.

There is also the need to iincrease the number of nurse prescribers. The NMC standards state that only a designated medical practitioner currently in GP practice can supervise nurse practitioner training. CP&R will need to consider payment to GPs in order to facilitate the increase in Nurse Prescribers. Additionally, it is important to recruit and continue to develop ANP roles to enable and support 7-day services and increased demand.

Whilst the trend towards Physician's Assistant roles is welcome in this case CP&R CCG believes that ANPs, as independent practitioners, are better able to relieve the workload of GPs. A pilot role could be introduced and evaluated. This might be in supporting care homes where GPs will benefit from the reduction in time spent on home visits.

Standardise the following for GPNs:

- Terms and conditions, this would include titles, job description, competencies, salary scales
- Indemnity would be covered as standard employer responsibility
- Access to development and training formalized and linked with appraisal
- Support with revalidation
- Career pathway opportunities

There is now an opportunity to continue to build upon earlier support to Practices and nurses to further develop new Specialist Leads roles to work across the CCG, linked with and supported by the GPs and Acute Sector. These could include

- Care Home Support and Link especially for triaging
- Care of the Elderly – work with the Social Workers on enablement as well as support
- Diabetes management
- COPD
- Dermatology

All of the above nursing roles should be available and in line with HEE (2015) standards as shown in Diagram 5. It should be noted that there is a large number of GPNs who are in Level 6 already.

Diagram 5 - HEE Framework

	Developing People for Healthcare - General Practice Education and Career Framework
	Minimum Professional and Educational Requirements for the role
Advanced	• Registered with the Nursing and Midwifery Council

Community Nurse Practitioner Level 8	• Post graduate diploma meeting ANP requirements and to include level 8 high intensity interventions (see NICE guidelines for descriptors of behaviour change interventions) • Masters degree • Independent and supplementary prescribing
Senior General Practice Nurse Level 7	• Registered with the Nursing and Midwifery Council • First degree and working towards postgraduate level qualification • NMC mentorship qualification • Independent and supplementary prescribing – V300
General Practice Nurse Level 6	• Registered on Part 1 of the Nursing and Midwifery Council register • Degree level qualification/equivalent experience • NMC Specialist Community Practitioner Qualification – Practice nurse/relevant experience • NMC mentorship qualification
General Practice Nurse Level 5	• Registered on Part 1 of the Nursing and Midwifery Council register
Assistant Practitioner Level 4	• Higher Care Certificate (currently under development) • Hold or working towards Foundation degree at level 5
Health Care Assistant Level 3	• Care Certificate (highly recommended) to include, or have as an addition, training for working alone in community settings and specific skills needed for the role • Level 2 brief intervention training (see NICE guidelines) • Level 3 apprenticeship or QCF level 3 Diploma in Clinical Healthcare Support or the equivalent • Maths and English functional skills qualification
Health Care Assistant Level 2	• Care Certificate (highly recommended to include, or to have as an addition, training for working alone in community settings and specific skills needed for the role • Hold or working towards Level 2 QCF Diploma in Clinical Healthcare Support or equivalent • Maths and English functional skills qualification – *some of the requirements may change when new NOS are published*
Pre-employment level	• Examples: work experience, traineeship, pre-employment programme, cadetship

To progress this vision, all of the above might be best achieved by GPNs being centrally employed and deployed into member practices. If this is not the preferred way forward the CCG has a role to play by ensuring member practices employ best HR practices and by offering advice and a lead on development.

12 Community Pharmacy - Care home medicine management: Opportunity for a pilot

Although the locality does have two community pharmacist roles in place which provide support, there is the potential to broaden the scope of support that could be offered. There

have been several pilots over the last 3 years whereby pharmacists have been involved in projects to monitor and review medicine prescribing and management in care homes (Andalo, 2014; Copeland, 2016; Okoli, 2013). These projects have reaped benefits in improving training of care home staff, quality improvement with the overall management and reduction in waste of medicines as well as tangible cost savings. Two examples are below:

- Savings on prescribing equaled £184 saved for each resident for a project covering 77 care homes (Copeland 2015);
- Reduced the volume of prescribed medicines by 15 per cent with a net saving of £62,000 on the drugs budget - in 15 care homes (Andalo 2014)

The pharmacist(s) considered the following elements:

- whether residents still need the medicines prescribed
- what symptoms they have
- what illnesses they have now

From this evidence plus the patient record, and any test results, consideration was given to the dosage they need with a full risk and benefits assessment. The pharmacist discusses the results of their review and recommendations with the patients' GPs. It is a one-stop medicines service to optimise the use of the patients' medicines at their time of life. This role could provide a very flexible model of employment for a community pharmacist(s). The role need not be tied to office hours if evening, weekend work was a more attractive option, along with possible part time working and directly patient facing.
The CCG need to consider a pilot and potential research project: The project would be for a pharmacist to undertake a systematic review of care home residents and their medications, the role to include the assessment of the medicine management competency of the care home staff, offering or facilitating further training/development to improve these as needed. Depending on the number of care homes in the area, it may be necessary to utilise a second pharmacist post or a pharmacy technician role to assist.

Funding may be possible to be sourced from current research funding, social care partners or if available redirect funding from any vacant community pharmacy post. The alternative is to sourcing research funding from relevant organisations or consider the potential return on investment from prescribing savings as being sufficient to fund the post. Flexible working could be an attractive option for these roles.

13 Recruiting and Retaining CP&R CCG staff

CP&R CCG is seen as a good place to work and has high retention across all staff groups which is reflected in the staff surveys, low attrition and recruitment levels. This good news message needs to have a higher profile perhaps on the CP&R CCG website.

This will include Embracing Apprenticeships, where the CCG is seen as a place where people can develop their working role.

However the current website could be better utilised to make Essex overall a more attractive place to work and live. The website should also be aligned to the Essex Council and Social Care website with joint messaging. This would be the "shop window" to help patients and service users navigate services available and be a useful "signposting" mechanism.

Undertaking work to develop more robust care pathways which include social care would mean it would be possible to consider administrative roles which are empowered to support patients along the pathway. This would involve monitoring the patient journey and expediting it when necessary by making referrals, appointments to other agencies and services such as diagnostics. This could be dovetailed with the signposting role in the hub.

An opportunity has been missed by referring any interested applicant direct to the NHS vacancy website. CP&R CCG member practices could benefit from having their vacancies also advertised on the website as could other stakeholders in Social Care.

Development opportunities for health and social care staff are not easily found and could be more prominent both for current staff and to make the area more attractive to prospective employees.

13.1 Revalidation for CP&R CCG nursing staff

A robust plan and supporting activities have taken place to ensure nurses are ready for revalidation. In addition, as previously stated, the CCG has invested in a supporting Lead Nurse role which will also provide Confirmer support to all nurses in both primary care and care homes. This is a real benefit and indicates the level of importance the CCG puts on clinical leadership and support.

However there is a need to review this plan again with regard to indemnity as the QNI (2016) report indicated that many GPNs believed their RCN membership included indemnity. The RCN does not provide indemnity cover if nurses are employed and it would appear that a number of GP Practices may be expecting that their nursing staff provide this themselves. This could be a disincentive to prospective applicants and it is important that this is clarified both for the nurses and to the GP Practices to avoid any misconceptions.

There are concerns that nursing staff may not be receiving sufficient and appropriate development opportunities to meet the criteria for revalidation. However, it is expected that the new Lead Nurse role will help assess this more clearly through the forum activity and via revalidation support process now in place.

This gives the CCG a number of opportunities to ensure that the primary care nurse workforce is supported to achieve their maximum potential – a benefit to patients, employers and the nurses themselves.

14 Next steps

Aims	*By whom*	*By when*
Leadership		
Individual Member practices to continue to provide excellent clinical leadership		
Commission a joint development programme		
Care Co-ordination		
Evaluate the role		
Hub core		
Consider where line management best sits		
Consider centralising roles such as procurement to support GP		

practices that 'feed'into the Hubs		
Trainee GP		
Recruit people living in Essex		
Mentors for GPs		
Increase training capacity		
Develop a rotational Trainee programme		
Offer placements early in the training		
GP		
Increase the use of salaried GPs		
Develop and support flexible working arrangements across CPR		
Make GPwSI appointments CCG wide with a focus on ▪ Long term conditions ▪ Care of the elderly ▪ Diabetes		
Consider Roving GPs model for the hubs		
Consider virtual GPs for the hubs		
Offer development opportunities in the CCG		
Develop a GP bank		
Negotiate with the GP Federation to increase cross cover		
Introduce a locum rate cap		
Apprentice		
Build on the success of the first two placements		
Student nurse		
Increase the commissioned numbers		
Offer a placement in the CCG		
Develop nurse mentors		
Preceptorship		
Develop a preceptorship programme for newly qualified or career change nurses		
HCA		
Standardise terms and conditions of employment		
Develop a strategy for implementing the Care Certificate		
Standardise core role and look at opportunities with Essex Council social care		
Associate Practitioner		
Consider a pilot role which works across health and social care and includes a navigator role		
GPN		
Standardise terms and conditions of employment		
Flexible working options		
CPD and support for revalidation		
GPNs to offer one stop shop QOFF clinics		
Increase the use of PGDs		
Increase the number of nurse prescribers		
Develop specialist lead roles across the CCG		
Clarify position in regard to indemnity		
Pilot ANP role with care homes		
Community Pharmacist		
Pilot and potential research project		
CCG		
Lead nurse support with revalidation and development		
Ensure member practices are employing best HR practices		
Develop the website to: ▪ Give a positive image of the area ▪ Advertise all vacancies in the area in health and social care		

▪ Make development opportunities obvious		
Care Homes – ensure the homes are included in any workforce initiatives.		
Reach out		
Care Navigator		
Work on care pathways so that a Care Navigator can be effective		
Consider a Care Navigator role		

15 Summary

It is clear that for the future service and workforce models to work a comprehensive estates and IT strategy is required to complement this strategy.

The Hubs need to have a number of roles and services embedded to enable the service to run as a One Stop Shop with near to patient diagnostics, nurse led services, midwifery/Health Visitor services, and Social Services along with Specialist GP sessions. This will then enable MDT formation and collaboration at a much enhanced level.

This strategy and vision paper is to lay the basis for the next stage in CP&R CCG's journey to deliver an innovative, integrated care workforce model. It will be a challenge to overcome deep rooted cultural and established practices to move to new roles, new practices and joint working not only individually but across individual organisations and care providers.

Senior leadership and clinical ownership to engage with all stakeholders is an essential criterion to deliver complex change on such a scale. The CCG has worked hard to develop and build relationships across all stakeholder groups and it is well placed to lead this strategy.

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