Wessex
Academic Health
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The Wessex Primary Care Project

A Lifeline for Patients and General Practice: new ways for Primary Care in Wessex

NHS
Wessex
Clinical Senate

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Health Education England

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The Wessex Primary Care Project is sponsored by Wessex Clinical Senate and the Wessex Local Office of Health Education England and hosted by Wessex Academic Health Science Network.

Introduction

General Practice is widely acknowledged to be under pressure. The demands of it from the population, the system and the government seem to be rising inexorably; general practice is being asked to manage more conditions and of greater complexity, the needs of patients are increasing as they get older and suffer from more diseases, they are often unable to be seen in a timely manner or as for as long as they and the clinician would wish, prescription requests and administrative tasks are ballooning, and we are struggling to recruit new GPs and nurses.

In this paper we describe a range of initiatives that general practice can adopt to weather this storm. We were commissioned to evidence the problem and to find examples of how changes in ways of working can support the general practice workforce. A wide range of potential solutions has been promoted and trialled, from working differently, using different technology and/or access methods, to creating a multi-disciplinary team. These are summarised in this document to provide a guide to how and what you might change in your practice. Every practice is different and so you need to determine what will work for your patients, and your team, which is why we are sharing what we have learned rather than dictating solutions.

To help you assess the state of your practice and the impact of an extended workforce, we have developed easily operated software tools which are available at **https://gptools.nq-m.com.**

We will publish a more detailed and fully-referenced project report later in the year. If you would like more information about any aspect please access our main document but if you are unable to wait for publication of the full report, please contact **julia.carthew@wessexahsn.net.**

Dr Stuart Ward | Julia Carthew

The Wessex Primary Care Project team
July 2017







Chapter 1:
What is the Problem?

General Practice is struggling; the workload is rising, funding has not kept pace with demand, trainee doctors are in short supply, current staff are leaving or retiring early, it is difficult to recruit GPs and nurses and those that do join do not wish to work full time.

Population: in the five years to 2019, the Wessex (Hampshire, Dorset and the Isle of Wight) population is predicted to grow by 3.3% to 2.75m and by 6.5% to 2.9 million by 2024. Critically, the increase in number of older people will be more pronounced, with the 75-85 year olds increasing by 11.1% and 38.8% and those over 85 by 11.6% and 30.4%, in five and ten years respectively. The prevalence of conditions requiring medical input increases with age, mirrored by an increase in consultation rates for older people.

Workload: in primary care has expanded in recent years, not only due to the population increase. Prescription numbers have increased, from an average of 13.7 items per person/year ten years ago, to 19.6 items. In the past five years, recorded patient contacts (face-to-face and phone) within Wessex have increased by 24.9%. This masks the complexity of and time taken by many of the patient contacts, as general practice undertakes more complex work and the range of tests and treatments expands.

WESSEX - CHANGE FROM 2014	2019	2024
The **population** is expected to grow by	**3.3%**	**6.5%**
The **75-85 year olds** will increase by*	**11.1%**	**38.8%**
Appointments will increase by	**16.5%**	**35.7%**

Table 1. Predicted population changes to 2019 and 2024

* By 2024, the NHS will be caring for an additional 94,400 people over 75 in Wessex

Funding: despite the general perception, funding for general practice has increased in recent years but has not kept pace with increasing workload. Whilst patient contacts have increased by almost 25%, funding has only increased by 12.5% over the past 5 years. This has been recognised nationally and an extra £2.4 billion has been identified for general practice as part of the General Practice Forward View (GPFV) published in 2016.

Morale: has been evaluated every three years since 1998 by Warwick University and the latest study (2015) shows that overall satisfaction is at its lowest ebb since 2001. This has contributed to more GPs working less than full time and fewer becoming partners. Resignations and retirements are increasing, with GPs retiring at the average age of 58 years. This is a particular risk to the Wessex workforce as 35% of Wessex GPs by headcount, and 41% by full time equivalent (FTE), are over 50.

A survey by the Wessex Local Medical Committees (LMCs) demonstrated that:

- more than 20% of GPs intended to retire earlier than initially planned;
- nearly 30% intended to reduce the number of sessions they worked;
- nearly 40% of practices were currently short of GP sessions; and
- 28% of practices had failed to recruit to a vacancy in the previous 6 months.

Satisfaction domain	Mean Satisfaction Rating								Change
	1998	2001	2004	2005	2008	2010	2012	2015	'12 – '15
Hours of work	3.70	3.32	3.94	4.86	4.21	4.39	4.09	3.56	-0.53
Remuneration	3.48	3.51	4.38	5.30	4.73	4.87	4.56	4.20	-0.36
Amount of responsibility given	4.90	4.59	5.05	5.43	5.20	5.33	5.16	4.85	-0.31
Recognition for good work	4.21	3.57	4.28	4.80	4.46	4.65	4.52	4.25	-0.27
Opportunity to use abilities	4.64	4.27	4.85	5.19	5.01	5.11	5.08	4.87	-0.21
Freedom to choose own method of working	4.87	4.35	4.66	5.00	4.65	4.91	4.78	4.58	-0.20
Amount of variety in job	4.94	4.76	5.06	5.26	5.23	5.38	5.28	5.16	-0.12
Physical working conditions	4.99	4.86	4.91	5.08	5.07	5.23	5.30	5.20	-0.10
Colleagues and fellow workers	5.31	5.37	5.60	5.65	5.49	5.54	5.56	5.71	+0.15
Overall Satisfaction	**4.65**	**3.96**	**4.62**	**5.21**	**4.68**	**4.87**	**4.54**	**4.14**	**-0.40**

Table 2. GP Worklife Survey comparison (University of Warwick)

Workforce: between 2011 and 2014 the number of NHS hospital consultants across Wessex increased by 22%, whilst GP numbers increased by only 1.3%. GP partner numbers in Wessex dropped by 8% between 2013 and 2016. This reflects a change in newly-qualified GPs' preference for salaried and locum employment, a pattern that seems set to continue. In addition, the total number of GPs practicing nationally dropped in the last three months of 2016. Wessex has increased the number of GP training posts in the last few years but more recently has been unable to fill all these places, in common with most schools of general practice around the UK.

There is a similar situation for practice nurses in Wessex, 48% of whom by headcount and 55% by FTE are aged over 50 years. Both recruitment and retention of this key workforce have combined to form another threat to the sustainability of general practice as we now know it.

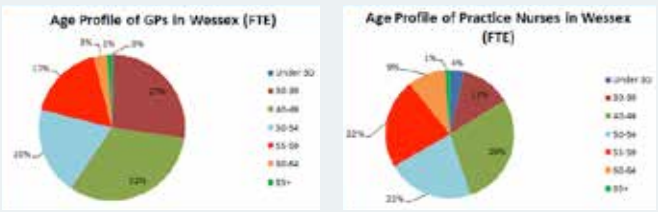


Figure 1. Age profiles of Wessex GPs and Practice Nurses

Chapter 2:
What can we do?

The public remains strongly supportive of the NHS and of general practice in particular, as shown in the latest patient survey (Fig 2). We need to change individual clinicians' ways of working and improve morale by doing things differently in Wessex. Although we continue to train GP registrars and practice nurses, their numbers are insufficient and we need to make general practice a more attractive option for them and for other staff who could contribute to patient care in practices.

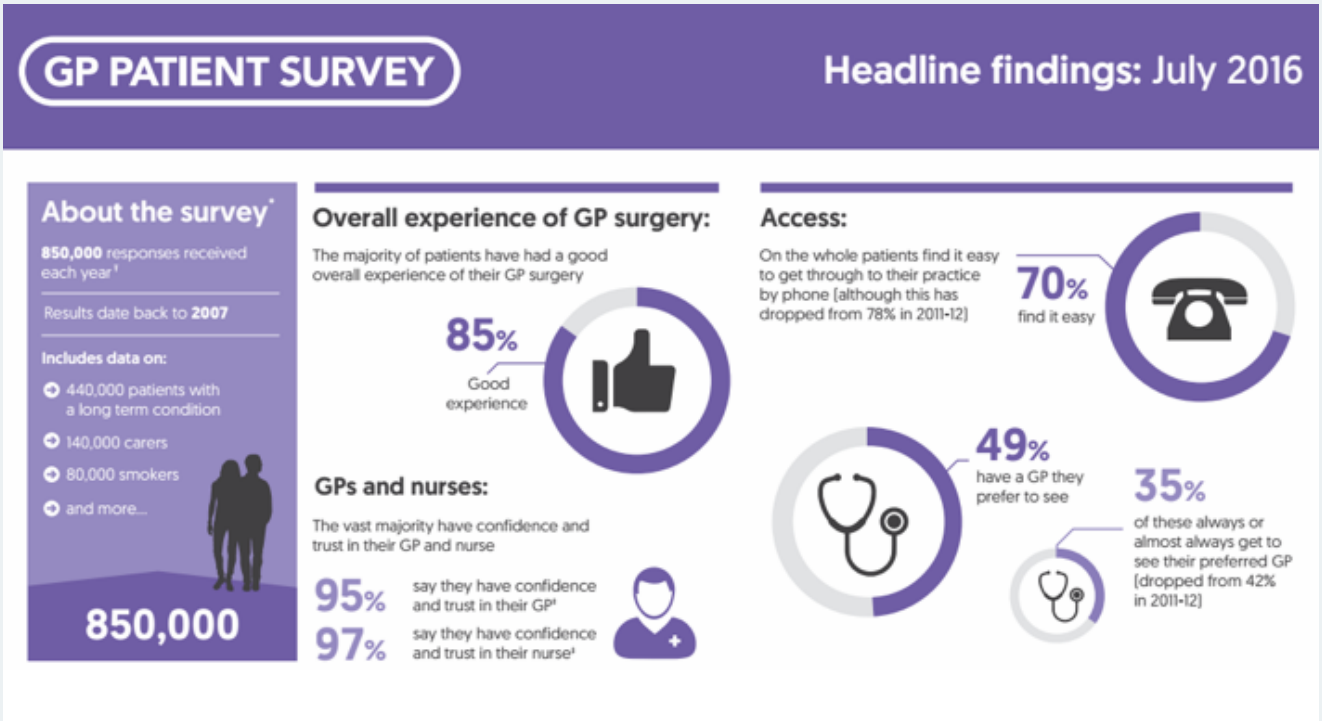


Figure 2. GP Patient Survey 2016 summary infographics

So how can we improve things, make the jobs more manageable and more attractive? Who else can work in general practice? How can we recruit these staff and what contribution can they make? We have attempted to provide answers to these questions using local examples.

This provides an opportunity for practices to assess the options which might best suit their situation. If you would like further information about any particular role or initiative, including the evidence for it, these will be provided in our full report.

We have focused on two main areas:

1. better management of demand and workload
2. new models of care through creating multi-professional teams who can meet the need of patients in general practice.

2.1: Making the job manageable

The volume of work within general practice is increasing and unlikely to reduce in the future, so how can we manage it better? The most important aspect of this is delegation, permitting and encouraging all staff to work to the 'top of their licence'.

This means best use of the clinical skills of GPs and Practice Nurses to do only those things that cannot be done by other staff. This involves the utilisation of other staff and systems to address both clinical and administrative tasks traditionally undertaken by the current clinical workforce.

Correspondence: the amount of correspondence arriving in a practice is enormous and up to 80% of this does not need to be reviewed by a GP. All correspondence can be screened by a suitably trained member of the administrative or clinical team. This can save at least an hour each week for the average GP and there are opportunities to increase this further by using more highly trained staff, eg for the management of prescription issues. Anecdotal evidence suggests that a reduction in incoming correspondence from 20 plus items to three or four important letters has an extraordinarily positive effect on GPs' morale.

- **Savings per GP per week = 60 minutes**
- **Cost to the practice:**
  - backfill for staff training
  - cost of staff time to manage mail, etc.
- **Training is currently available through CCGs (funded by the GPFV).**

Test Results: the average GP is likely to see 20-30 investigation results in a day. Many of these are for monitoring purposes only and can easily be managed, according to defined protocols, by staff other than GPs. Even if such screening of test results only saves ten minutes of GP time a day, this helps to relieve the pressure on each GP and makes better use of their skills to focus on the more complex patients.

- **Savings per GP per week = 45 minutes**
- **Cost to the practice:**
  - time to develop protocols and train staff
  - cost of staff to manage results
- **Training is not yet available, but 'in-house' protocols can be developed for relevant staff (eg Health Care Assistants or Pharmacy Technicians).**

Prescribing: is the most common health intervention within general practice. An average GP will deal with more than 50 prescriptions each day, the majority being repeat requests. In the past, each prescription required a physical signature but there are now safe and robust electronic systems which link to the Electronic Prescriptions Service (EPS). The EPS has the added advantage of forwarding the script directly to the pharmacist, making the process even more efficient and convenient for the patient and the practice, saving administrative time in printing and collating paper prescriptions. Although the GP time saved is only seconds for each prescription, the number dealt with each day means that this change can release over half an hour each week per GP.

Further time can be saved with the use of Repeat Dispensing Services (RDS), whereby the requirement for a regular prescription item is confirmed for six or 12 months and the pharmacist advised accordingly. This is also advantageous to the pharmacy for stock control. The pharmacist will dispense the item directly to the patient, with no further input required from the GP. This can avoid a significant proportion of prescriptions, improving convenience for patients and saving a further 15 minutes each week for each GP.

- **Savings per GP per week – EPS = 30 minutes + RDS extra 15 minutes**
  - extra savings in admin time (up to 3 hours a week)
  - minor savings in printer ink and wear
- **Cost to the practice:**
  - backfill for staff training
- **Training in EPS and RDS is currently available through CCG Medicines Management Teams.**

Making the job manageable: summary of time savings possible per week

Subject	Time saved per GP/week	Administrator time saved per week	Patient experience
Correspondence	60 mins		Neutral
Test Results	45 mins		Neutral
EPS	30 mins	60 mins	Improved
EPS + RDS	45 mins	180 mins	Improved
Total	**2 hours 15mins to 2 hours 30 mins**	**1 to 3 hours**	

Table 3. Summary of time savings possible per week.

2.2: Alternative patient contact

Currently the default method of managing a patient is through face-to-face consultation in the surgery. This is unnecessary if the issue can be managed without the patient present and is a potential waste of patient and GP time, using an appointment which could be offered to other patients. Telephone consultation is becoming more popular with patients as they do not need to rearrange their day to attend scheduled appointments. Occasionally, no GP contact is required and a telephone call from another member of the practice team is all that is needed. There is also an opportunity to expand the use of the internet for communication, particularly where an immediate response is not needed.

Telephone appointments: it is imperative that adequate time is allocated for these, such as during or after a 'normal' surgery. Telephone contact is usually quicker than face-to-face so a shorter appointment time can be allocated allowing more patients to be dealt with and improving access.

- **Savings per GP per week – variable - depending on internal processes**
- **Cost to the practice:**
  - increased practice telephone bill
- **Training – provided by practices in house.**

Telephone triage: is one way to control demand by triaging patients at the time of their initial contact with the general practice rather than immediately booking an appointment. A staff member, usually GP or nurse (occasionally others), telephones the patient back and either deals with the issue or arranges appropriate face-to-face contact. Speaking to the patient first can avail of a wider workforce as the patient can be directed to the most appropriate clinician for their problem. Dedicated time is required to manage these call-backs as an average practice can deal with 150 patient contacts each day. Depending on urgency, the patient may have to wait, occasionally for some hours, for the return call. Any subsequent face-to-face contacts may result in the workload shifting to later in the day.

There is a risk that the perceived ease of contact can increase the number of calls made, but this may be outweighed by the saving time by reducing the face-to-face contacts. For this process to be efficient, at least 50% of contacts need to be managed without recourse to face-to-face appointments and practices outside of Wessex have achieved this. The use of staff other than GPs to perform triage can yield more time for face-to-face contact.

- **Savings per GP per week – variable - depending on internal processes.**
- **Cost to the practice:**
  - increase in practice phone bill
  - triage clinician time (may be absorbed if process is efficient enough).
- **Commercial providers of triage systems may offer training.**

Remote access (e-consulting): online communication is becoming ever more popular and its use in general practice could substitute for some face-to-face contacts. Patients use online forms to record their problem for the GP to review. Again, an important element of using this type of communication is ensuring that time is made available for it. Most practices using this method have dedicated times for dealing with e-consultations. An e-consultation may result in a face-to-face contact, so the overall time taken to manage contacts in this way needs to be assessed to ensure efficiency as this is not avoiding work but dealing with it differently. Patients may find the process frustrating if they spend time working through a website only to find they still need an appointment that may be weeks away.

The ease of submitting e-consultations can lead to a significant increase in contacts, although there is only limited anecdotal evidence for this. At least one system does not allow use by those under 18 years old, nor accept relatives and carers submitting on behalf of the patient.

NHS England sees e-consultation as major component of the future of general practice, so CCGs have access to non-recurrent central funding to support the initial purchase and licence fees. A high proportion of patient contacts must be via this channel, instead of face-to-face, to make it cost-effective. There are two main commercial systems available to support this process, one of which is being used across Hampshire as part of the Better Local Care Vanguard.

- **Savings per GP per week – variable – depending on internal processes**
- **Cost to the practice:**
  - system licence annual renewal
  - admin support for the system
- **Staff training is part of commercial packages.**

2.3: Avoiding duplication

Several tasks currently dealt with by GPs could be more efficiently performed by others. Some of these are covered by six new requirements in the NHS Standard Contract for hospitals in relation to hospital/general practice interface, introduced in 2016/17. It is important that that general practice and CCGs co-operate to ensure that these efficiency measures are implemented. These include: discharge medication, consultant to consultant referral, results of tests requested by hospitals and non-attendance at hospital clinics.

Discharge medication: Wessex CCGs and Trusts have agreed that patients should be provided with 28 days of medication, as appropriate, upon discharge from hospital. Local arrangements are now recognised in the national NHS Standard Contract. Often one or two drugs are missing, necessitating the patient contact and/or visit the GP to complete the prescription. At best, this is an inconvenience for the patient, at worst it causes them distress especially if they have run out of tablets.

- **Savings per GP per week – variable. Around 15 mins.**
- **Costs – NIL**

Consultant to consultant referral: Some years ago, to reduce the number of 'internal' outpatient referrals, consultant to consultant referral within secondary care was halted by commissioners. This resulted in the patient needing to visit the GP to obtain further referral, which has now been recognised as a source of frustration and inconvenience for patients, GPs and hospitals. The policy has been revised in the NHS Standard Contract and all clinically relevant and linked internal referrals should now take place directly without reference to the GP.

- **Savings per GP per week – variable. Around 5 mins + 15 mins administrator time**
- **Costs – NIL**

Hospital tests: when hospital doctors request tests and ask GPs to follow up the results, this is potentially unsafe and an inappropriate use of GP time. The NHS Standard Contract specifically requires hospitals to notify patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner, for example, by telephoning the patient. In addition, there are a small number of tests which are not included in the outpatient tariff, meaning that hospital doctors need to ask GPs to request them. This is clearly unsatisfactory for the patient, GP and hospital doctor and the underlying contractual issues should be addressed.

- **Savings per GP per week – variable. Around 15 mins.**
- **Costs – review of some OPD tariff rates**

Hospital clinic non-attendance: in order to help manage the high non-attendance rate for outpatient appointments, a patient has to see the GP for a new referral if they have missed their appointment. This has been recognised nationally as an inconvenience for patients and GPs, and has been addressed in the NHS Standard Contract. Trusts could invest in reminder processes, eg texting, to reduce these non-attendances.

- **Savings per GP per week, assuming 2 each week - 10 mins + 30 mins secretarial time**
- **Costs – nil to general practice (possible costs to Trusts)**

In addition, there are other processes that could be changed to reduce the waste of GP time and inconvenience to patients.

Ophthalmic referrals: direct referral by Optometrists to secondary care is already part of the Ophthalmic Services contract. However, patients are frequently required to visit their GP to request referral. Direct referral by the Optometrist is better and faster for the patient, and avoids wasting GP time.

- **Savings per GP per week, assuming 2 referrals each week - 10 mins + 30 mins administrative time**
- **Costs - nil**

Fit notes: fit notes are not always issued by hospital doctors, who instead write to the GP requesting the GP provide the note for a given period. Those provided in hospital rarely cover a long enough period. In either case the patient must contact the GP to obtain an appropriate fit note, which can be inconvenient, especially for those patients who are less mobile. A fit note should be provided to the patient for an appropriate period by the relevant clinician at the point of decision.

- **Savings per GP per week, assuming 2 each week - 10 mins**
- **Costs - nil**

Avoiding duplication: summary of time savings possible per GP per week

Subject	Contacts saved per GP/ week	Time saved per GP/ week	Admin time saved per week	improved patient experience	System cost
Discharge medication		15 mins		YES	neutral
Consultant to consultant referral	1	5 mins	15 mins	YES	Secondary care admin
Hospital tests		15 mins		YES	limited increase in tariff
Hospital clinic non-attendance	2	10 mins	30 mins	YES	neutral
Ophthalmic referrals	2	10 mins	30 mins	YES	neutral
Fit notes	2	10 mins		YES	neutral
Total	**7**	**1 hour 5 mins**	**1 hour 15 mins**		**limited**

Table 4. Summary of possible time savings per GP per week





Chapter 3: Workforce

Having nurses working in general practice is now the norm, and we are seeing this extended to include Health Care Assistants. There is increasing recognition that a range of other staff from pharmacists to physiotherapists could provide some of the care, within general practice, currently managed by GPs and nurses, as well as providing an extension to the service offered. Administrative staff can also help manage aspects of the GP workload as illustrated above.

Historically, practices have employed a nurse and then explored the application of their skills, subsequently adjusting the practice workload. This approach does not focus on the needs of patients and the practice and is not an effective way of exploiting the available skill mix. There is need for greater awareness of the range and extent of the skills of the staff who could work in general practice, especially the 'newer' roles such as Physician Associates. Our Skills Matrix and Skill Mix Tool enable review of the range of skills by staff type and highlight those who could contribute to your practice.

The new roles in primary care that we describe below are those for which there is evidence of effectiveness in reducing the workload of GPs and potential improvements in patient experience and outcomes. We provide information about pay and training, but not indemnity costs. The issue of indemnity is being looked at nationally but there is yet to be guidance and each practice should check with their own insurer. Further information about training and support can be found from the Wessex Community Education Provider Network and the Primary Care Workforce Centre in Dorset.

There are a number of other staff who can significantly improve patient outcomes, or facilitate patient journeys, but the impact on the workload of GPs has either not been assessed or is not clearly beneficial. These are discussed in our full report but are not included here for the sake of brevity. These roles include Care Navigators, Health Trainers and Mental Health Practitioners. There is need for ongoing monitoring of the outcomes of these initiatives so as to assess their future impact on GP workload.

Nursing

The majority of practices already employ Practice Nurses and use them in a wide range of roles. However, they are becoming harder to recruit. Some practices are not aware of the range of nursing staff able to work in primary care. These range from Health Care Assistants (HCAs), able to manage the basic tasks (eg blood pressure monitoring) through to Advanced Nurse Practitioners (ANPs), able to run acute presentations and chronic disease management clinics independently. One advantage of HCAs is that they can be trained 'in-house' and are available from an extensive pool of people not currently in the health system and thus more accessible. Inevitably the more highly skilled and trained the staff the more expensive (and often more scarce) they are, so understanding the range of competencies against the cost is an important element to maintain a viable practice. It is important, when using this skill mix, to ensure that all staff work to the 'top of their licence' – it would be inappropriate to use an ANP to routinely take blood rather than an HCA.

A new nursing role, Nursing Associate (NA), bridges the gap between Health Care Assistants (HCAs) and registered nurses and will provide career progression for HCAs creating a stepping stone to full registration with appropriate training. The first cohort of NAs began their two-year training in the autumn of 2016. Southern Health Foundation Trust and its partners have recruited 49 trainees to start in April 2017.

		Action	Health Care Assistant	Nursing Associate	Newly Qualified Nurse	General Practice Nurse	Advanced Nurse Practitioner
Chronic disease *		Monitor	some	✓	✓	✓	✓
		Manage/treat				some	✓
Procedures *			some	most	✓	✓	✓
Vaccinations	Flu & Pneum	give	✓	✓	✓	✓	✓
	Travel & Child	give			✓	✓	✓
	All	advise				✓	✓
Wound Care *			some	✓	✓	✓	✓
	Tissue viability						✓
Repeat Prescribing support *							✓
	Medication reviews					✓	✓
Women's health	Cervical smears	perform				✓	✓
	Contraception / HRT	Monitor	✓	✓	✓	✓	✓
		Manage/treat				✓	✓
		Advise				✓	✓
	IUCD/implant	Monitor				✓	✓
		remove					✓
Acute presentations *							✓
Home visits *						some	✓
Admin	Letters	triage	✓	✓	✓	✓	✓
		act upon		✓	✓	✓	✓
	Results	triage		✓	✓	✓	✓
		act upon				✓	✓

Table 5. Summary matrix of nursing skills applicable to general practice practice (* a detailed list is given in the full Skills Matrix)

Health Care Assistants: what do they do?

The skill set for an HCA will depend on the needs of each practice and the training provided by the practice team. Ideally, the HCA will be supported to maximise their potential and acquire the whole skill set: this can relieve the Practice Nurse of many of their more basic activities, freeing the nurse, in turn, to accept more work delegated from the GP.

The RCGP, together with the Royal College of Nursing, has developed and published a formal competency framework for HCAs working in general practice. HCA is not a regulated nor registered profession, so it is important that competency is assessed on a regular basis.

HCAs are the easiest clinical staff group to add to the practice team. They can join the workforce at any age, training is easy to access and they can work while training. It is feasible for any practice to support an HCA through appropriate training and this also provides an opportunity to achieve relevant qualifications to support their career progression.

The role could be combined with also working as a receptionist and/or phlebotomist.

Health Care Assistants: where can I employ them from?

- 'Grow your own': train in house admin staff, recruit 6th form leavers, recruit people of all ages.
- Recruit from existing roles – but we do not encourage you to destabilise other services.

Health Care Assistants: how much do they cost to employ?

- Usually employed on Agenda for Change pay bands 2-3 or equivalent, depending on qualifications and experience.
- At 2017 pay rates this equates to £15,404 – 19,852pa (£7.88-10.15/hr) plus about 20% for 'on costs'

Health Care Assistants: training information

- HCAs should be trained to national standards. They should obtain the Cavendish Care Certificate (which covers a set of 15 competencies) through outside training (eg as part of the Healthcare Support Worker Apprenticeship route) or achieve the competencies in house without external training.
- A Level 2 Health & Social Care apprenticeship can be undertaken by those with no qualifications and those with qualifications up to and including A level. There is no age limit for undertaking an appren-ticeship.
- Staff can be recruited with BTEC Health and Social Care, undertaken at further education/6th form level, or an appropriate level 2 or level 3 qualification (Clinical Support or Health & Social Care QCF).
- Ad hoc training can take place in post and this should be mapped to a competency framework.
- Study days and a pilot for an accredited training programme are delivered through the Wessex educa-tional framework for general practice

Practice Nurses (including Newly Qualified and Specialists): what do they do?

A **Newly Qualified Nurse** (NQN) will have all the basic skills required to work as a treatment room nurse until they acquire the specific practice nursing skill set. All NQNs must undertake a 'preceptorship' period of between six and 12 months, during which they are mentored by a preceptor nurse. There is no reason, therefore, why nurses should not enter general practice immediately upon qualifying, provided the supervising Practice Nurse is an accredited mentor. To become a qualified Practice Nurse, the NQN will need to undertake training in core practice nursing skills (cytology, immunisations etc), which can be undertaken during the preceptorship period.

Practice Nurses are registered nurses with additional training in specific skills. The RCGP published a Practice Nurse competency 2012 and Health Education England published a district nursing and general practice nursing service education and career framework in 2015. Extra training to focus on the wider chronic disease monitoring can be provided in house, or through formal training courses.

Clinical Nurse Specialists (CNSs) are Practice Nurses with additional training in specific skills. This role varies from practice to practice. The nurse will specialise, in depth, in one or more long term condition, eg asthma, COPD, diabetes or hypertension.

Practice Nurses & Clinical Nurse Specialists: where can I employ them from?

- Recruit NQNs direct from University. Support will be available through the Community Education Provider Networks (CEPNs) and Health Education England Wessex (HEEW).
- 'Grow your own' Practice Nurse from a NQN or other nurse new to general practice, employ and support the return to practice of lapsed registered nurses.
- 'Grow your own' Clinical Nurse Specialist from your Practice Nurse team
- Recruit from existing roles in other practices, Trusts and the private sector (including care homes) – but we do not encourage you to destabilise other services.

Practice Nurses & Clinical Nurse Specialists: how much do they cost to employ?

- NQNs and Practice Nurses are employed on Agenda for Change pay bands 5-7, or equivalent, depending on skills and experience. CNSs are employed on bands 6 or 7.
- At 2017 pay rates this equates to £22,128 – 28,747 pa (£11.31 – 14.71/hr) at band 5, £26,565 – 35,577 pa (£13.58 – 18.19/hr) at band 6, or £31,697 – 41,787 pa (£16.21 – 21.37/hr) at band 7, plus about 20% for 'on costs'.

Practice Nurses & Clinical Nurse Specialists: training

- Foundation training programmes (for nurses new to General Practice) are provided by Universities, typically take 9 months and typically involve one day a fortnight contact time

Practice Nurses & Clinical Nurse Specialists: training

- HEEW currently fund the Practice Nursing foundation training fees for up to 40 nurses (2 cohorts). Currently 31 are enrolled. From 2018/19, it is planned to expand to 3 cohorts a year (up to 60 places).
- Certificate in Practice Nursing training (for nurses employed for 18 months or more in General Practice but with no formal recognition of their practice nursing skills) is provided by HEIs, typically takes 6 months and typically involves 9 days contact time.
- Accredited and non-accredited CPD training includes management of LTCs, management of minor illness, diabetes, respiratory (inc asthma and COPD), chronic kidney disease, liver disease and motivational interviewing. This is usually funded by HEEW.
- 15 places across Wessex on non-medical prescribing training courses are funded each year by HEEW. The trainee must either have completed a history-taking and physical assessment module or the practice must commit to the trainee undertaking this module. This training is accessed via application to the Programme Director for General Practice Nursing at HEEW.
- Funding is available from HEEW for mentorship training. A Practice Nurse trained as a mentor will be able to supervise NQN and RTP nurses in practice.

Advanced Nurse Practitioners: what do they do?

Advanced Nurse Practitioners (ANPs) work both independently and in conjunction with other health care professionals. They are independent prescribers and a competent and appropriately qualified ANP can: take full medical histories, examine patients and see patients who present with undifferentiated conditions, perform diagnostic and therapeutic investigations, request tests (including x-ray) and interpret results, make a diagnosis and manage patients who present with acute and long term conditions including all medical emergencies. They can refer to other disciplines within or outside of the primary care environment. They also have an emphasis in providing health promotion and disease prevention for the patient, their family and carers.

ANPs have been utilised within emergency departments and out of hours services, including 111, for some years. They triage, see and treat patients with a wide range of complaints. These skills are directly transferrable to general practice and have been utilised in many locations. There is an obvious advantage in the direct transfer of workload from GPs to ANPs running clinics within the practice. An ANP is unlikely to need more than the standard ten-minute appointment for these patients and will be more cost effective than a GP. ANPs frequently manage urgent care clinics in general practice and some undertake home visits.

This role has become adopted within general practice. However, due to wide use of local grades and pay scales, some Practice Nurses have acquired the title of ANP through time served rather than having met the national requirements for this advanced practice role.

An updated ANP competency list was published in December 2015 by the RCGP and RCN. Wessex has a Multi-Professional Advanced Practice Network and launched a Framework for Advanced Practice in 2016.

Advanced Nurse Practitioners: where can I employ them from?

- 'Grow your own' through facilitating formal Advanced Practice training for and development of your Practice Nurse(s).
- Recruit from existing roles in other practices and Trusts – but we do not encourage you to destabilise other services.

Advanced Nurse Practitioners: how much do they cost to employ?

- ANPs are usually employed on Agenda for Change pay bands 7 or 8a or equivalent, depending on qualifications and experience.
- At 2017 pay rates this equates to £31,697 – 41,787 pa (£16.21 – 21.37/hr) at band 7, or £40,428 – 48,514 pa (£20.67 – 24.82/hr) at band 8a, plus about 20% for 'on costs'.

Advanced Nurse Practitioners: training

- ANPs should be trained in advanced practice at University, to the local and national frameworks and competencies.
- Training can be undertaken in two years if the nurse has a good first degree (2:1 or first), otherwise it takes a minimum 3 years and a maximum of 5 years. Each module takes about 3 months, students typically cover 2 a year, it is approximately 53 contact days altogether.
- Funding for training is scattered. Some funding might be available from some CCGs (eg the Isle of Wight, SE Hants, Fareham & Gosport). Otherwise it is down to individual practices and current training costs are £7-8,000 for the Postgraduate Diploma (Masters degree-level qualification).
- Funding may be available from HEEW as a consequence of the GPFV, but this will only pay for the training itself and there will be no provision for backfill or travel.
- Currently 20 Practice Nurses across Wessex and undertaking Advanced Practice training.

Pharmacy

Many years of working with the CCG Medicines Management teams has shown general practice how Pharmacists can help with prescribing matters. It is often overlooked that Pharmacy Technicians have a range of skills pertinent to general practice and can be a useful addition to the practice team. All practices should have dedicated administrative staff managing repeat prescriptions who could take on a wider range of prescription-related tasks with appropriate support. This is an opportunity which has not been availed of by all practices.

In addition, a Clinical Pharmacist has the clinical skills required to manage patients. The government has recognised this and is investing in supporting the recruitment of such staff to general practice, by providing funding for the training and partial support for salaries through the GPFV. When fully trained, Clinical Pharmacists can manage many clinics independently.

		Action	Prescription Clerk	Pharmacy Technician	Clinical Pharmacist
Chronic disease *		Monitor	some	many	✓
		Manage/treat			✓
Procedures *			some	most	✓
Vaccinations	Flu & Pneum	give		✓	✓
		advise			✓
	Travel & Child	give			✓
		advise			✓
Wound Care *	Remove sutures				✓
Repeat Prescribing support *			some	✓	✓
Women's health	Contraception / HRT	Monitor		✓	✓
		Manage/treat			✓
		Advise			✓
Acute presentations *	Surgery visits				many
Home visits *				some	some
Admin	Letters	triage	✓	✓	✓
		act upon			✓
	results	triage	✓	✓	✓
		act upon			✓

Table 6. Summary matrix of pharmacy skills applicable to general practice

* a detailed list is given in the full Skills Matrix

Prescription Clerks: what do they do?

A Prescription Clerk will process requests for repeat prescriptions. This role can be combined with other clerical/ administrative roles within the general practice. They should be able to highlight discrepancies in orders (ie drugs not had before or excess requests for drugs, especially drugs of concern). They are able to set up and run electronic prescribing systems to link to the EPS, may also manage the RDS for the practice, and liaise with both the GPs and local pharmacies to facilitate smooth running.

A trained Prescription Clerk can add non-drug items to a repeat list, remove redundant drugs, restart 'time-expired' or previous acutely-prescribed items, and update patient records with advice from hospital letters. These are then highlighted to the prescribing clinician to ensure safe and appropriate prescribing occurs.

Prescription Clerks are also able to discuss availability of and queries about prescriptions with patients and pharmacists and can follow up queries with secondary care clinicians. They can manage a medication review system, instigating a reminder contact with the patients for such reviews along with organising pre-emptive blood tests according to local protocols. They are able run audits and searches of the patient list related to prescribing.

Prescription Clerks: where can I employ them from?

- 'Grow your own' from your admin team, either existing staff or new recruits.
- Recruit from existing roles, such as community pharmacy dispensers – but we do not encourage you to destabilise other services.

Prescription Clerks: how much do they cost to employ?

- Prescription Clerks are usually employed on Agenda for Change pay bands 2 (above mid-point) or 3, or equivalent.
- At 2017 pay rates this equates to £15,404 – 18,158 pa (£7.88-9.28/hr) at band 2, or £16,968 – 19,852 pa (£8.68 – 10.15/hr) at band 3, plus about 20% for 'on costs'.

Prescription Clerks: training

- Prescription Clerks will be trained in-house within the general practice.

Pharmacy Technician: what do they do?

Pharmacy Technicians are regulated by and registered with the General Pharmaceutical Council. They are unable to sign prescriptions.

A Pharmacy Technician has an understanding of drugs and their uses, provides expertise in the use of medicines, reduces inappropriate poly-pharmacy and wasteful prescribing through elements of medication review, reconciles medicines following hospital discharge and works with patients and community pharmacists to ensure patients receive the medicines they need following discharge. They support patients to get the best outcomes from their medicines and identify and address medicines related issues, including liaison with Care and Nursing Homes.

The additional qualification in medicines management allows a Pharmacy Technician to carry out enhanced services. For example, with this extra knowledge about the use of drugs in some long-term conditions, they can talk to patients about their medicines and usage, advise on adverse drug reactions and drug interactions, and interpret blood results.

They are able to follow a protocol-led process to manage routine investigations relating to monitoring certain drugs, eg methotrexate. The protocol would need to include clear escalation procedures, eg what action to take following discovery of an abnormal result.

Pharmacy Technicians will need supervision and support from a nominated prescribing clinician and may benefit from a close link with the CCG medicines management team.

Pharmacy Technicians: where can I employ them from?

- Recruit from existing roles in hospitals, CCGs and community pharmacies – but we do not encourage you to destabilise other services.

Pharmacy Technicians: how much do they cost to employ?

- Experienced medicines management Pharmacy Technicians are employed on Agenda for Change pay band 6 or equivalent.
- At 2017 pay rates this equates to £26,565 – 35,577 pa (£13.58 – 18.19/hr) plus about 20% for 'on costs'

Pharmacy Technicians: training

- Pharmacy Technicians must be qualified as recognised by the General Pharmaceutical Council. Quali-fications include BTEC or NVQ Level 3 in Pharmaceutical Science, are obtained through Further Educa-tion Colleges, and trainees must undertake a minimum of two years relevant work-based experience in the UK under the supervision, direction or guidance of a pharmacist.
- Pharmacy Technicians without additional training in medicines management can undertake a number of tasks in general practice.
- For a broader role, additional training to obtain the Certificate in Medicines Management for Pharmacy Technicians (CMMPT) is advisable. The programme takes one academic year, entails 450 hours of learning and is delivered via accredited NHS training centres. Cost to NHS £200.

Clinical Pharmacist: what do they do?

Pharmacists are registered with and regulated by the General Pharmaceutical Council. Clinical Pharmacists working in general practice undertake additional training as part of the national learning pathway 'Developing Clinical Pharmacists in General Practice'. They are either independent prescribers or will undertake the qualification whilst working in a general practice. Clinical pharmacists should be employed to undertake patient-facing roles.

They can run their own clinics undertaking history taking and examination, prescribing within their competency. This can include clinics where medicines are the main interventions eg anticoagulation clinics and certain long term conditions including the titration of medication for a defined complaint, eg hypothyroidism or hypertension. The Clinical Pharmacist will review pathology results for patients on specific medications, manage the repeat prescribing process and implement the RDS. They are also able to provide advice to patients on the use of medication, particularly relevant with inhaler use and thus support asthma/COPD reviews and monitoring.

Clinical Pharmacists can provide emergency contraceptive advice with prescriptions and run smoking cessation clinics with prescriptions. They can undertake minor ailments triage and treatment and give basic immunisations.

This level of autonomy would equate to an ANP and require only indirect support, particularly for escalation, and would enable work to be transferred from the GP, but also could permit work to be transferred from the Practice Nurse if necessary to free up a scarce resource for tasks uniquely suited to the nursing skill set.

Clinical Pharmacists: where can I employ them from?

- Hospitals and community pharmacies – but we do not encourage you to destabilise other services.
- NHS England has a rolling programme to part-fund the recruitment and first 3 years of employment of Clinical Pharmacists in general practices facing the biggest workload pressures. While employed, the Pharmacists are provided with additional training, including a general practice pharmacist training pathway and training for an independent prescribing qualification if they do not already hold one. Practices must bid for inclusion in this programme.
- **https://www.england.nhs.uk/gp/gpfv/workforce/building-the-general-practice-workforce/cp-gp/**

Clinical Pharmacists: how much do they cost to employ?

- Clinical Pharmacists are employed on Agenda for Change pay bands 7-8b or equivalent, depending on qualifications and experience.
- At 2017 pay rates this equates to £31,697 – 41,787 pa (£16.21 – 21.37/hr) at band 7, £40,428 – 48,514 pa (£20.67 – 24.82/hr) at band 8a, or £47,091 – 58,216 pa (£24.08 – 29.77/hr) at band 8b, plus about 20% for 'on costs'.

Clinical Pharmacists: training

- Pharmacists with at least two years' post graduate experience can undertake appropriate training such as the nationally agreed programme developed and run by The Centre of Post graduate Pharmacy Education (CPPE) at Manchester University.
- Portsmouth University provides post graduate training for Pharmacists.

Physiotherapists, Paramedics, Physician Associates

In addition to the well-recognised roles of nursing and pharmacy in primary care, there is growing acknowledgement of the significant contributions that can be made by allied health professionals and newly-emerging associate roles.

Physiotherapy: Various studies indicate that up to 50% of GP consultations relate to musculoskeletal conditions. Physiotherapists with higher training are able to manage most of these patients independently, on a first contact basis, and do so with a reduced use of radiology, drugs and referrals. The only issue with employing these staff is the current shortfall in the NHS. However, we have found that a high proportion of private physios would consider working on a sessional basis.

Paramedic: These clinicians are experts in the assessment of patients presenting de novo. This is primarily in the home setting and so they are ideal for helping practices manage the increasing burden of home visits. However, these competencies can also be applied to the assessment of patients presenting in general practice. They can conduct acute duty day assessment clinics, but they are unable to prescribe. Paramedics have a wide range of skills relating to physiological monitoring of patients and may also assist with the review of some patients with long term conditions.

Physician Associates (PAs): are a novel group of staff only recently available in the UK, but used extensively in the USA. As a new clinical group, their employment does not deplete the staff of any other healthcare providers. PAs have a first degree in a health-related science and then spend two years gaining a masters-level degree in clinical work, although they are yet to be formally regulated and currently cannot prescribe. In the UK, they predominately work in secondary care. The government has committed to training 2,000 PAs a year by 2020, which should provide a pool to work in general practice.

		Action	Advanced Practice Physio	Paramedic	Physician Associate
Chronic disease *		Monitor	some	most	✓
		Manage/treat	some	some	most
Procedures *			most	most	most
Vaccinations	Flu & Pneum	give	✓	✓	✓
	Travel & Child	give		✓	✓
	All	advise			
Wound Care *			most	most	most
Repeat Prescribing support *			some	some	most
Women's health	Cervical smears	Perform			
	Contraception / HRT	Monitor		✓	✓
		Manage/treat			
	IUCD/implant	Monitor		✓	✓
		Remove			
Acute presentations *			some	✓	some
Home visits *			some	✓	
Admin	Letters	triage	✓	✓	✓
		act upon	✓		✓
	results	triage	✓	✓	✓
		act upon	✓		✓

Table 7. Summary matrix of physiotherapist, paramedic and physician associate skills applicable to general practice

* a detailed list is given in the full Skills Matrix

Advanced Practice Physiotherapist: what do they do?

An Advanced Practice Physiotherapist (APP) is a fully trained physiotherapist with specialist training and extended skills in the diagnosis and management of a group of specific clinical conditions. They are independent, autonomous, regulated practitioners (holding their own professional liability indemnity if self-employed), and able to work in general practice without the direct supervision of a GP. An APP will not provide a course of physiotherapy as this duplicates services provided elsewhere and loses the cost-effectiveness of this role.

Musculoskeletal (MSK) specialists are trained to: identify serious pathology; assess, investigate and refer appropriately, including the use and interpretation of radiology (following IRMER regulations); and provide self-management advice to the patient. Some are qualified to perform joint injections and some to prescribe. With this range of skills an APP can see, diagnose, treat and/or refer any patient within two attendances (depending on the need for review of tests), either as the first point of contact or via referral. An APP will take 20 minutes per appointment to achieve this. Any patient requiring more than one follow up appointment would be referred to local physiotherapy or orthopaedic services. The outcome of longer appointments must be better for the patient and the system to make it cost-efficient. Pilots have demonstrated this to be so.

Physiotherapists have the skills to manage respiratory conditions and some will have extended practice in this area. There are well-established community-based respiratory assessment and rehabilitation programmes led by specialist physiotherapists. Although we are not aware of evidence of this approach in general practice, there are clearly opportunities to extend these roles into practices. A respiratory APP would be able to assess, monitor and manage many lung diseases and assist in 'flu and pneumonia vaccination programmes thereby providing support to both GPs and Practice Nurses.

MSK Advanced Practice Physiotherapists: where can I employ them from?

- Recruit from existing roles in Trusts – but we do not encourage you to destabilise other services.
- Recruit from the private sector. If they are self-employed they may be interested in sessional work to combine private and NHS practice (shown by our 2016 survey of Physiotherapists in private practice in Wessex).

MSK Advanced Practice Physiotherapists: how much do they cost to employ?

- Advanced Practice Physiotherapists are usually employed on Agenda for Change pay bands 7-8b or equivalent, depending on skills and experience.
- At 2017 pay rates this equates to £31,697 – 41,787 pa (£16.21 – 21.37/hr) at band 7, £40,428 – 48,514 pa (£20.67 – 24.82/hr) at band 8a, or £47,091 – 58,216 pa (£24.08 – 29.77/hr) at band 8b, plus about 20% for 'on costs'.

MSK Advanced Practice Physiotherapists: training

- An APP will have studied to Masters-level or equivalent and have relevant experience within the field. This might include an injection or prescribing module or other relevant Masters-level modules.
- The University of Southampton has an Advanced Clinical Practice MSc course.
- The Universities of Southampton and Bournemouth both run prescribing modules and Southampton runs injection modules. Bournemouth will soon start radiography modules.

Paramedic: what do they do?

Paramedics are trained to degree level and are registered with and regulated by the Health and Care Professions Council. Their normal scope of work is with the ambulance services assessing and managing acute presentations, developing an immediate care plan and acting on it: reassuring the patient, contacting other services, or transferring the patient to hospital. Given these skills, it is a logical step to use these staff in general practice for emergency surgeries and home visits although they are unable to prescribe. Deploying Paramedics in this way could release a significant amount of time for GPs to see more patients in surgery, as much GP time is spent travelling between home visits. The GP would only undertake home visits for those requiring GP intervention.

Part of the normal Paramedic duty at an ambulance trust is to answer 999 calls. The Paramedic is therefore fully trained in and capable of managing telephone triage, a skill which is readily transferrable to general practice, where they would be working under the guidance of a GP.

Paramedics are rapidly becoming a popular addition to the general practice team, are being used in various practices across Wessex, both within and outside the MCP Better Local Care Vanguard, and have been universally successful to date. However Paramedics are in short supply and SWAST and SCAS both report a staff shortage and unfilled vacancies.

Paramedics: where can I employ them from?

- Recruit from existing roles in Ambulance Trusts – but we do not encourage you to destabilise other services.

Paramedics: how much do they cost to employ?

- Paramedics are usually employed on Agenda for Change pay bands 5-7 or equivalent, depending on skills and experience.
- At 2017 pay rates this equates to £22,128 – 28,747 pa (£11.31 – 14.71/hr) at band 5, £26,565 – 35,577 pa (£13.58 – 18.19/hr) at band 6, or £31,697 – 41,787 pa (£16.21 – 21.37/hr) at band 7, plus about 20% for 'on costs'.

Paramedic: training

- In house induction and continued professional development

Physician Associates: what do they do?

Physician Associates (PAs) are a group of staff designed to support doctors in the diagnosis and management of patients. They are trained in 'the medical model', work under the direct supervision of a doctor and are not independent practitioners. A PA will work alongside a GP, requiring ready access for supervision, advice and prescribing, in a similar manner to a Practice Nurse without prescribing qualifications.

The scope of practice for a PA falls completely within that of a GP, in contrast with that of Nurses, Pharmacists and Physiotherapists who have skills beyond that of a general practitioner. PAs can manage a proportion of the GP workload, freeing the GP for work which only they are able to perform. PAs skills include: taking medical histories, examining patients, seeing patients with long-term conditions, performing certain diagnostic and therapeutic procedures and requesting and interpreting other investigations, formulating differential diagnoses and management plans, delivering appropriate treatment, and providing health promotion and disease prevention advice for patients.

Currently, PAs are not able to prescribe, use Patient Group Directions, or request investigations involving ionising radiation, as the profession is not yet regulated. The BMA holds a voluntary register of PAs.

Physician Associates: where can I employ them from?

- Recruit from the Universities. Surrey and Reading Universities are the nearest to Wessex

Physician Associates: how much do they cost to employ?

- Physician Associates are usually employed on Agenda for Change pay band 7 or equivalent, rising to band 8a with experience.
- At 2017 pay rates this equates to £31,697 – 41,787 pa (£16.21 – 21.37/hr) at band 7, or £40,428 – 48,514 pa (£20.67 – 24.82/hr) at band 8a, plus about 20% for 'on costs'.

Physician Associates: training

- PAs are trained through a two-year intensive postgraduate degree. They must have a first degree in life science and/or significant experience in healthcare.
- The Universities in Wessex do not currently offer this course but some are said to be considering it. The nearest courses to Wessex are at the Universities of Reading and Surrey.

Workforce Planning Tools

In April and May 2016, we undertook a real-time survey of GPs regarding how many patients could be seen by other professionals, distributed by Wessex LMCs (University of Southampton eprints id 399366). The results showed that Wessex GPs believe that 35% of patients could be seen and appropriately managed by another healthcare professional. From the results of the survey and related feedback, two software tools have been developed, the Skills Matrix and the Workforce Tool.

The Skills Matrix: shows which of the tasks in general practice can be undertaken by other healthcare professionals. It identifies which professional(s) can undertake a range of user-selected tasks and should encourage a move away from silo thinking and towards the full use of staff to the top of their skill set and registration. A similar tool could be developed for secondary care specialties.



Figure 3. Screen shot of test version of Skills Matrix tool

The Workforce Tool: uses the survey results, national average data for consultations by age and gender, together with practice demographics, to show how many appointments other professions could cover in place of the GP. It calculates the whole-time equivalent required of each staff group and the likely employment costs. This tool is completely scalable and can apply to anything from one general practice to a whole STP footprint and we would encourage any practice using it to run their own survey first to identify the local thinking around delegation to other professions. Again, the concept has potential to be used by specialties in secondary care.

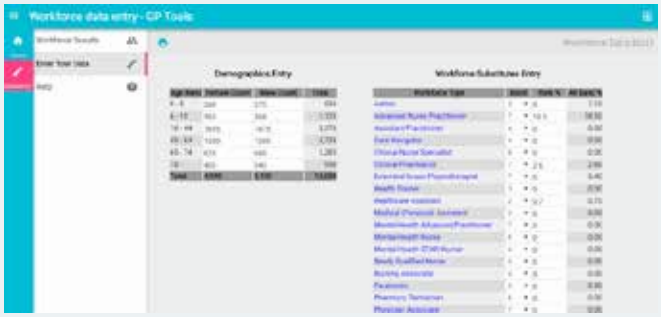


Figure 4. Partial screen shot of test version of Workforce Tool – data entry screen



Figure 5. Screen shot of test version of Workforce Tool - results screen

A third tool has been developed following discussions with the Wessex LMCs and the NHS England Local Area Team, who were finding some general practices were not succession-planning. The Age and Sessions RAG rating tool highlights requirements for replacing staff in two and five years by flagging shortfalls in sessions and by assuming that staff will retire by the time they are 60.



Figure 6. Screen shot of test version of RAG tool

All three tools have been developed into a web-tool and tools will be given – free of charge – to all Wessex practices starting from July 2017. They, and information about the survey, are available at **https://gptools.nq-m.com**

Summary

There is no single measure to relieve the increasing workload in general practice, the shortfall in GPs and the resultant problems with access for patients.

This document provides some ideas of how to manage this situation. To gain the full benefit available, each practice needs to review its internal processes and see if it can run more efficiently prior to exploring the utilisation of additional workforce. However, running more efficiently may be insufficient to manage the clinical workload, so consideration should then be given to extending the practice team. To do this:

1. Assess your future staffing gaps using the RAG Tool
2. Decide whether the gaps can be filled by replacing GPs like-for-like or consider utilising other staff
3. If considering using other staff, determine what tasks could be undertaken by them. Using the Skill Mix Tool you can determine which staff would be appropriate for your practice's particular needs.
4. Use our Survey to determine how much of your current GP workload could be undertaken by the different staff you wish to utilise
5. You can ascertain associated costs from the results of the Survey using the Workforce Tool.
6. Consider working with local practices to either share some of these staff or jointly employ them on a mutually accessible site.

It is important to work with other practices and the CCG in planning your new workforce as recruiting new staff into general practice may have impact on the current workforce in provider Trusts.

These innovations represent an opportunity to enhance patient access to and experience of general practice. However, these changes will only be successful if patients are informed of the range of new staff available to them and of their roles and levels of responsibility. Communicating with the practices' patients and the local community about these changes is essential for successful implementation of sustainable general practice models.









The Wessex Primary Care Project

A Lifeline for Patients and General Practice: new ways for Primary Care in Wessex