# Review of Development Approaches for the non medical workforce in Primary Care

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1    Objectives

Review emerging models of primary care, drawing on existing academic research to document future models of primary care with specific reference to the priorities identified in the Next Stage Review.

2    Approach

All SHAs in England were invited to speak to the researchers about their arrangements, or known arrangements within local PCTs to support the development of the non medical workforce in primary care, particularly nurses. All responded except for London and Yorkshire and Humberside. Some SHAs referred on to local PCTs, who were known to have programmes to develop primary care staff. Others referred on to the Deanery.

16 interviews were held with representatives from SHAs, PCTs and Deaneries. Detailed descriptions of the training and development models in each area are provided in the appendices.

3    Key Points

1. There is no consistent strategic framework in place to enable the planning for and the development of the non medical workforce in primary care across SHAs. Numerous respondents referred to the Working in Partnership project, a national programme which explored the competencies and career development of practice nurses. The programme has now finished. All material is available through the RCN website. Workforce planning for the primary care workforce is locally determined. The extent to which it is undertaken at SHA level depends on SHA philosophy, its perception of its role and others and the extent to which it has a historical commitment to the sector with local leaders.

2. In general, the numbers of nurses and the age profile of nurses working in primary care settings were unknown, unless an SHA or PCT had systems in place to support the development of nurses and strong collaborative relationships with their local GP practices. Only two people interviewed were able to give data on numbers of nurses working in primary care in their locality and their age profile. A few others said they could access the data, but it may not be a
complete picture.

3. The use of training and development monies, such as NMET, to fund nurse development in primary care is subject to local determination. Training of staff in primary care is not always viewed as a priority by education commissioners.

4. Lack of data about the workforce and its development needs mean that nurses working in primary care lack a ‘voice’ to influence local policies on curricula development and access to training. There appears to be no agreed competency framework, beyond that from the Working in Partnership project, or recognised career path for nurses, who are increasingly being expected to perform broader and more advanced roles in primary care. There are no agreed clinical governance arrangements therefore, to ensure that nurses are competent to perform their roles. Concerns were raised by some of those interviewed that the results of the Working in Partnership Programme and other local surveys, which evidenced that, in some practices, nurses were required to perform functions that they were not competent to perform. Not only were the systems not in place to independently assess the competencies required to perform these roles, (such as being included in contracts with GPs by commissioners), but in general, that there seems to be no system in place to determine what competencies are required for non medical staff beyond their professional registration.

5. There were examples of specific training programmes rolled out by PCTs to support new policy initiatives eg liquid based cytology screening programme, which also have processes in place to enable staff to update/refresh their competencies.

6. The independent nature of General Practice, mean that non medical staff’s terms & conditions vary widely. Access to training and development depends on a number of factors including:
   a. Ability to release nurses from clinical care responsibilities (lack of backfill available)
   b. Cost of training and development programmes to practices
   c. Recognition by GPs of the need for training and development
   d. Resistance by some to invest in training when it is perceived that nurses with more advanced skills will leave the practice and therefore the investment made by the practice in the individual will be lost.
   e. Lack of understanding by some GPs of the different roles performed by nurses and associated competency development required.

7. Qualified nurses who wish to enter primary care, have difficulty, because they do not have the right skills required. In general, there is a lack of ‘access’ courses to support nurses wishing to
make that transition, supported by relevant practical training places in practices. However, there are notable exceptions, such as that developed by South Central, South East Coast and East of England SHAs, and some PCTs.

8. General Nurse training courses geared towards aspiring Health Visitors and District Nurses do not provide the practical training required for nurses wishing to enter primary care. Education providers are unwilling to invest in curricula designed for the needs of primary care nurses without assurance from education commissioners of the demand. Some interviewees raised concerns about the amount of goodwill required by GPs to support nurse development. Nurse prescribing, for example was one such case as GPs are not funded to provide this support. It was felt that the training programme was not as robust as it could be.

9. Some education commissioners and SHAs view the primary care workforce as ‘outside the NHS’ and therefore the development of staff in primary care is viewed as the sole responsibility of individual General Practices. These SHAs argue that funding for training is accounted for in funding formulae to General Practice.

10. The role of the Deaneries, the SHA and PCTs is unclear. Whilst there are structures in place, through the Deaneries, to plan for the development of the medical workforce, no such arrangement exists for other clinical staff.

11. Specific structured approaches to primary care development, were also led at PCT level. Stoke on Trent PCT, for example has established a Primary Care Development Unit. Incentive payments for practices reaching excellence targets are offered by the PCT. The Primary Care Development Unit supports the developments of all staff at the practice. Each practice participating in the scheme must develop a workforce plan for their staff. Torbay PCT has linked nursing development with support to practices in the supply of nurse practitioners. The data obtained about the workforce informing their workforce planning processes.

12. Other PCTs ie Essex PCTS (through EQUIP), Kent & Medway, Buckinghamshire all had learning and development teams, funded by practices either through membership or top slicing GP budgets. These teams are important for post registration training. Some are taking a more strategic development path towards supporting the development needs of all primary care providers.

13. Those PCTs which have embedded development programmes for the non medical workforce in primary care emphasise how important it is to establish clear and adequate funding.
arrangements, to attract a competent and stable core workforce to facilitate access to the training. Decision making mechanisms between General Practice and PCTs need to be in place to enable both parties to be responsive to training and development needs.

14. There is concern that those PCTs who have demonstrated leadership in primary care development in the past may be disinvesting in this area as their focus moves towards commissioning. Mechanisms are not being put in place to retain the function elsewhere.

15. NHS East Midlands has recognised the strategic opportunity for achieving improvements in the quality of primary care provision as greater numbers of independent providers deliver community health services. A more structured training and development approach will improve quality of care and outcomes. Other primary care practitioners, such as pharmacists and dental practices, also now require more support to ensure their workforce has the competencies to meet the growing agenda. The East Midlands model is being looked at closely and beginning to be applied in at least one other SHA.

4 Next Steps

South Central SHA could play a greater role in facilitating the development of all staff in primary care, not only in General Practice, but also in other areas. Dental, Pharmacy and Optometry teams are increasingly viewed as integral to the delivery of choice policies as well as providing expert advice to primary care teams in General Practice as part of the care pathway. It is a cause for concern that there is no system to support robust workforce planning for this workforce, at any level in the SHA.

Recommendation 1: Leadership
Consolidate leadership arrangements for development of the whole primary care workforce in South Central SHA.

Recommendation 2a: Network Development
Build on the WIP Programme. Create a network of strategic leads to take forward the development of the non medical and medical workforce, to create a ‘voice’ for the primary care workforce.

Recommendation 2b
Consider establishing a provider forum for primary care development (or forums if geographically based). Proposed terms of reference are provided in Appendix 7.
Recommendation 3: Establish a Primary Care Workforce Planning System in South Central
Develop a business case for the Primary Care Taskforce to facilitate the creation of a workforce planning system for all primary care clinical staff and which includes other independent providers (dentists, pharmacy, and opticians) who are providing health services. The suggested scope of the business case is provided in Appendix 8.

Recommendation 4: Use of new technologies to support a training and development infrastructure in primary care
Explore how new knowledge management tools and techniques, and clinical applications such as ‘Map of Medicine’ can enable infrastructure development, promote awareness of learning and development needs in relation to new roles and competencies, which may derive from clinical pathways. Consider how the collection of data about the workforce in primary care may be supported in a more structured and consistent technical framework.

Recommendation 5: PCT Commissioners role
Develop a checklist for commissioners to enable them to assure themselves that practices employ staff competent to perform their roles. Consider building on the Tower Hamlets programme with a PCT partner in South Central SHA to link care pathway implementation with competency development in primary care and locally driven incentive systems.

Recommendation 6: Funding Arrangements
Clarify the current funding arrangements in place in South Central SHA to support professional development of the non medical workforce in primary care.

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Appendices
Appendix 1: SHA Case Studies

The concept of workforce planning within the NHS has a long history, with a high point being the creation of Workforce Development Confederations in 2001 to bring national coherence to the process. Since 2004 however as the functions of WDCs were subsumed within the SHAs more local approaches have been adopted.

The workforce is complex, and becoming ever more so, with health care staff working in the public, private and third sectors. With a plethora of professional qualifications, emerging new roles, developments in care and treatment and changes in legislation it is essential that continuing professional development is available, accessible and appropriate.

1.1 NHS East of England

East of England SHA has a Professional Adviser in Primary Care. Her role has been to improve the education of practice nurses and to support the expansion of the multi professional nature of General Practice teams.

1. Practice Education Facilitators, responsible for making placements and supporting mentors in those placements were persuaded, on their accreditation visit, to change their approach to find out about nursing teams and take students into practice. There is also an apprenticeship scheme, which PCTs lead to ensure appropriate standards for nurses new in post.

2. The SHA has ensured that funding for education and training is earmarked for Practice Nurse education as part of the CPD contract. The funding is apportioned to them and identified within each PCTs allocation. It is supported by a portfolio of development opportunities, provided by the Higher Education Providers.

3. She has enabled social worker and pharmacy students to access placements in General Practice.

4. The SWIFT money has been used to build on the multiprofessional learning developed by the East Midlands.

5. A preceptorship and assessment tool for Practice Nurses enables them to measure their development.

6. Nationally she is working with other colleagues to agree a standard competency set for practice nursing, based on the work undertaken by the Working in Partnership project. It is hoped the Department of Health will recognise the competency set.
7. The RCGP have set up a Foundation for practice nurses, practice managers and physician assistants. It is hoped that the elearning modules available for GPs and others can be applied to practice nurses, who would have an elearning account, as GPs currently do. It is hoped that membership will be allowed on a practice basis.

1.2 NHS East Midlands

East Midlands is made up of five counties, each of which acts as the units for workforce planning. Each has a workforce planning team, whose role is to ensure an appropriate workforce for the geographic area covered, e.g. Nottinghamshire, Leicestershire.

Within the SHA there are three directorates/ organisations with a responsibility for practice nurse development- Nursing and Patient care, System Development and the Healthcare Workforce Deanery.

Information collected

The SHA oversees an annual census of staff working in health including general practise each year, and this shows the age profile for practise nurses currently employed.

This information is collated and then examined in the light of future strategy to decide what if any interventions are needed, e.g. focused recruitment, additional training. Education commissioning staff within the SHA then develop appropriate contracts with HEIs.

Funding for training

The learning beyond registration budget is available to support the provision of continuing professional development for staff working in practises. In some parts of the SHA GPs agreed many years ago to create a training budget for staff from a top slice across their budgets. Backfill is dependent on local arrangements

Innovation

Workforce plans are scrutinized to ensure that the impact of Darzi developments are built in to training requirements
1.3 NHS West Midlands

The SHA expects a five year workforce plan for every provider in the West Midlands. A general workforce plan is developed annually. Workforce planning for primary care has been through PCTs to date, using PCT provider arms as the source of information. This year however the SHA has moved to seeking information through commissioning. They have also used external agencies such as Ipsos Mori to research issues such as dentistry.

SHA processes

There is a regional stakeholder board, which pulls together the work of the five sub-regional boards which lead on workforce planning.

There is a health education partnership with the nine HEIs in the region. Clinical leads have now been appointed to lead the Darzi pathways.

The Primary Health Care Team

The SHA has commissioned work on dentistry, and are working on pharmacy staff, with Boots, Lloyds and other smaller commercial outlets fully signed up. They have scrutinised school nursing working with local authorities to provide an overview of those staff directly employed by schools. Their next challenge will be optometry

Role of professional bodies

All professional bodies within the SHA are expected to contribute to and scrutinise workforce plans, both to ensure that information is accurate and also to check that future developments within the profession are included.

Funding for training

There is collaborative working across practises to cover backfill.

1.4 NHS South West

South West have 40 GP nurse trainers. They are now considering setting up training practices.
The SHA are leading a project on developing advanced practice for practice nurses in GP training practices (but taking into account whole practice). This project is at an early stage. Starting in October 2008, there are now 20 participating practices. The project is PCT based, giving them leverage to support practice nurse training. All PCTs recognise the need to improve training and development systems in primary care. The SHA are adopting a flexible approach, developed on a PCT by PCT basis. Practice nurses are given financial support to attend courses.

The outcomes of this project will inform what needs to be put in place to support the training and development of practice nurses.

1.5: NHS South East

The SHA has devolved education commissioning to a local level (not contracting) to enable it to be linked to local workforce planning & risks/needs associated with commissioning plans. Each local health economy has a local education partnership (NHS Providers, local HEI), which identifies through provider and commissioning workforce planning what pressures there are and what needs adjusting. Each local education partnership makes recommendations to the SHA in line with their local strategic priorities.

Some PCTs are already hitting critical constraints in delivering their commissioning plans because the workforce is not available. At the same time, effective systems for collecting information about the primary care workforce have yet to be developed, because of the difficulties in obtaining that information from GPs.

The Directors of Nursing group at the SHA is reviewing and redefining the competency framework against a career framework for all post registered nurses. They are currently considering practice nursing.

1.6 NHS North West

Like most SHAs in NHS England, NHS North West have developed an eight step strategic approach to producing a workforce strategy and plan, however, they are still at the developmental stage with Workforce Planning and Development in Primary Care.

They are using National Policy to drive some of this development and drawing on their local policies such as Northwest Healthier Horizons and the Northwest Workforce, Education and Learning and Education Commissioning Strategy 2008-2018 that has been consulted on and will be launched officially in early June 2009.
Education Commissioning

They have just reviewed, consulted and launched their Specialist Practitioner education commissioning programme from September 2009. They are also using the Joint Investment Framework with LSC for bands 1-4 development and have launched a new Apprenticeship scheme.

Developments

The following developments are in progress:

- Building on their successful assistant practitioner and advanced practitioner development programmes
- Encouraging “employer” led planning built around the needs of patients / children / people using various models some of which are still developmental
- Using the Northwest commissioning roadmap to signpost Commissioners to assure their process
- They are using eight clinical pathway groups from the NHS review to drive changes across primary care
Appendix 2: Stoke on Trent PCT: Primary Care Development Unit and Quality Improvement Framework

Stoke on Trent PCT and Keele University, have established a Primary Care Development Unit. One of the primary objectives of the Unit is to support innovation and continuous quality improvement in community oriented primary care services. The Unit will commission support from local education provider stakeholders such as Staffordshire University and Further Education Colleges.

In addition, the PCT has established a Quality Improvement Framework for General Practice, which consists of a set of aspirational standards, which is linked to an incentive and rewards scheme commissioned by the PCT. The scheme sets standards above the Quality and Outcome Framework, allowing primary care teams to strive for and maintain standards over and above the current contractual and statutory requirements.

The Quality Improvement Framework focuses on populations and interventions which deliver the greatest public health outcomes such as patients with long term conditions and issues such as smoking, alcohol and obesity. Each Practice participating in the scheme will have a Practice Development Plan. The Unit’s three key deliverables are:

- Support practices to transform from good to exemplar
- Create and produce development options for practices to achieve the best health outcomes
- Intensive support for the poorest performing practices in order for them to improve

Practice Development Plans may require help from the PCDU in such areas as education or training for practice team members, help with organisational issues or the identification of resource needs particularly if a new skill mix is needed to deliver standards.

Practices qualifying for the scheme they will examine their performance in relation to the exemplary standards, aiming to meet all the exemplary standards in a 3 year plan, supported by annual milestones. The PCDU will

- Develop and organise teaching and training around patient pathways
- Collate learning needs for the primary care workforce: appraisal, national/PCT priorities & requirements
- Commission courses to match learning needs
- Produce resources to enable in-practice learning and individual health professions
- Prepare health professionals for revalidation
- Provide/commission leadership training
- Run learner sets: leadership, special interest, teachers & trainers, career development
Appendix 3: Torbay Care Trust

The Head of Nursing at Torbay Care Trust leads the workforce development programme in primary care. The Trust recognised that they needed to be assured as commissioners that the workforce in primary care was fit for purpose and competent in their roles. When the Care Trust does its annual training needs analysis, General Practices are automatically included. They have access to any core and additional modules and SHA funded places. Primary Care is always included in any initiative. All GP practice teams are entitled to access training free of charge.

The development opportunities for practice nurses include the following:

- They have two students per year on a one year practice nurse BSc course. Places are advertised nationally, so they often attract new people into the area. 50% of their time is spent in practice.

- NVQ 3 support workers in primary health care. They have put 4 cohorts (15 people per cohort) through training. Practices are paid to release staff. NVQs are nationally funded but practices also paid for a peripatetic NVQ assessor. Practices were interested in participating to ensure that their workforce was fit for purpose and to reduce the risk of potential litigation if the workforce were not adequately skilled.

- A Foundation in Practice Nurse course is open to anyone new to a GP practice. Funded by the SHA, the practice contributes £500 towards the cost of the training. It was originally supported locally by the workforce confederation. There are 40 places across the South west Peninsula ie so 2 or 3 for each PCT.

The PCT keeps a database of Practice Nurses with such information as their hourly rate, skills, competencies and education completed whilst in General Practice. The database is also used to register those nurses who are interested in working additional hours for other practices.

Practices contact the PCT about vacancies that are coming up. Any nurses moving into the area also contact the PCT if they are looking for work. The PCT puts them in touch with practices they know are looking for staff.

Many practice nurses have a mentorship qualification

The Care Trust also supports networks of primary care nurses. They have a provider forum for nurses in General Practice. Four sessions per year focus on CPD. The Care Trust also pays for one nurse per
practice to attend a monthly forum. Only practices who attend are paid. Minutes are sent to every practice in hard copy and to each practice manager.
**Appendix 4: Tower Hamlets PCT**

Tower Hamlets PCT in East London has developed an innovative programme to provide support and clinical skills training to registered nurses who wish to develop a career in General Practice Nursing. Called the ‘Open Doors’ Practice Nurse Development Programme, it aims to meet the most pressing health needs of patients in THPCT and to reduce the impact of the barriers of recruitment into practices. It also supports Health Care Assistants across three levels: for levels 2 and 3 they have developed a new training programme which runs alongside the current Trust NVQ provision and supports HCAs who need clinical skills development and a recordable qualification. For senior HCAs there is an option of a Foundation Degree at South Bank University leading to an Assistant Practitioner qualification (level 4).

Practice nurses in post are also supported to join the training programme provided for the Practice Nurses on the development programme. Educational support salary reimbursements (including on costs) are available for study days and all training is fully funded by the PCT. SLA contracts are agreed between the practice and the PCT for those nurses participating in the programme, which ensures that all of the nurses appointed have the same pay and guarantees practice support for the education programme. Practices receive a considerable amount of salary support for the nurses in recognition of the commitment and time needed when staff are in training. Practices employ the nurses on their standard employment contract and the PCT reimburses the salary as below;

First 6 months- 90% plus 14% employer’s on costs contribution  
Second 6 months- 75% plus 14%  
Third 6 months (Year 2) -50% plus 14%  
Fourth 6 months- 25% plus 14%

The PCT has divided Tower Hamlet GPs into networks on the basis of the patient pathway. Except for the initial appointment with the GP, everything will be done by nurses. The PCT has invested £2million in the programme. It aims to develop all levels of nurse in primary care, so that the PCT can commission as a network. They will also make more explicit the links between practice nurses and community nurses, and define a common skill set. Investment is justified on an expected reduction in need and use of secondary care resources: inpatient, outpatients and Accident & Emergency. Care packages have been designed and costed to improve outcomes for patients. Care packages cover diabetes, Immunisation and vaccinations, smoking, hypertension, COPD, CHD, Asthma, Depression, Chronic Kidney Failure. To deliver care packages all members of the primary care team must be qualified to certain levels. The illustration below shows that required to deliver the diabetes care package.
<table>
<thead>
<tr>
<th>Role</th>
<th>Minimum competency levels</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>All staff providing diabetes management (1 nurse, 1 GP per practice)</td>
<td>Training session for care planning discussions</td>
<td>Multiple session to be held</td>
</tr>
<tr>
<td>Nurses</td>
<td>Warwick certificate in diabetes care or equivalent (e.g. Bradford or other accredited courses in diabetes management) plus two years minimum experience in relevant setting</td>
<td>Next available April 2009</td>
</tr>
<tr>
<td></td>
<td>Probable High F, Low G minimum (Whitney Scale) or Band 8 (AFC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level 3 (RCN Integrated Care and Competency Framework for Diabetes Nursing)</td>
<td></td>
</tr>
<tr>
<td>GPs</td>
<td>2 years minimum experience in relevant setting</td>
<td>Next available April, December</td>
</tr>
<tr>
<td></td>
<td>In absence of qualified nurse, GP successfully completes Warwick certificate in diabetes care or equivalent (e.g. Bradford or other accredited courses in diabetes management)</td>
<td></td>
</tr>
<tr>
<td>HCAs</td>
<td>To be determined in collaboration with early adopting practices and networks</td>
<td>To be determined</td>
</tr>
<tr>
<td></td>
<td>Level 1 (RCN Integrated Care and Competency Framework for Diabetes Nursing)</td>
<td></td>
</tr>
</tbody>
</table>

* The PCT will work to ensure that those not already qualified will have access to training in 2009/10

**Source:** RCN – Integrated care and competency framework for diabetes nursing

The minimum level of care is illustrated below.
### Expectations of practices

<table>
<thead>
<tr>
<th>Activity (* = required)</th>
<th>Minimum skill level required</th>
<th>Duration (* = length required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call / recall / coordination</td>
<td>Clinical</td>
<td>Typically 1 day per week for each 300 patients</td>
</tr>
<tr>
<td>Clinical baseline (annual review)*</td>
<td>HCA</td>
<td>25 minutes</td>
</tr>
<tr>
<td>Retinal screening*</td>
<td>Accredited provider(^2)</td>
<td>N/A</td>
</tr>
<tr>
<td>Care planning*</td>
<td>Practice nurse</td>
<td>45 minutes*</td>
</tr>
<tr>
<td>Group education*</td>
<td>Band 7 nurse / dietician</td>
<td>1 hour, delivered in classes of 10 on average</td>
</tr>
</tbody>
</table>
| 6 month interim review* | • Practice nurse (prescriber level or with GP prescribing support)  
• HCA | • 15 minutes for care planning*  
• 10 minutes for Biomedical test |
| Medication review* | Pharmacist | 15 minutes |
| MDT* | Practice nurse | • Typically 2 hours every two months for both nurse and GP |

**SOURCE:** Diabetes care package group

Implementation of the care package approach will require significant organizational development within primary care teams. Practices are offered financial incentives for signing up patients to the scheme for which they also need to deliver certain performance targets.
Appendix 5: PCT Led Practice Based Development Programmes

A number of PCTs have education, learning and development programmes for primary care staff. Three PCTs were interviewed:

Buckinghamshire PCT
Kent and Medway GP Staff Training Scheme
Essex PCTs - EQUIP

PCTs fund their programmes either through an annual membership scheme or by ‘top slicing’ practice funding. In the latter case, this is done with the support of the LMC. At Kent and Medway, for example, the training budget is provided direct from the GPs as a topslice from the GMS global sum, on the basis of 27p per head of patient population, plus an additional levy of approx 3p to cover an HR helpline for the surgeries. The total annual GMS training topslice is approximately £470K, and all practices subscribe. In Essex, the PCTs agreed to contribute money for EQUIP to undertake training, plus agreed a levy on each practice. Practices which belong to EQUIP have free places on courses offered. If a practice does not belong, they have to pay full rate.

In the case of membership schemes, the membership is for one nurse within a practice and cannot be transferred to another practice if the nurse leaves her current employer. Membership rates vary. At Buckinghamshire PCT, an annual membership fee of £60 per individual entitles members to five study days (ten training sessions) and ten update topics. Further training can be accessed by practice nurses and HCAs in general practice outside the membership scheme at an additional cost (each course is individual priced) for new skills training which is competency based eg venepuncture, spirometry and various short course delivered at different levels eg Obesity, Family Planning, Implanon, paediatric minor illness.

Buckinghamshire has worked in partnership with the Universities to develop modules that meet the needs of general practice eg Foundation in Community and Practice Nurse Module, IUCD module.

Most training teams also receive additional funding from the PCTs and from the SHA for specific projects (e.g. cervical screening e-learning), and in non-promotional sponsorship from the pharmaceutical and supplies industry.

However the funding is obtained, it usually supports a small local training and development team. In all cases the team undertakes an annual training needs analysis with practices and also usually consults with the PCT.
Buckinghamshire PCT’s Continuing Professional Development Programme attracts members from practices in all neighbouring PCTs. The Kent & Medway GP Staff Training Team commissions and delivers training and development for 4500 members of staff employed in the 300 GP practices in the geographical area covered by Eastern & Coastal Kent, Medway, and West Kent PCTs.

Participation in the training schemes on offer is voluntary, and depends on the importance placed by GPs on developing practice nurses. Several training teams mentioned the difficulty they experienced in obtaining a complete picture across General Practice of the competencies practice nurses had, their role or even their age. Two respondents had attempted to obtain this information through a questionnaire based survey. In both cases only approximately 35% of General Practices responded. This results in difficulties for education commissioners to assess the demand for training and therefore the type of courses and amount of training to commission from education providers.

Despite the systemic problems experienced, some primary care training and development teams are looking to expand their role. Kent and Medway, for example, have suggested that there needs to be a more equitable approach to primary care development to support new entrants to the market. There is also nothing in place for dental or pharmacy practices, despite policy development which will see both staff groups playing an increasing role in care delivery. Should the existing programme, which focuses on the needs of primary care staff in General Practice be extended to include the continuous professional development opportunities for dental assistants, for example? At Kent and Medway the LPC are keen to do work to improve training needs. New practices commissioned under the Equitable Access to Primary Care scheme, without large patient numbers have more and different training needs which outstrip their contribution to the training funds. They have a much broader remit and their staff have different training requirements. Some of those interviewed expressed concern that the development needs of those undertaking broader primary care roles, such as in walk in centres, was not being addressed, leading to issues of competence and quality of care.

The key to the successful establishment of Learning and Development programmes seems to be in the quality and stability of the team employed to design and deliver the programmes. Long term funding is required and a team which has as its central ethos a commitment to listen and be responsive to the needs of its members.
Appendix 6: Role of the Deaneries

There was a lack of clarity about the role of the Deaneries in supporting the continuous professional development of nurses and other practice based staff. Some, such as London, have adopted a facilitation and leadership approach. In London, PCTs request advice on practice development. When new policies emerge from the DH, the Deanery liaison lead considers the impact of the policy on the primary care workforce and makes local groups aware of the implications for continuous professional development of primary care nurses. This approach allows the Deanery to respond to the local structures and primary care engagement systems in each PCT.

In one London PCT, there is an education steering group representing GPs, practice nurses, management and administration. They arrange education programmes for all practice staff. It is lead by the PCT Medical Director, resources are made available and the tutor is interested in multidisciplinary education. The group makes sure practice nurses and administration staff are trained.

Every PCT in London has a nurse practitioner forum which meets monthly. The first part is business focused covering such areas as for example, Terms & Conditions. The second part is a learning set focused on a particular topic, such as ear syringing, or producing training for health care assistants. Practice nurses attend in their lunch hour so that no backfill is required.

Some PCTs have practice nurse advisers. They go out to practices, do mini appraisals and identify training needs. Each PCT adopts their own approach, sometimes considering the training needs of all staff working in the practice, but this is not always the case. The Deanery, with the University of Westminster, run a train the trainers course which is accessible to anyone in primary care with an interest in education.
Appendix 7. Terms of Reference for Primary Care Network

Purpose
To plan and develop the primary care workforce to support the delivery of health care in the community. Influence the commissioning of education providers.

Scope
All primary care staff in General Practice, Dentistry, Pharmacy and Optometry.

Responsibilities

1. Guide curricula development
2. Establish systems for succession planning
3. Establish non curricula based development eg learning sets for specific issues
4. Manage risk associated with the supply and competencies of the workforce
5. In collaboration with PCTs and Primary Care Organisations facilitate strategic workforce planning (see Recommendation 3).
Appendix 8. Business Case for Workforce Planning System in South Central

a. Scope of business options
   i. Professional focus (eg should focus be extended to all primary care clinicians including pharmacy, dental, opticians), as well as general practice
   ii. Alignment with Darzi & policy goals including transforming community services & increase in independent sector providers
   iii. Clinical focus: should focus be on core roles or also extended primary care roles (eg walk in centres, substance misuse) and new roles (eg dementia adviser that are emerging).
   iv. Alignment with NESC, funding for education programmes,
   v. How far should such an infrastructure support other needs eg advice on terms & conditions?

b. Infrastructure required – options
   i. Geographical/locality ownership or SHA wide
   ii. Organisational form – part of Primary care taskforce or separate organisation
   iii. Governance systems & structure
   iv. Extent of infrastructure required related to potential demand
   v. Funding options & issues eg specific support required for new practices (eg Darzi practices) where demand for training outstrips ability to pay (because patient numbers not high enough in first few years).

c. Consultation with primary care clinicians on need for more structured learning and development system and most acceptable governance arrangements, recognising existing areas of good practice (Bucks/Hants) & emerging structures (eg Oxfordshire Workforce Development Programme).

d. Cash flow

e. Funding options

f. Risk analysis eg difficulty finding enough nurse trainers to support trainees

g. Marketing plan

h. Transition plan for existing areas of good practice in South Central eg Buckinghamshire & Hampshire.
## Appendix 9: Interviews

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