Better understanding of current and future training needs of staff working in GP practices

Report for NESC Primary Care Taskforce from Fiona Reed Associates Ltd.

1. Introduction
Fiona Reed Associates was commissioned by NESC Primary Care Taskforce in January 2009 to develop and test an approach to engage primary care in planning for and developing its clinical (non medical) workforce. The authors of the Report defined clinical (non medical) staff as those directly employed by General Practitioners in roles where patient contact is part of the role. This includes Nurse Practitioners, Practice Nurses (GPNs), health care assistants and phlebotomists, Allied Health Professionals, reception or Patient Services Staff. Also included are Practice and Business Managers, who play a pivotal role in managing these staff, developing training plans and in the allocation of budgets.

The Report is structured as follows:

2 Context
3 Purpose
4 Methodology
5 Findings
5.1 Job titles and roles
5.2 How education and training is currently organized
5.3 Training needs which are hard to meet
5.4 Barriers to meeting training needs
5.5 If money was no object
2. The Context
The shift of care from secondary to primary care and the emphasis on the early detection of disease, health promotion and the management of long term conditions provides primary care with many challenges, as does increased competition from complementary services such as NHS Direct, Walk in and Darzi Centres. This shift is occurring against a background of concern about supply and demand of GPs in the future as articulated in a briefing paper Expanding GP Training Numbers to the SHA Board from Dr Simon Plint GP Dean and Head of School of Primary Care, NHS Education South Central.

As Dr. Plint’s paper argues, baseline demand for primary care services is predicted to grow substantially in the next few years, with increasing expectations, complexity of care, and volume of care with an ageing population, even without the proposed transfer from secondary to primary care and the realisation of the Next Stage Review pathways.

Whilst policy has increased expectations of primary care, there has been relatively little systematic work to analyse and meet the training needs associated with these developments, although some useful initiatives provide pointers to good practice,
including those funded by the NESC Primary Care Taskforce – Practice Leaders Programmes in Portsmouth and Milton Keynes, and the GPN Pilot Programme.

The Next Stage Review priorities give a flavour of the way primary care is expected to develop with inevitable implications for the roles and development of non medical clinical staff: ‘Support GPs to help individuals and their families stay healthy’; Personalised individual care plans for everyone with a long term condition; Integrated care organisations (based around groups of GPs) to manage health care resources for local populations; Introduction of Personal health budgets; Extended choice of GP practice; Improved Safety and quality; Provision of information about quality of care through Quality Accounts; GP practices brought within the scope of the Care Quality Commission; New patient pathways for eight conditions requiring primary care to play a pivotal role in managing more patients with complex needs and in working with other elements of the pathway.

Virtually every health related policy initiative from the National Dementia Strategy (DH 2009) to Pandemic Flu Planning (DH 2008) has implications for primary care (see Appendix for comprehensive list).

Access to GP services is a major concern. Primary Care’s ability to manage demand for urgent care was highlighted in a Primary Care Foundation Report (2009) which argued that more than one third of practices in 5 PCTs had insufficient staff to respond reliably and quickly to calls at peak times, leading to unnecessary attendance at A and E.

In summary, recent policy developments indicate that there is a range of training and development needs in General Practice if these initiatives are to be realised. These include:

- Long term conditions management within the context of Darzi pathways
- Personalised care
- Health promotion
- Support for self care
- Improved access and responses to people with dementia and learning disabilities
- Multi disciplinary Team working within practices
Partnership working with the wider health and care system

Improved IT skills

Improved systems management for access to appointments

Underpinning this, good HR practices will be required to review roles and skill mix, identify individual training needs, and to negotiate appropriate ways of meeting these needs.

3. The Purpose
The purpose of the study was better understanding of current and future training needs of staff working in GP practices.

FRA was tasked with the following:

- Document the job titles and roles of non-medical clinical staff
- Describe how education and training is currently organised in the practice, and what processes are used (e.g. appraisal, performance development review, training needs analysis)
- Identify any training needs that practices currently find difficult to meet
- Advise NESC on ways in which we might routinely gather workforce and training data which are cost effective for practices
- Propose options for effectively engaging with primary care practices to assist them to plan for and engage with education providers to deliver future clinical workforce requirements.

4. The Methodology
- Literature Review
- In depth engagement with four practices across the SHA patch
- Questionnaire to geographical sample of practices
Meetings with Practice Manager Groups in three areas (Slough, Wokingham, Portsmouth)

Focus Group with staff from the four GP practices

Interviews with staff member responsible for Protected Learning Time in one PCT, two other Practice Managers, two private providers of Training and Development for staff working in GP practices

Attendance at Milton Keynes Practice Leaders Programme sessions, and at the 14th July Shared Learning event.

5. Findings

5.1 Document the job titles and roles of non-medical clinical staff
- Consistent range of job titles, though health care assistant / phlebotomist used interchangeably

- Skill mix – roles performed by GPs, Nurse Practitioners, Specialist Nurses, Practice Nurses and Health Care Assistants / Phlebotomists vary considerably between practices

- Artificial divide between Practice and Community Nurses unhelpful in terms of roles and shared training. One rural practice combines the two roles with satisfactory results

- In some large practices there is a Patient Services Team which combines administrative and front of house reception functions

- In one practice a Business Manager role has been developed to lead on strategy

5.2 Describe how education and training is currently organised in the practice, and what processes are used (e.g. appraisal, performance development review, training needs analysis)
- Considerable variation across practices

- Larger practices are able to meet highest HR standards, but most struggle
• Few practices have an annual training plan; instead they tend to respond on an ad hoc basis to individual training needs identified through appraisal or in response to business needs

• Training Budgets are held by GPs / Practice Managers. Few practices allocate an annual budget but rather fund individual requests / identified need

• The management of Practice Nurses is a particular challenge – ‘flat’ hierarchy and lack of professional leadership noted as barriers. Range of models for management, including nurse managers and management by practice /business manager working with a GP.

• Practices struggle with the induction of new practice nurses in the absence of a bespoke training pathway and in-house capacity for mentoring. One PCT provides mentoring by experienced GPNs on request

• 16 of 22 practices cited ‘in house capacity to deliver education and training’ as a barrier, 6 requested help with Training Needs Analysis

• Protected Learning Time is resourced by most Primary Care Trusts. The amount of time and the organisation varies. Smaller practices struggle to use in-house time productively

5.3 Identification of Training Needs which are hard to meet

These results are derived from 22 returned questionnaires of a total of 100 distributed to Practice Managers in four areas, a 22% response rate. Respondents were asked to weight their highest priority. The higher the number in the ‘Weighting’ column, the more urgent the identified need.
<table>
<thead>
<tr>
<th>Questionnaire Top Scores</th>
<th>Number of Practices Citing</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service Training for reception staff</td>
<td>14</td>
<td>37</td>
</tr>
<tr>
<td>IT Skill Development</td>
<td>11</td>
<td>31</td>
</tr>
<tr>
<td>Specific clinical skills for nurses / AHPs (includes induction)</td>
<td>9</td>
<td>33</td>
</tr>
<tr>
<td>Exchange visits to learn from other practices</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td>Management / Leadership Training for nurses / AHPs</td>
<td>7</td>
<td>14</td>
</tr>
</tbody>
</table>

Note: although respondents were asked about the need for training to support partnership working across the local health economy there were no positive responses.

5.4 Principal Barriers to meeting your staff’s Training and Development Needs
These results are derived from questionnaire responses

<table>
<thead>
<tr>
<th>Questionnaire Results</th>
<th>Number of Practices citing</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of funding</td>
<td>16</td>
<td>48</td>
</tr>
<tr>
<td>In-house capacity to deliver education and training</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td>Availability of suitable courses locally</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>Covering staff absence</td>
<td>11</td>
<td>47</td>
</tr>
<tr>
<td>Locating high quality trainers</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Lack of opportunity to learn from other practices</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

The extent of part time working was cited by several Practice Managers in addition, as it increases costs and presents timing problems e.g. in relation to attendance at Protected Learning Time events.

5.5 If money was no object …
The questionnaire asked respondents to consider what they would like if money was no object
Professional development for Practice Managers was explicitly requested by 3 respondents

5.6 Suppliers

The questionnaire asked about suppliers of education and training.

All 22 practices use in-house training and PCT provided training.

Comments on PCT resource for training, Protected Learning Time (PLT), were positive. It is regarded as a vital resource. The resource is used in two ways:

1. To fund practices to close for a period (normally half a day or 3 hours) to deliver training within the practice

2. To provide external events which are organised by the PCT.

Several people commented on ways in which the quality of the PCT organised events could be improved:

- Stipulate level and intended outcomes of external courses in advance
- Consult with stakeholders to establish priorities
- Approaches and topics which involve all practice staff, not only GPs and nurses
- Use of external PLT events to meet statutory training needs such as child protection
- PCT staff would benefit from an improved understanding of General Practice.
‘Time resource is a major block. Courses are often not targeted at a particular level, contents are vague. This can lead to wasted time. PCT no longer asks what is needed, TIPS (PLT) sessions used to be more useful’ (Practice Manager).

For in-house PLT, smaller practices undoubtedly struggle to locate trainers and topics for sessions. 16 practices identified capacity within the practice as a barrier to meeting training needs.

A minority (5) used Universities. Of those who did, there was some dissatisfaction at the length and suitability of courses for Practice Nurses. They required substantial time out from the Practice, and did not always deliver the practical skills needed. ‘Nurses coming from hospital cannot take BPs with GPs’ ‘old fashioned’ mercury equipment’ (GP). Two GP interviewees from Stage 1 expressed the view that the University-delivered training led nurses to risk aversion, rather than giving them the confidence to undertake autonomous practice.

In the Wessex Deanery two private providers which specialise in primary care were extensively used. Both were highly regarded, and lay on local courses for practices to meet recurrent needs. Both have the capacity to provide bespoke courses on request or to signpost other providers (such as AMSPAR for practice managers). We identified no similar resource in the Oxford Deanery.

We found little evidence that practices are aware of external sources of training moneys (for example Train to Gain funding).

5.7 Ongoing Data Collection
FRA was asked to advise on ways in which NESC might routinely gather workforce and training data which are cost effective for practices.

We found that Questionnaires were ineffective. Despite careful piloting and local sponsorship from Practice Managers, only 22 of approximately 100 circulated were returned.

Primary Care Trusts are required to collect basic workforce data annually from all practices and other primary care providers. Our recommendation is that the format and content of this data collection should be agreed and data shared with NESC. This should include information on salary scales, whole/part time working, age, gender, ethnicity and specialist skills.
To maintain dialogue over commissioning of appropriate education and training we advise that Practice Manager Networks which meet monthly, often with a PCT in attendance, may be the most suitable forums for engagement. Engagement with PCT staff who attend these meetings may be a cost effective route for NESC to use. The three Practice Manager groups visited by the FRA team indicated willingness to participate, though it should be noted that some Groups struggle to reach 50% attendance from local practices.

6. Conclusions

6.1 Capacity in General Practice

The report indicates that GP practices vary considerably in their capacity to manage education and training. We found some examples of excellent practice. The best practice we visited compared well with any high performing organisation. It had an annual training plan, regular meetings to cascade learning, a sophisticated system to make use of Protected Learning Time for the multidisciplinary team, Vision and Values, confidence and commitment, annual appraisal with biennial review of job descriptions, supported by high quality paperwork. This was a rare example in a very large practice with 130 staff and 26,300 patients.

Most practices surveyed had ad hoc processes for staff development and training, and it was noticeable that few had a training plan or dedicated budget, though examples of good practice were not hard to find. Funding for training was regularly cited as a major deterrent, combined with difficulty in providing cover, and part time working.

‘Training for staff died a death when Training Budgets changed to being paid with the PMS / GMS budget as GPs generally do not want to spend their money on training courses for their staff’ (Practice Manager).

Capacity for sophisticated HR is also a barrier. One Practice Manager in a large practice commented ‘Staff competence and capacity has hampered us in implementing appraisal beyond a ‘tickbox’ approach, and in revising job descriptions as roles change’.

Locating high quality and suitable courses and trainers was also a challenge for Practice Managers. This was particularly acutely felt in small practices which lack in-house expertise. The private companies located in / near Wessex were able to fill this gap to some extent, but we discovered no such providers in the Oxford Deanery.
The role and development of Practice Nurses provoked considerable debate. ‘Practice nursing is not defined on competence, but on where you work. The job is contingent on what doctors delegate and what they feel competent to do. These do not currently match,’ commented one experienced Practice Manager. We do not dwell on this in detail, as this is the province of another NESC funded initiative, but note that the NESC sponsored Practice Nurse Development Programme was widely welcomed.

Even the best practices were unlikely to have the objectives of Darzi’s High Quality Care for All high on their list of priorities. The exception was one practice in a PCT where NESC has sponsored a Practice Leadership Programme. This practice was participating with other practices and the PCT to develop the Diabetes pathway, and the stimulus and organisation provided by the Practice Leadership Programme was apparently the driver.

GPs vary considerably in their willingness and ability to engage with the training, development and workforce development challenges. Said one: ‘The consultation has not changed but everything has changed around it, so GPs feel their job is to stay in the consulting room, change is someone else’s job, so GPs don’t volunteer’. We noted, however, that NESC’s investment in GP leadership through the Practice Leaders’ Programmes in Portsmouth and Milton Keynes was already beginning to change attitudes to training of non-medical clinical staff, particularly customer service (reception) staff.

Overall we conclude that capacity in primary care to sponsor sophisticated learning and development is limited, and over reliant on Practice Managers’ capacity, skills and ability to influence GPs to prioritise activity which constitutes a cost to the Practice and presents practices with practical challenges in providing cover. Other than (nascent) competition there are few material incentives to focus on education and training, and there are numerous barriers: financial, practical, absence of suitable provision locally, cultural resistance amongst staff, and fear of poaching by other practices if staff become highly trained.

6.2 The Role of Primary Care Trusts

PCTs are the commissioners of General Practice, and thus have the role of performance management and contract compliance. As commissioners, Primary Care Trusts also have a role in ensuring that the health workforce, including those working in General Practice, is fit for purpose. Although we were not tasked with considering the role of PCTs, and did not do so in detail, it does of necessity impinge upon this topic. PCTs provide some resource for practices:
Protected Learning Time (most)

Training linked to specific DES and LES requirements, for example IT and Learning Disabilities

Professional Leadership for GPNs (though some indications that this is declining).

In addition, PCTs have existing links with Practice Manager Groups which is potentially a resource for the Primary Care Taskforce.

There has been discussion in the literature that PCTs in their commissioning role could have a more creative role in relation to education and training (see Appendix 1). However, there was little indication that the PCTs in South Central SHA were adopting this approach, other than in Milton Keynes and Portsmouth where NESC’s investment in Practice Leadership has been supported by the local PCTs. Practice does vary. Hampshire PCT offers experienced GNs to practices to support the induction of new Practice Nurses; for example, a service that is chargeable to the practice, nevertheless widely appreciated.

Most Primary Care Trusts do provide resource for Protected Learning Time, enabling practices either to hold in house training and development for their staff, or to attend PCT organised external events. This is a resource valued by practices. However, our investigations indicate that better use could be made of this significant resource – see Para 5.6.

Other than in these areas, most PCTs were regarded with suspicion by practices. PCTs were regarded as inhibiting innovation – one Focus Group participant believed they regarded innovation as ‘awkwardness’, because it does not ‘fit’ established monitoring frameworks. We suggest that although PCTs may have the potential to be agents for improving practice, they currently lack capacity, and that solutions which involve PCTs, are unlikely to meet with immediate approval from GPs.

6.3 The value of developing professional networks

We concluded from our investigations that professional networks with an interest in education, training and workforce development in primary care are, at best, dispersed, and at worst, non existent. Several of our recommendations relate to developing networks: of practice managers; of GPs with an interest; and of PCT staff with responsibility for commissioning GP practices. In this way NESC will be able to understand and begin to influence the education, training and workforce
development agenda. We detected some willingness amongst the practices with whom we consulted for such networks, though it has to be recognised that there will be some resistance to spending time on activity which does not meet immediate targets. Building on the networks and energy developed by NESC’s Practice Leaders’ Programmes in Milton Keynes and Portsmouth in 2008/9 will be important.

7. Recommendations
Our Recommendations to the Primary Care Taskforce are detailed below, with suggestions for specific pilots where appropriate:

7.1 Ongoing Collection of Data relating to workforce numbers
- Our recommendation is that the Primary Care Taskforce negotiate with PCTs to access the data collected annually which gives crude data on numbers and categories of staff employed in General Practice
- To maintain dialogue over how best to meet training needs, we advise that NESC should meet with Practice Manager Groups annually to review the previous year, and plan for future needs.

7.2 NESC should commission specific programmes of learning for non medical clinical staff
- Commission short (2 to 3 day) courses for specific clinical skills development aimed at GPNs. It will be important to advertise level and learning outcomes in advance.
- Experiment with clustering of practices to commission training for administrative and reception staff through a competitive tendering process
- Continue the existing Practice Nurse Development Programme
- Pilot a 6/12 conversion course to support the selection and training of hospital based nurses for Practice Nursing: selection and training to be undertaken prior to taking up GPN role
- Distance learning options in specific target areas such as the Learning Disability and IT DES could be explored
- NESC to consider a system of kitemarking courses and providers for quality, responsiveness and relevance

7.3 NESC should build infrastructure to support organisational development for GP practices
- To sponsor and evaluate an experimental Practice Leaders’ Programme for GPs and Practice / Business managers in one locality with the brief of supporting effective practice management, and finding ways to support staff and organisational
development in local practices including use of PLT for customer service and multi
disciplinary team development
• To provide funding for local half day facilitated events where practices exchange
good practice in Training and Development for non medical clinical staff
• To find ways of supporting the professional development of Practice Managers (see
Jan McCall’s recommendations for details)
• To publicise resources available in the WIPP website, by building links into NESC’s
website
• To publicise Train to Gain funding for staff who do not hold a Level 2 qualification.
• To offer a programme of coaching for staff in leadership roles.

7.4 NESC should build infrastructure for ongoing dialogue with practices relating to
training and development
• To develop a network of PCT staff with responsibility for education and training in
General Practice and support a dialogue about roles and relationships
• To develop relationships with Chairs of Practice Manager groups in order to sustain
dialogue and keep training on the practice agenda
• To develop the NESC website as a resource for education and training in primary
care
• To sponsor an online General Practice Innovations Forum where practices can share
and celebrate innovation online

7.5 NESC should take steps to encourage better use of Protected Learning Time
• To maximise the value of Protected Learning Time to more effectively meet the
needs of multi disciplinary teams. This means using external sessions to meet statutory
training requirements, and, for example, general professional skills development and
customer service. This will enable practices to use in-house sessions for team multi-
disciplinary training that enhances team working.
• NESC could work with a PCT and GP practice representatives to develop
approaches to PLT which could serve as a model SHA wide. This working group
could then address ways of stimulating engagement with Darzi pathways. It should
seek to find ways to include community staff (Midwives, District Nurses and Health
Visitors) in practice training initiatives.

7.6 Longer Term National Solutions
• Pre registration nurse training to include PN - i.e. more than current short student
nurse attachment Combined Practice / Community Nurse model.
• Build education and training targets for non medical clinical staff into the QOF.
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- coaching • facilitation • training •

- An assured nationally agreed framework for annual appraisal and personal development for non medical clinical staff in General Practice.
Appendix 1: Literature Review

A literature review was undertaken to:

- Summarise existing research on new models of primary care and explore their impact upon roles
- Review previous initiatives to address the training and development needs of non medical clinical staff working in GP practices
- Summarise policy guidance with implications for the roles and responsibilities of General Practice staff

The authors of the Report defined non medical clinical staff as those directly employed by General Practitioners in roles where patient contact was part of the role. This includes Nurse Practitioners, Practice Nurses (GPNs), health care assistants and phlebotomists, Allied Health Professionals, reception or Patient Services Staff. We also included Practice and Business Managers who play a pivotal role in managing these staff, usually alongside doctors, and in developing training plans and allocation of budgets.

New Models of Primary Care and Impact on Staff Roles

The NHS Next Stage Review: Our Vision for Primary and Community Care (2008) sets out the future of General Practice. GP led health centres providing a broader range of services, opening hours extended, work with community teams, greater patient choice of GP practice, rewards for quality, accreditation of Practices, inspection by the Care Quality Commission, active promotion of early intervention to avoid long term health problems. Patients can expect personalised care plans, support with self care, healthy living initiatives to prevent ill health, integrated care organisations, and data which supports patient choice. GPs will need to focus on prevention and quality for everyone if they are to meet this vision.

Primary Care has a pivotal role to play in implementation of patient pathways. Effective diagnosis and signposting where necessary, as well as supporting post acute phase rehabilitation make unprecedented demands on the skills of the GP led teams in primary care.
The implications for NHS South Central were set out in a briefing paper authored by Dr. Simon Plint (2008),

- Baseline demand for primary care services is predicted to grow substantially in the next few years, with increasing expectations, increasing complexity of care, and increasing volume of care with ageing population, even without the proposed transfer from secondary to primary care and the realisation of the Next Stage Review pathways
- Transfer of care will require significant expansion of primary care infrastructure and creation of new training pathways for the wider primary care workforce, as well as increasing further the demand for General Practitioners to lead service delivery.

There is no question that new models of primary care as set out in Lord Darzi’s paper will make significant demands on the workforce. However, surprisingly little attention has been paid to this in the literature.

**Education and Training for non Medical Clinical Staff**

The shift of care from secondary to primary care and the emphasis on the detection of disease, health promotion and the management of long term conditions provides primary care with many challenges. Whilst policy has been to increase expectations on primary care, there has been relatively little systematic work to analyse and meet the training needs associated with these developments, although some useful initiatives provide pointers to good practice.

These include: WIPP ‘Working in Partnership Programme’ a DH funded initiative 2004-8 which was set up under the nGMS to support general practice with capacity building resources and strategies [http://www.wipp.nhs.uk](http://www.wipp.nhs.uk)

WIPP produced a set of useful toolkits, a Good Practice database and detailed advice on training and development for GPNs and hcas now housed on the RCN website [http://www.rcn.org.uk/development/hca_toolkit](http://www.rcn.org.uk/development/hca_toolkit)

A Kent, Surrey and Sussex SHA funded investigation into its Strategy to Promote Life Long Learning in the Primary Care Workforce (Mclaren et al 2008) concluded that there were early indications of successful transition into embedding lifelong learning in primary care (p. 154) (n.b. work carried out in 2003 prior to nGMS contract)

A Scottish study introducing the concept of Senge’s learning organization to a Learning Practice in Primary Care (Rushmer at al 2004) which the characteristics of a learning oriented primary care organization
A study by Cunningham et al (2007) into the use of Protected Learning Time (PLT), an established mechanism for meeting General Practice learning needs found that committees had difficulties in planning events which could meet non medical staff learning needs, ambiguity over the inclusion of community staff not directly employed by GPs, and that PLT entailed considerable work for Practice Managers.

The NPCRDC WISE approach to support self management currently being rolled out in a PCT (http://www.npcrdc.ac.uk/Publications/frontline23_webprint7.pdf) aimed at the entire multi-disciplinary team.

Responsibility for Training and Development: where does it lie?
The responsibility for Training and Development of NMCS in General Practice is diffuse since the nGMS contract made this the responsibility of individual GP employers commissioned by PCTs to provide a whole service.

The responsibility for commissioning education and training is clear. Lord Darzi’s Next Stage Review allocates responsibility for workforce planning, education commissioning and quality assurance of health education in their Regions to SHAs (para 105).

As commissioners, Primary Care Trusts also have a role in ensuring that the health workforce, including those working in General Practice, is fit for purpose:

‘PCTs and Local Councils will need to be confident that service providers have workforce strategies in place to deliver these services’ (para 122).

The role PCTs could be expected to play in training and development of the primary care workforce is considerable. In relation to Practice Nurses (GPNs) it is articulated by WIPP as:

- Professional Leadership and Support for Nurses working in General Practice
- Best recruitment practice
- Competence development as part of the broad responsibility for Clinical Governance
- Dialogue with nurses working in General Practice
- Support to nurses to deliver a service based on population need
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• coaching • facilitation • training •

• Increasing capacity including support for an organisation to provide nursing services across a group of GP practices
• Provision of clinical placements
• Performance Management

However, WIPP acknowledges that technically the practice is responsible for T and D, hence there is considerable ambiguity as to expectations of PCTs in this regard other than ensuring that practice is safe and meets commissioning standards. Our respondents acknowledged that T and D was indeed the practice’s responsibility, though a significant proportion argued that because there was no longer ring fenced funding budgetary constraints limited what could be achieved.

Appendix 2 The Brief

The aims were to:

1. Support primary care providers to access educational support for their existing and new clinical roles, including planning for Next Stage Review
2. Undertake a current state assessment of the existing roles and the numbers and types of staff performing those roles working within GP practices
3. Summarise existing research on new models of primary care and explore their impact upon roles
4. Identify new and emerging roles in primary care
5. Propose options for effectively engaging with primary care practices to assist them to plan for and engage with education providers to deliver future clinical workforce requirements.

Evaluate the effectiveness of the options from the following perspectives:

• Uptake ie provision of workforce information from practices
• Acceptability to GPs
• With academic partners assess the sensitivity and specificity of the different approaches in relation to roles and functions performed
• Quality of the information provided
• Costs of collecting the information.

Advise on
• Options for collecting workforce information from primary care.
Interpretation of workforce information received.
How workforce plans can be shared with primary care leaders and further developed.
Roles and responsibilities for managing engagement and its costs.

We translated this brief into a fourfold statement of Purpose:

- **Document the job titles and roles of non-medical clinical staff**
- **Describe how education and training is currently organised in the practice, and what processes are used (eg appraisal, performance development review, training needs analysis)**
- **Identify any training needs that practices currently find difficult to meet**
- **Advise NESC on ways in which we might routinely gather workforce and training data which are cost effective for practices**
Appendix 3 The Project Team’s Methodology

The FRA team adopted a multi-method approach:

Stage 1: In depth research with four practices
February to March 2009 in-depth research into practice relating to education and training in primary care in four GP practices (Stage 1 Practices), selected to represent a range of characteristics:

2 from each of the Deaneries, Oxford and Wessex

Rural / urban

Large / medium

Affluent / deprived population

The brief to practices was:

- Document the job titles and roles of non-medical clinical staff
- Describe how education and training is currently organised in the practice, and what processes are used (e.g., appraisal, performance development review, training needs analysis)
- Identify any training needs that you currently find difficult to meet
- Advise us on ways in which we might routinely gather workforce and training data which are cost-effective for practices
- Write a short report on each practice, which will be available to NESC, and, of course, the practice concerned
- And finally, help us see how we can add value to what you are already doing.

The consultant(s) will require access to your staff for brief interviews, to job descriptions and other relevant documentation, and will need interview time with you / your nominee. We are, however, confident that there will be benefits for your practice and patients:

- an opportunity to reflect on your practice development planning with the support of an expert team
- access to small bursaries to meet some specific learning needs identified through the process,
- and

the opportunity to influence our commissioning strategy. Following each visit a confidential feedback report was prepared for each practice, and discussed with practice or business manager.
Stage 2 Wider Consultation
April / May 2009: telephone and face to face interviews with stakeholders including Primary Care Trusts, private providers of education and training, other practice managers

May / June 2009 Face to Face Consultation with Practice Manager Groups in Slough, Wokingham and Portsmouth

May 2009: development and administration of questionnaire to practices, disseminated via practice manager networks in East Berkshire, Portsmouth, New Forest and Wokingham

June 2009 Analysis of questionnaire responses

June 2009 Development Day with multi disciplinary representatives of the four Stage 1 Practices to check preliminary findings

July 2009 Attendance at Milton Keynes Practice Leaders Programme Shared Learning event

The Team reported back to the NESC commissioning team at monthly intervals.

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Primary Care Foundation (2009) ‘Urgent Care - a practical guide to transforming same-day care in general practice’ Lewes Primary Care Foundation


**Summary of Policy Guidance with implications for General Practice Staff**

DOH (2008) *Darzi High Quality Care for All;*

- Locally led
- Patient centred
- Clinically driven
• Increase availability of information
• Increase choice

Every PCT will commission well being and prevention services, in partnership with local authorities offering personalised services to meet the needs of the local populations eg tackling obesity, reducing alcohol harm, treating drug addictions, reducing smoking rates, improving sexual health and mental health.

DOH (2009) Healthy lives, brighter futures The child and young people's strategy

- Young people should be involved in commissioning process
DOH (2008) NHS next stage review; our vision for primary and community care DOH

Raising the profile of long term conditions

- Successful PBC will be rewarded with extra freedom in managing resources and designing services

- Integrated care organisations (based around groups of GPs) manage health care resources for local populations

- GPs to work with carers to produce care plans

- GPs to select quality indicators reflecting local health improvement priorities.

- Voluntary accreditation scheme for GPs

- Should be responsive to patients' feedback

- Personalised service provision with an emphasis on prevention

- GP led walk-in health centres to be introduced.

DOH (2008) Healthy weight, healthy lives

To develop a local overweight and obesity strategy

- Understand the problem in the area and set local goals, look at the prevalence, the local costs and priority groups
- Local leadership multi-agency approach, sub committees
- Choosing interventions- how to commission services
- Monitoring and evaluation- details how to deliver a successful evaluation strategy.

Assess weight problems using BMI index and waist circumference measurements.

Raising issue of weight with patients and assessing readiness to change

Document provides resources for health professional such as guide to BMI and waist circumference monitoring.
DOH (2009) National Dementia Strategy
- GPs working side by side with mental health services
- GPs knowing how to spot the first signs of dementia
- Making information and support available to people with dementia as soon as possible
- Giving everyone with dementia their own personal dementia advisor to help them
- Help people to stay in their homes for longer

No details about staff training although the importance of raising public AND professional awareness and knowledge is raised.


Department of Health qualitative services evaluation pilot on the case management of LTCs April 2007

Our health, our care, our say: A new direction for community services, DH, January 2006

Promoting independence and personal dignity - services should support and maximise the well being of the individual ensuring that they live their lives as well as they can

- recommend local strategic partnerships and community based commissioning
- vision to put people in charge of their own health and care
- Enabling and supporting health and independence and well being
- Rapid and convenient access to high quality, cost effective care.


DOH (2008) Refocusing the care programme approach; Policy and Positive Practice Guidance

DOH (2006) GP patient survey: your doctor, your experience, your say - guidance for strategic health authorities, primary care trusts and GP practices


DOH (2008) Pandemic flu planning. Agreement on GP remuneration: guidance note for Primary Care Trusts

DOH (2004) You can make a difference: improving primary care services for disabled people - Good practice guide for primary care service providers


DOH (2008) Report of the National Improvement Team for Primary Care Access and Responsiveness

DOH (2005) Choice at Six Months: Good practice

DOH (2005) Framework for the Primary Care Development Scheme
DOH (2008) No patient left behind: how can we ensure world class primary care for black and ethnic minority people?


DOH (2005) Commentary on the national out-of-hours quality requirements, and their performance management

NICE Guidelines

**Long term sickness guidance and Incapacity for work**
Consider offering ‘light’ or less intense interventions, along with usual care and treatment, to those who are likely to return to work

- Consider more intensive, specialist input when there is recurring long term (or repeat episodes of short-term) sickness absence or where the outlook for a return to work is poor

- Consider ways of helping people to overcome the barriers to returning to work using psychological interventions (see page 10)

- Where appropriate, offer a management programme for back problems (see page 11)

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The person planning, coordinating or delivering the interventions or services should have relevant experience, expertise and credibility. They may need:
Invest in interventions and programmes that identify and build on the strengths of individuals and communities and the relationships within communities. These include interventions and programmes to:

– promote and develop positive parental skills and enhance relationships between children and their carers

– improve self-efficacy

– develop and maintain supportive social networks and nurturing relationships (for example, extended kinship networks and other ties)

– support organisations and institutions that offer opportunities for local people to take part in the planning and delivery of services—support organisations and institutions that promote participation in leisure and voluntary activities

– promote resilience and build skills, by promoting positive social networks and helping to develop relationships

– promote access to the financial and material resources needed to facilitate behaviour change

NICE

NHS Institute for Innovation and Improvement Quality and value
Focus on: Heart Failure
Heart Failure nurses offering seamless care across the system for heart failure patients

“...highly trained with regard to symptom management and care of conditions such as diabetes and COPD” pp 35

Key characteristics

7- GPs are pivotal and valued as professionals for ongoing management of patients with heart failure

- GPs regularly review register to ensure accurate diagnosis and coding.
- GPs share ideas and focus on secondary prevention and work to agreed goals.
- GPs run a heart failure clinic with practice nurses
- GP is Primary Trust lead CHD and is focused on improvement by pushing the boundaries of where care can be delivered by setting up dedicated heart failure clinics in Primary Care
- A GP offering enhanced services should have appropriate training in service development and needs assessment.

8- Heart failure specialist nurses impact within GP practices.

12- Expertise provides audit support, advice and training to teams across the system pp27

COPD
Children
Coronary heart disease
Diabetes
Long term (Neurological) conditions
Mental health
Renal
fiona reed associates
• coaching • facilitation • training •

Stroke
Vascular
Cancer

NICE/SCIE (2006) Dementia: supporting people with dementia and their carers in health and social care
   -Primary care to encourage help seeking and help offering (referral for diagnosis) by changing public and professional understanding and behaviour
   - Make early diagnosis
   - Allocate diagnosis to a specific part of the system
   - Provide good quality early diagnosis and intervention for all
   - GPs to diagnose
   - Good quality information for people with dementia and their carers.
   - Enabling easy direct access to a contact who can signpost and facilitate health and social care input through life with dementia.

National Service Frameworks

Population wide prevention
   – self management healthy people, smoking cessation, diet and nutrition, physical activity, screening.
   – Disease management- providing timely and appropriate guidance and support around diagnosis and treatment options
   – Case management- expanding choice and developing a personalised service for patients
fiona reed associates

- coaching • facilitation • training •

Long term (neurological) conditions (2005)
- Promote independent living
- Care planned around the needs and choices of the individual, make access to services easier
- Joint working across all agencies and disciplines involved.