Transforming Services Together

Report to the Inner North East London Joint Health and Overview Scrutiny Committee

7 November 2016

Contents

1. Introduction

The following information supports a presentation to the INEL JHOSC.

At a meeting between the INEL JHOSC Chair and Vice Chair and CCG Chief Officers it was agreed to arrange two meetings to discuss specific elements. The two meetings have been scheduled to allow sufficient time for a more detailed debate on key proposals to inform future plans.

This meeting sets out:

- Financial implications and progress
- Workforce implications and progress.

A meeting on 17 October 2016 will discuss:

- Self-care and progress
- Elective care and progress
- Movement of services and patient journeys and progress.

The information summarises and updates the information provided to the public and stakeholders during the engagement period (29 February to 31 May 2016) in the strategic investment case http://www.transformingservices.org.uk/strategy-and-investment-case.htm

2. Summary of Financial Implications

Further published detail can be found in the strategic investment case at:

- Part 2 (Main report) page 16: The financial case for change
- Part 2 (Main report) page 61: Financial and activity assessment. This describes the expected revenue and capital impacts of TST in conjunction with expected activity
- Part 3 (High impact changes): Describes the investment costs and impact on activity and revenue for each of the 13 high impact changes.

2.1 Summary of Demand and Spend

Total current annual CCG expenditure on healthcare services in Waltham Forest, Newham and Tower Hamlets is £1.16billion[1], providing an associated bed base of 6,498 across acute, community care, primary care and mental health sectors. The three CCGs are all forecasting a small surplus in 2016/17.

Over 52% of this amount is commissioned from the main acute provider Barts Health NHS Trust. At approximately £608m in 2016/17, the remainder being comprised of smaller acute providers, primary care, mental health, community services, and continuing/other services.

There is an ever-increasing demand for healthcare services in the area, driven by demographic increases in the age and size of the population. This increasing demand leads directly to increased costs for the provision of services, forecast to be some £236million a year extra by 2021, giving a 20% increase in cost over the next five years.

2.2 Summary of Funding Allocations

Nationally, against this rising level of demand and costs there is relatively constrained funding growth for the NHS (of c1.1% per annum). Local total recurrent funding allocated to WEL CCGs is forecast to increase in each of the next five years, above the national average because of our increasing population. So by 2020/21 we will receive over £142million a year more than now. Although this is a significant amount of increase, it will not cover the costs of increasing activity.

2.3 Combined Financial Forecast

Combining the demand and resourcing trends into a local perspective, Figure 1 illustrates the widening gap between CCGs' funding and the forecast increase in cost arising from increasing healthcare demand. Although annual funding is anticipated to rise at a rate of c.2.8%, demand and investment costs are expected to rise faster at a rate of approximately 3.8% per annum.

[1] This spend does not include a) patients living in other boroughs which will have their own method of ensuring efficiency and sustainability b) areas of specialist healthcare commissioned and funded by NHS England.

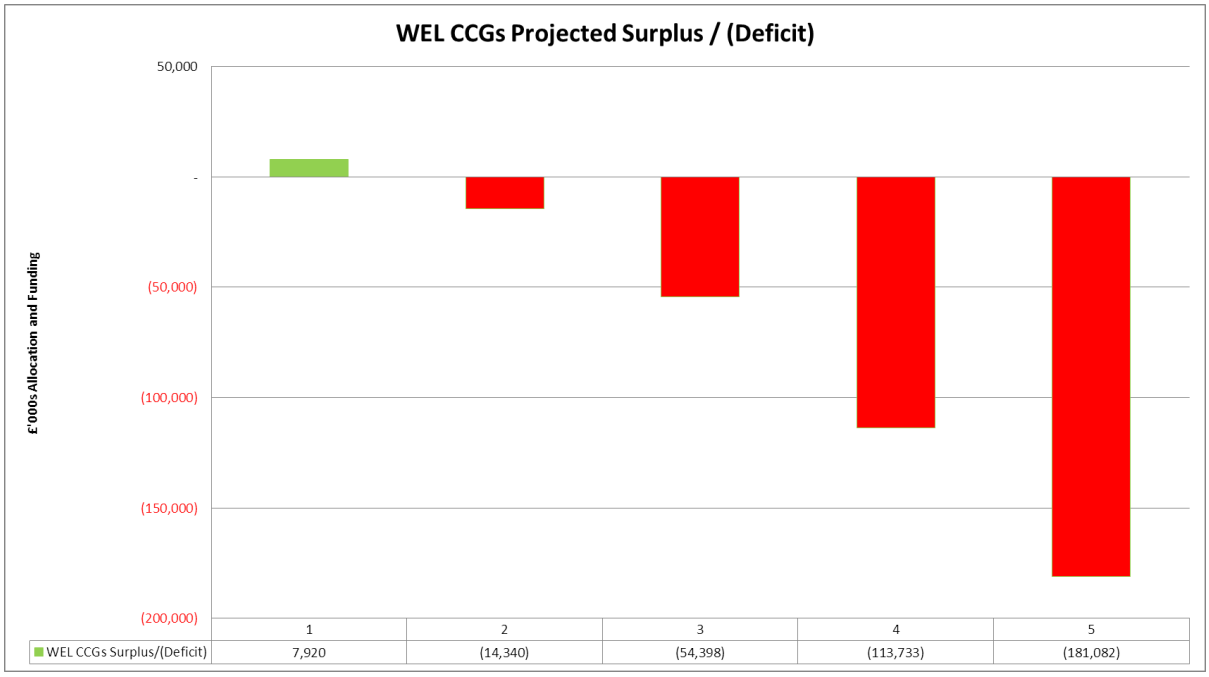

Figure 1: WEL CCGs' financial performance without TST programme[2]

2.4 Commissioner Deficit and Savings Challenge[3]

- Because of the growth in demand (both by the existing population and the population growth) and the investments required, by year five there will be, if no action is taken, a recurrent commissioner deficit of £181million which is likely to be unsustainable, even in the shorter term. This will be associated with a larger accumulated deficit of (c. £355million) over the five year period.
- The redress of this deficit and the achievement of financial sustainability will be principally met through changing the methods of healthcare delivery so that the same or better healthcare outcomes are achieved through a less costly process, a significant element of this is to be delivered by the TST Programme.

The TST programme is designed to try to seek these efficiencies through transformational service redesign. There are currently 12 work streams being implemented which are felt to have the largest possibility of delivering the necessary efficiencies whilst either improving or not adversely affecting service quality.

These schemes will come into effect gradually over the next five years reaching maximum effect by 2020/21. The final efficiency saving level is currently forecast to be £46.2million recurrently by 2020/21. The phasing of these schemes is shown below:

[2] The gap between funding, expenditure and the indicated surplus/(deficit) is the requirement for CCGs to save a 1% annual surplus.

[3] The figures do not include the TST footprint provider deficit which is associated largely with Barts Health NHS Trust. The TST forecasting assumes that the size of the annual deficit will decrease slightly over the coming years driven by: increases in tariff prices paid per unit of healthcare activity; and the achievement of internal cost improvement plans internally reconfiguring service to reduce the unit cost of each element of healthcare delivery. By year five the annual provider deficit is expected to be (c. £38m) albeit with a significant accumulated deficit.

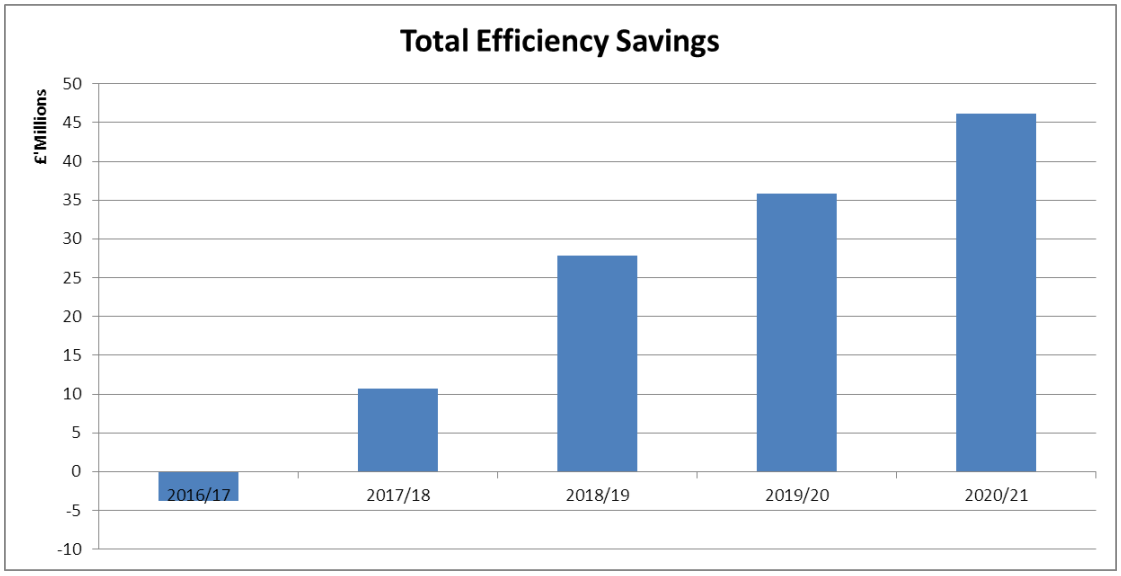

Figure 2: Projected TST efficiency savings

These savings are split across the 12 work streams shown below – approximating to a 4% efficiency saving by 2020/21. It is worth noting that the savings are the difference between the costs of the growing demand provided in the traditional way and providing the same services in a new, more efficient way. The efficiency savings figures do not represent a net reduction in the investment in any service; they are simply a measure of efficiency gain.

Workstream	2016/17	2017/18	2018/19	2019/20	2020/21	Total
Primary Care	-	1,598,187	4,286,820	(155,756)	1,481,691	7,210,942
Urgent Care	-	1,955,640	1,992,443	2,020,617	2,045,757	8,014,457
Integrated Care	-	185,712	365,356	305,030	244,834	1,100,932
End of Life Care	61,564	82,093	121,700	138,049	127,417	530,823
Acute Care Hubs	3,407,805	7,029,725	11,295,188	16,195,403	19,229,160	57,157,280
Surgical Hubs, incl. IR	-	-	-	-	-	-
Modern Maternity Care	971,682	993,068	1,310,432	1,334,329	1,567,692	6,177,203
Outpatient transformation	1,681,963	5,139,053	10,457,772	14,205,690	18,043,384	49,527,862
Reduce unnecessary testing	1,466,073	4,399,331	6,599,327	8,799,252	8,799,252	30,063,235
Shared Care Records	(1,042,196)	(1,687,810)	(1,883,143)	(1,807,724)	(1,932,213)	(8,353,086)
Physician Associates	-	-	184,108	1,069,240	2,902,916	4,156,264
Whipps Cross Hospital	(143,500)	(430,500)	(717,500)	(1,004,500)	(1,291,500)	(3,587,500)
Pump priming Costs (Non Recurrent)	(10,125,389)	(8,503,520)	(6,120,832)	(5,293,659)	(5,058,235)	(35,101,633)
Total Savings	(3,721,998)	10,760,980	27,891,670	35,805,973	46,160,154	116,896,779

Figure 3: TST efficiency savings (black) and investment (red)[4]

[4] Surgical hubs show no efficiency savings for commissioners as all savings are internal to Barts Health

These savings are based on the schemes below:

Work stream	Key points
1. Primary care	Improve access, coordination and patient empowerment. To do this we need smaller practices to work together so that patients can access more services in the community at times that suit them. Savings generated from the sustainability of primary care practice.
2. Integrated care	Extend integrated care to those at medium risk of hospitalisation (it is currently available to high risk patients) and provide care in the patient's home or in the community to help them stay well or manage their illness. Savings from reducing hospitalisation of those patients who do not absolutely require it.
3. Urgent care	Develop a single point of access with the ability to appropriately redirect patients to self-care services and/or book patients into local clinical services over a 24 hour period.
4. End of life care	Enable staff to have conversations with patients to ensure we understand their wishes, establish better partnership working and put in place specialised services to support more patients to be able to die in their choice of location. Savings from releasing hospital capacity currently used by those patients who would prefer to die elsewhere.
5. Improving surgical services	Create centres of excellence at each hospital by bringing together surgical services. This would a) support the viability of these hospitals b) release much-needed capacity at Royal London c) provide a better patient experience (and outcomes), reducing cancellations and waiting times. Pre-operative and post-operative care would be at the patient's local hospital.
6. Acute care hubs	Bring together clinical areas focused on rapid assessment, treatment and recovery. This would allow more people to be seen and treated quickly, avoiding the need for admission to a bed, which can occur, for example, whilst patients wait for tests.
7. Modern maternity care	Provide more informed choice and continuity of care to increase the proportion of natural births (usually midwifery-led).
8. Outpatient transformation	Improve the quality of referrals, make better use of technology, so that people can receive a consultation without having to travel to hospital (where appropriate) and improve the effectiveness of patient pathways across a range of specialties.
9. Reducing unnecessary testing	Reduce the number of high-cost unnecessary tests requested by some GPs. Consider GPs being able to directly refer patients for hospital tests (rather than to a hospital consultant who then does the referral). Improve IT to share tests.
10. Shared care records	Invest in the roll out of an 'East London Care Record', ensuring records are secure, accessible (both to read and to add comments and treatment given) and are used by staff.
11. Workforce including physician associates	Looking at introducing new workforce models, including the role of physician associates and pharmacists. Also it became clear during engagement that the work stream needed a wider remit around recruitment and retention, developing the workforce and promoting 'east London as a destination'.
12. Whipps Cross Hospital	Prepare for the re-design and rebuild of a full service hospital at this site.

Applying these work stream savings to the forecast c355million deficit in 2020/21 (£181million deficit after we take into account the income growth) would of course leave a significant gap. The chart below (figure 7) shows the impact of the TST savings as an element of the proposed improvement to the 2020/21 position[5].

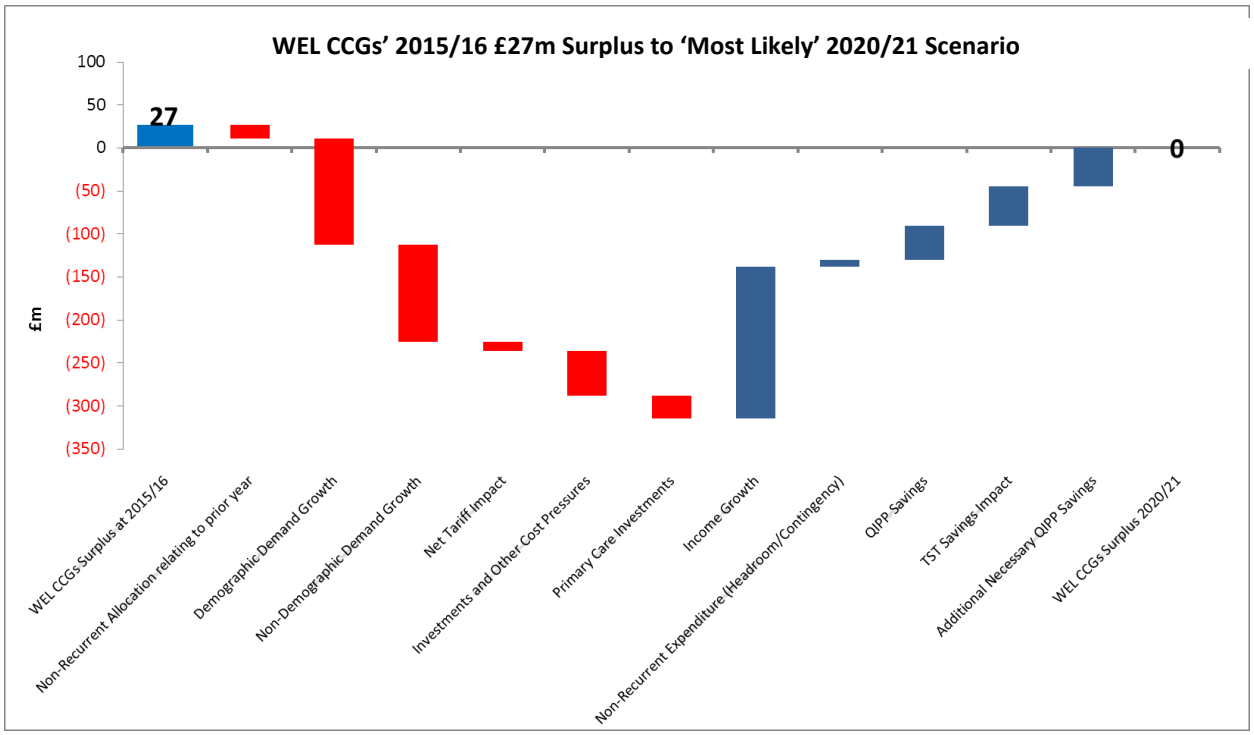

Figure 4: How CCGs will bridge the funding shortfall

As can be seen TST efficiency is significant, but far from the only element in addressing the savings need by 2020/21.

It is worth noting that all of the proposed savings will not lead to a reduction in the overall resource expended on healthcare in Waltham Forest, Newham and Tower Hamlets; indeed the total expenditure continues to rise in every year of the programme period.

2.5 Capital Costs

Many elements of the WEL healthcare estate are ageing and in need of repair. There are significant capital expenditure requirements to progress these schemes. In addition, failure to seek efficiencies in the delivery of healthcare services would impose a capital spend requirement to design and build an additional District General Hospital.

When comparing different scenarios (with and without TST) the potential capital costs breakdown into five categories:

- Minimum costs of backlog repairs & IT enhancements, mostly (77%) at Barts Health
- The re-design and rebuild of Whipps Cross Hospital on its existing site
- Procuring land required for an additional District General Hospital
- The design and build of an additional District General Hospital
- Capital costs of implementing TST.

[5] QIPP is Quality, Innovation, Productivity and Prevention schemes

The costs for doing these are best expressed over either a five or 10 year time frame and are shown in the table below.

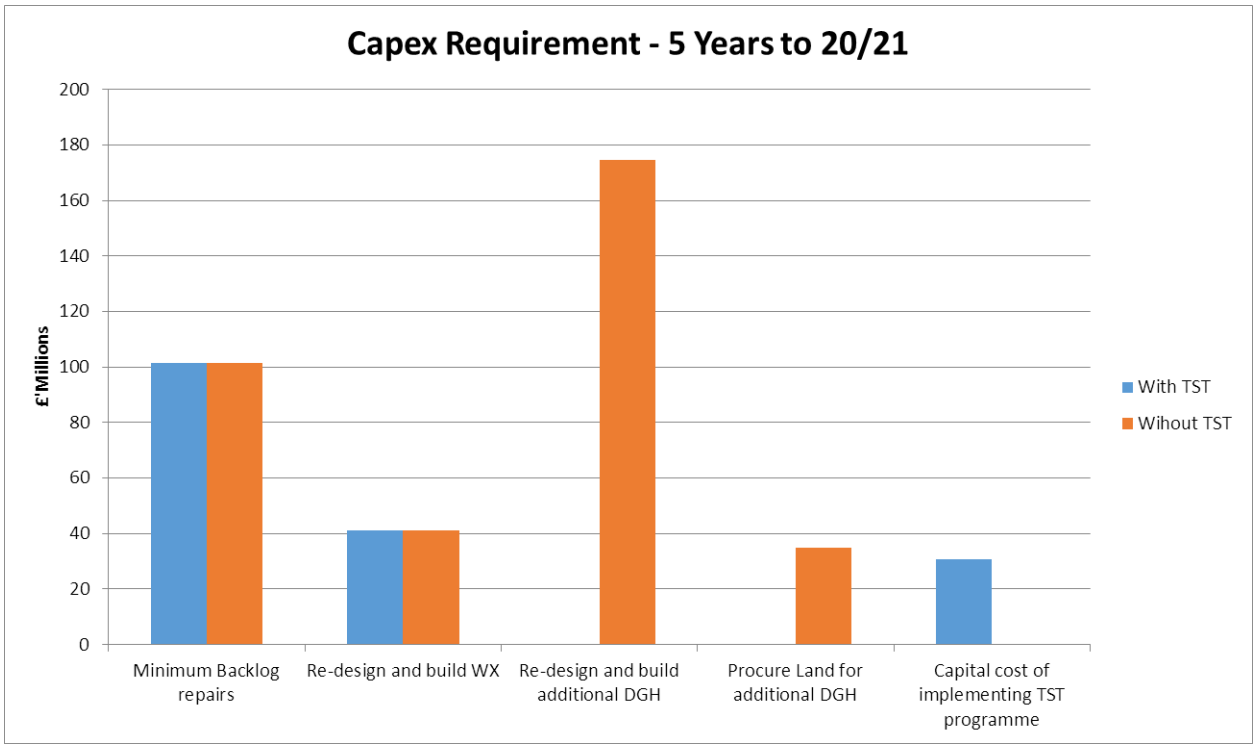

Figure 5: Total Capex over give years 'with' TST is £173m and 'without' TST is £352m

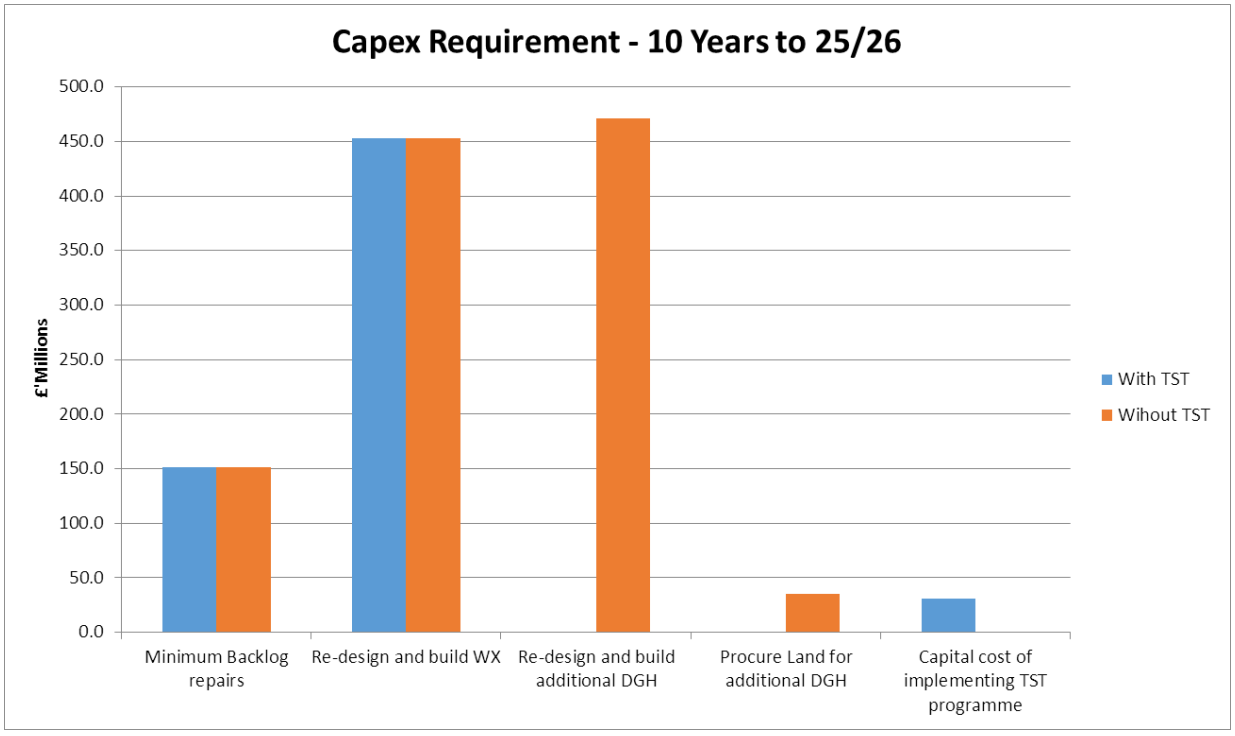

Figure 6: Total capex required by 2025/26 'with' TST is £636m, and 'without' TST is £1,111m

Sources of capital funding

Some smaller areas of the required funding (particularly parts of the TST driven programme) are planned to be sourced from nationally ring-fenced funding streams – most notably the Estates and Technology Transformation Fund. However it is worth noting that this fund is extremely oversubscribed and it is unlikely that WEL will receive a sufficient allocation to progress all of the TST programme requirements.

The principal source of funding for the redesign and rebuild of Whipps Cross Hospital or for an additional hospital should the TST programme not progress, is to follow the traditional process of full business case submission to NHS England.

The national availability of capital funding is extremely limited with much of the Department of Health capital allocation being redirected to support NHS revenue costs in each of the last two years. There are significant programme risks therefore around Barts Health NHS Trust being able to access sufficient capital funding to enable a re-development programme to progress. Any help to support the availability of capital from the submission of the full business case in 2018/19 would be welcomed.

2.6 Bed Base

The growth in demand in WEL is such that over the next five years approximately 440 additional inpatient beds would be required to provide the necessary healthcare activity delivered in its current form.

This is equivalent to an entire additional District General Hospital to be constructed; the cost of doing so (and staffing it) would be prohibitively large. It is anticipated that the application of the TST programme and local QIPP schemes will mitigate the need for many of these beds, allowing the extra capacity to be delivered organically at existing sites without the need for an additional hospital site to be developed.

The table below illustrates the schemes which are intending to affect the bed base requirement. Note that not all TST work streams are intended to reduce the bed base.

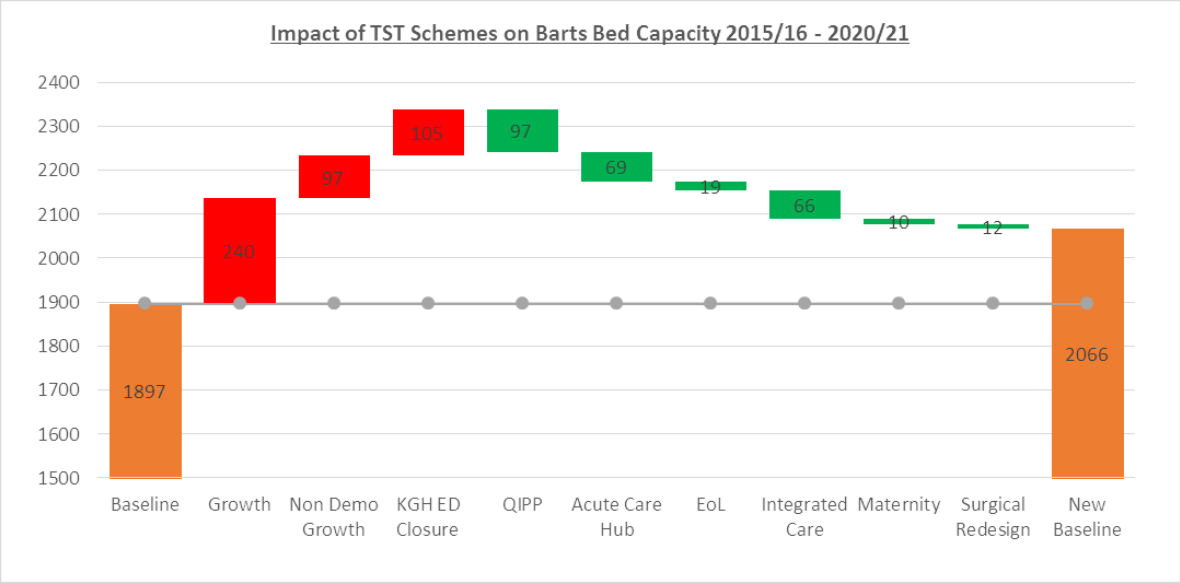

Figure 10 – Impact of TST schemes on Barts bed capacity
N.B. the second column 'Growth' means increased requirement due to demographic growth.

2.7 TST in action – progress

We recognise the efficiency targets are challenging as is managing the flow of people attending A&Es. However WEL CCGs have achieved the required efficiency savings in the last three years and are on track to deliver the 2015/16 target. New schemes in the TST programme (and others) will continue to ensure we achieve our targets. For instance:

Waltham Forest Integrated Care

Population based approach to systematic risk stratification involving community based intervention(s) for adults according to level of need e.g. planned case management; unplanned care rapid response and psychiatric liaison; GP national & local enhanced schemes; care coordination and self-management.

This has achieved an 18% reduction in unplanned hospital admissions in 2015/16 and £2million health savings which have been reinvested in other service.

Tower Hamlets urgent care

This scheme introduced streaming of people attending A&E and a tariff restructure to encourage urgent care centre (UCC) usage. This resulted in A&E attendances being reduced by c14, 000 and savings of c£3million.

East London Foundation Trust community rapid response

Aims to prevent avoidable emergency admissions and readmissions to hospital using short term intensive packages of clinical and social care and a presence in A&E/UCC. The Service works closely with all care homes in Newham through regular visits.

51% of referrals have prevented an admission to A&E.

Reducing unnecessary testing

Local discussions with clinicians (over 100 attended an event in October) agreed that c25% of pathology tests are unnecessary and 20% of primary care initiated MRI requests could be avoided (as per clinical guidance).

In the first two months, enabling and encouraging GPs not to request Gamma GT tests (which have no clinical value in the vast majority of cases) has saved around £54,000. The test is still available but guidance has been developed and circulated to GPs.

Anomalies in the budget spent on AST tests (£1000/year in Newham compared with £400,000 in Tower Hamlets) suggests that sharing good practice would result in significant savings.

These small changes suggest our target efficiency of £5 million a year is achievable.

2.8 Summary

In summary, the increasing demand driven by the existing population and increases in population and the need of that population, cannot be reasonably afforded if provided in the existing model of care and given the expected levels of resource allocation.

In order to continue with the current model of care and cope with this situation, demand would have to be curtailed requiring the rationing of key healthcare services or additional funding would have to be sought from central government. Neither of these options is reasonable or feasible and therefore efficiencies in the delivery of healthcare need to be found.

The acute providers will continue to look for internal cost improvement plans to improve their efficiency in delivering standard items of care, and thereby improve their financial viability.

Commissioners will look to more transformational measures to change the method by which some aspects of care are delivered to move towards more efficient methods.

The Transforming Services Together programme provides an opportunity to significantly improve care provided to our population and will provide a sizeable but not exhaustive proportion of the necessary transformational efficiency measures.

3. Modelling for the primary care workforce

Further published detail can be found in the strategic investment case:

- Part 2 (Main report) page 12: The workforce case for change
- Part 2 (Main report) pages 23-27: Describes the recruitment and retention approaches and discusses organisational development and plans for joint working
- Part 3 (High impact changes): Workforce and organisational development costs are described for each work stream. The physician associate chapter is particularly relevant.

3.1 Introduction

This paper includes:

1. The initial primary care workforce modelling to address the reduction in GPs that was included in the Strategic Investment Case. It also highlights the shifts in activity that underpin the model.
2. Provides an update on specific projects in pharmacy and physician associates and some of the work ongoing in operationalising the workforce model.
3. The initial data modelling that has been carried out by Healthy London Partnership in October 2016 (this is ongoing) and gives an outline of next steps in this process.

The current primary care workforce model was developed in June 2016 and addresses the issues highlighted in the Strategic Investment Case Part 3 (High Impact Changes Page 41). If we do not change our model of care:

- In Newham, Waltham Forest and Tower Hamlets we would require an additional 195 GPs (over current levels) within 10 years if we do not change the way we work and introduce new roles
- Whilst we have examples of good practice, around 40% of those responding to the GP National Patient Survey report they cannot see a GP of their choice and over 30% find it difficult to get through on the phone
- Up to half of practices in some areas are shut at lunchtime
- Patient experience of GP out-of-hours services is ranked one of the worst in England
- Less than a third of the capital's GPs believe they have received sufficient training to diagnose and manage dementia
- We don't have sufficient career development opportunities for GPs and nurses in training
- Some (particularly single-handed) practices are in premises unfit for modern practice
- We do not have sufficient multi-disciplinary teams
- Rising living costs are making living locally almost impossible
- Many outcome indicators (e.g. for cancer survival and support for people with long term conditions) are in the bottom 20% nationally.

Whilst this paper focuses on the model of care and activity in **GP surgeries** it should be noted that TST and other local schemes describe a range of other activities that are intended to support the GP surgery and wider primary care workforce including:

- the development of multi-disciplinary teams
- the development of proactive care which will identify people at risk and diagnose patients more quickly - reducing the burden of disease on both patients and the NHS
- support for helping people to lead healthier lifestyles, support to put patients in control of their own care and to self-care
- shared care records and interconnectivity between primary care and between primary and secondary care - reducing time spent in gaining health histories, reducing the need for repeat tests, enabling people to be treated more quickly and providing more opportunities to access the primary care system
- more opportunities for innovative ways of conducting appointments e.g. online, by telephone or by video - reducing the need for face-to-face services
- the development of federations of practices and hubs which will increase back office efficiency and be able to offer more services in one place
- cross-system recruitment and retention schemes into new and existing careers, to make east London a destination for a highly skilled workforce
- provision of key worker housing
- financial incentives for staff e.g. support with student loans
- flexible working options
- improving career development opportunities.

3.2 Activity shifts and workforce numbers in GP practices

In order to meet the demand within GP practices and the expected reduction in available GPs we will need to shift activity from GPs to other, more appropriate and more efficient roles.

PRIMARY CARE DEMAND							
	2014/15	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Baseline Activity (incl growth)	4,641,745	4,732,256	4,817,936	4,914,155	5,020,515	5,126,353	5,230,997
Shift to Pharm/Com	0.00%	2.96%	4.00%	5.00%	6.00%	8.00%	9.00%
Shift to Self Care	0.00%	1.85%	2.96%	4.07%	5.60%	6.70%	7.41%
TST Shift to 1ry Care	0	0	9,331	53,174	63,507	74,046	84,793
1ry Care Workforce		**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Activty % to GPs	80.0%	79.5%	74.0%	72.0%	64.8%	61.7%	59.4%
Activty % to nurses	20.0%	20.0%	24.0%	24.0%	26.0%	26.0%	26.0%
Activty % to PAs	0.0%	0.0%	0.0%	0.0%	3.2%	4.3%	5.6%
Activty % to Pharm	0.0%	0.5%	2.0%	4.0%	6.0%	8.0%	9.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL Activity		4,732,256	4,827,268	4,967,329	5,084,023	5,200,399	5,315,790

Table 1: Activity Shifts within (and from) GP practices. June 2016-2021

*Pharm/com is activity shifting to pharmacists in the community and other community-based staff.

The model describes a shift of activity to Physician Associates (PAs) and Pharmacy and Community Workers where (in 2021) GP activity is reduced by 20.1%. This reduction is made up by an increase in activity taken on by nursing of 6%, Physician Associates 5.6%, and Pharmacy of 9%.

The model integrates the activity described above with the number of staff required:

- using a baseline for activity within GP practices as 80% for GPs and 20% for Nurses (including administration and clinical duties).
- using efficiencies based on local statistics and tested locally with clinicians including a 26% reduction in 'Did Not Attend' (DNA) rates (which waste GPs time) over five years – to be tackled by quality improvement initiatives such as text reminders, more proactive care and better management of the issue
- building in an increase in the number of 'longer appointments'
- using data from focus groups that has shown that around 30% of the GP workload can be transferred to other health and social care professionals (e.g. treating coughs and colds)
- using national data that indicates that around 11% of a GP's time is spent on administrative tasks such as filling in data returns.

The data shows that an additional 81 clinical staff and 23 administrative staff would need to be in place in GP surgeries to meet the activity shifts set out in Table 1. We are already building the supply for physician associates and pharmacists to meet this challenge.

Staff Required - Post TST productivity/efficiency savings							
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**Change from 2015-16**
GP	601	559	532	477	454	445	-156
Nurse	158	206	211	214	207	220	+62
PA	0	0	0	24	33	44	+44
Pharmacist	4	16	33	49	65	73	+69
Locum	0	0	0	0	0	0	0
Admin	133	134	135	137	137	138	+5
Community	25	35	45	55	75	87	+62
Senior Admin	0	4	7	11	14	18	+18
TOTAL	921	954	964	967	986	1025	+104

Table 2: GP Surgery Workforce Modelling June 2016-2021 based on activity shifts in Table 1 and efficiency savings

*Due to different data extractions, 'Community' currently includes healthcare navigators, medical assistants, physician associates etc but in later years physician associates have their own line.

3.3 Healthy London Partnership (HLP) Modelling

We have been working with Healthy London Partnership (HLP) across Waltham Forest, Newham and Tower Hamlets and had two initial workshops in October 2016 to build on the existing workforce modelling.

This process builds on national data and, working with local clinicians, we will model current efficiencies and those being proposed; and then look at how these ways of working can be used to introduce new roles or reassign roles to reduce workforce gaps. Initial efficiencies include the use of telephone appointments and benefits in practices that have multi-disciplinary professionals.

The initial modelling from HLP with a 'do nothing' plan shows a consistent picture with the TST modelling. By 2021 if we do nothing we will have a shortage of 122 GPs. Assumptions made are that 15% of GPs over 55 will retire by 2021, (29% of GPs are aged 55 and over), a population increase in WEL of 76,000 to 2021 (8%) and that we recruit available GPs in line with current London levels.

Analysis shows a gap in the nursing workforce required if we do nothing and this gap is likely to increase as in Waltham Forest 52% of the workforce is over 55 and in Newham 43% of the workforce is over 55.

HLP has highlighted significant differences in baseline numbers of staff across the TST footprint. Tower Hamlets has a lower than the national average of patients per GP and nurse, but Waltham Forest and Newham have higher numbers of patients per GP and nurse.

3.4 Training posts and careers

Work is ongoing to map and review training posts and pilot posts to see where training takes place. The data suggests that to deliver a sustainable model we will need to encourage mid-size and smaller practices to provide training as well as large practices to build sufficient capacity and a system to train the workforce of the future.

We are working with colleges to encourage careers in health and build pathways into new roles. We are developing a careers and jobs portal to signpost job seekers to posts and career pathways available in the CCGs.

3.5 TST in action – progress

Physician associate at Allum Medical Centre

Allum Medical Centre in Waltham Forest has used a physician associate as part of a range of innovative changes to the way practice staff are working. By sharing the workload the practice can see more patients. The physician associate sees more than 100 patients a week so the patient list size has increased by more than 1,000 without the need to employ more GPs. The practice offers up to 120 same-day appointments each day.

Physician associates programme

The business case was developed in January 2016 to move this project forward and a steering group and a clinical lead appointed. A new curriculum for a physician associate (PA) role in primary care has been developed (other PA roles have been successfully based in secondary care).

- Recruitment is taking place in November 2016 with students starting the two year course in January 2017.
- The CCGs have agreed a matched funded sponsorship arrangement for the first cohort of 24 students for second year fees on successful completion of year 1.
- An engagement event with GPs across TST in September 2016 to discuss the placement and training requirement for physician associates resulted in all 24 placements being filled with an even split across the three boroughs.
- In conjunction with GP practices we are developing posts for successful candidates.

In addition we are looking at developing alternative methods of training to give future cohorts different options to undertake training. Twenty GPs in the TST footprint have signed up as prospective employers to start development of a higher level apprentice standard for physician associates. We will explore different funding streams from Health Education England and providers as this system develops from April 2017 which could allow us to have a flexible employment and training model to sustain the role, and multi- disciplinary teams in primary care across TST.

Pharmacists in GP practices

We have a three year pilot funded by Health Education England (HEE) of 13 pharmacists in Newham GP practices. Further funding has been made available from the GP Five Year Forward View to increase numbers for April 2017. Feedback from practices in the pilot is that this role allows GPs to increase clinical time.

We have two events in November to promote new ways of working and for community pharmacists to shape working practices and roles in GP practices and primary care.

We will be introducing a rotation scheme for pre-registration pharmacists into primary care and GP practices, and an agreed discharge pilot scheme for pharmacy to support patients with respiratory, diabetes and cardiovascular problems. Both schemes are scheduled to start in April 2017 and will see pharmacists working with patients from secondary to primary care.

Practice nurses and support within GP surgeries

We have 26 GP practice nurses in training posts in Newham, Tower Hamlets and Waltham Forest. The Community Education Provider Networks (CEPN) are co-ordinating work to retain nursing staff in the area from this cohort. Recruitment for the January 2017 intake is ongoing through the CEPNs for similar numbers of nursing staff.

There are two other initiatives to build the nursing multi-disciplinary workforce:

- A nursing pilot for rotational nursing posts between acute and primary care will be recruited to – for commencement in January 2017.
- North East London Foundation Trust (NELFT) has just been selected as a pilot site for new nursing associate roles. These posts will start in early 2017 and be based in secondary care (at NELFT), with placements in primary care to be developed.

3.6 Summary

In order to meet the shortfall of supply of GPs in NEL, (high retirement rates and a shortage of available new GPs) and to develop a more efficient, patient-centred service, we will need to develop and increase the numbers of practice nurses, physician associates and pharmacists to provide a full multi-disciplinary team (MDT) workforce model. We are currently on target to deliver physician associate training placements in 2017 and a workforce supply in 2019. We have a pharmacist pilot programme in Newham GP practices and will look to expand this across TST in 2017-18.

This, combined with ensuring that we continue to develop and deliver portfolio careers and flexible employment options for GPs, will allow us to develop our multidisciplinary teams in GP practices.