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| **Project 4 Brief**  **Development of Extended Portfolio GP Role in Urgent and Acute Care (rotational post)** |

**OVERVIEW**

The direction of travel for the GPs of tomorrow is for a more varied portfolio career.  This project seeks to develop a new salaried Extended Portfolio GP role working across the Integrated Urgent Care Service (IUCS) and secondary care.  This project will produce an evidence-based business case, job description and an example rotational plan(s) for local implementation.

1. **Aims/Objectives**

* To develop a role that increases the workforce resilience of Integrated Urgent Care Services
* To develop a role in which the GP can interface between urgent and acute healthcare services across health settings for the benefit of patients and the health system
* To enhance the function of the GP within urgent and acute secondary care teams such as ED, Frailty and Paediatrics
* To raise GP interest in urgent care and emergency medicine career paths
* To design an attractive job role that will support urgent and emergency care system-wide recruitment and retention

1. **Work packages (approach)**
2. Data analysis
   1. Gather, analyse and validate local, regional and national evidence of rotational posts (across healthcare settings)
   2. IUCS demand profile/onward referrals to inform role rotations
   3. Financial analysis to establish impact of salaried roles on existing business model
   4. Gather, analyse GP input re: need/desire for portfolio roles (existing BMA, RCGP survey data)
   5. Soft test interest in role locally
3. Feasibility / business case
   1. Develop high level feasibility paper / business case
4. Design (with stakeholders)
   1. Develop role/job outline, rotation options, level/grade of role
   2. Employment options (prime/honorary contracts; indemnity; salary)
   3. Funding arrangement for new role
   4. Agree induction, training, supervision, mentoring approach
5. Implementation preparation
   1. Develop recruitment strategy for new role (including advert, channels)
6. Implementation (out of scope for this phase)
7. Evaluation preparation
   1. Develop evaluation framework / approach to assess the extent to which the new role is achieving the aims and objectives of the pilot
8. **Products / deliverables**

* Summary of data/evidence gathered and analysed
* Feasibility paper / business case
* Job description, person specification, competencies
* Employment options paper including contracting approach, indemnity, salary and on costs/funding (with benefits/risks identified)
* Rotational job plan(s)
* Summary of induction, training, supervision, mentoring approach
* Outline recruitment strategy
* Evaluation framework / approach
* Project Management documentation
  + Project Brief (this document)
  + Project Plan
  + Stakeholder Analysis
  + Communication Plan
  + Risk Log
  + Highlight Reports

1. **Scope and exclusions**

4.1 **In Scope**

* Data analysis sufficient to demonstrate need and potential benefit
* Development of a role spanning the IUCS and urgent/acute secondary care teams (can include elements of routine care as required by the role)
* Development of all associated HR documentation to support recruitment to the role

4.2 **Outside Scope**

* Recruitment to the new role
* Evaluation of the impact/benefits of the new role

1. **Assumptions**

* LWABs/STPs/CCGs/Acute Trusts have sufficient capacity and want to engage with the SW Pan-STP UEC Workforce Programme and provide support (when needed) to the project
* HEE South West are sufficiently committed to the pilot to provide expert input (when needed)
* Local implementation of deliverables by LWABs/STPs/CCGs/SWAST etc., including adaptation of business cases to fit local need

1. **Dependencies**

* Dedicated project management resource
* Input from clinicians and SMEs (HR, Finance, Medical Staffing)
* Acute Trust capacity to engage and collaborate on design of new role and contracting/HR arrangements
* Members of the Programme Board to:
  + Advise and support project leads throughout the project duration;
  + Disseminate key messages to their LWABs and other identified stakeholders;
  + Advice and support to overcome obstacles
* HEE to provide senior project leadership and clear direction

1. **Strategic drivers**

The evolution of General Practice is an essential component to meeting the aspirations of the NHS *Five Year Forward View* - to centre care holistically on the needs of patients and populations and blur the boundaries between primary and secondary care; health and social care; physical and mental health.

It is accepted that our population continues to grow and continues to get older with those living longer often living with multiple long-term conditions and more complex needs. This increase in complexity means the way we think about the provision of healthcare is changing and so too is the way we think about the workforce needed to deliver such change.

The RCGP acknowledges that GPs will be vital to the ‘interface of care’ when their role as integrator will mean they can work across health care settings using their expert generalist skills to quickly assess patients’ needs to help manage the pressures on emergency admissions.

Working at the ‘interface of care’ naturally means new roles are needed that will enhance the function of the GP working alongside urgent and emergency colleagues in different care settings to improve patient experience and outcomes.

Securing a sustainable workforce for Integrated Urgent Care Services is becoming harder as the pressures on the health system increase and as individuals seek a better balance between work and life. Careful design of new urgent care roles that combine the challenge of working across health care settings with the opportunity to experience a varied rotational week with support from colleagues may encourage more clinicians to work locally after completion of training and may encourage others to return to the service.

1. **Benefits**

* Improved communication and understanding between clinical teams and across health care settings
* Transfer of knowledge (both clinical and of alternate services) between different health care settings
* Increased skills mix within the secondary care team
* Potential to positively impact key performance indicators such as A&E waiting times, length of stay
* Improvement in patient experience and outcomes
* Continuity of workforce within the integrated urgent care service
* Increased job satisfaction for clinicians and potential to reduce burn-out
* Improved workforce retention within the integrated urgent care service

1. **Risks**

* Winter/system pressures mean that project work is secondary to frontline delivery and negatively impacts project timescales
* Key stakeholders are not able to engage sufficiently to provide input to the design process
* Contracting and indemnity options are too costly to fit with existing business model
* Deliverables / outputs from project are not transferable to other areas
* Deliverables / outputs from project are not used by LWABs/CCGs/STPs
* Future national guidance in some way conflicts with this work

1. **Timescales for delivery**
2. Data analysis – Jan / Feb 18
3. Feasibility / business case – Feb / March / April 18
4. Design – Feb – May 18
5. Implementation Preparation – May / June 18
6. Evaluation – May / June 18
7. Key steps webinar – June 18
8. **Reporting**

Monthly Programme Board (via Webex) consisting of SCW Programme Leads (Joint Chairs), representatives from at least 3 of the 6 LWABs (including those leading any local LWAB-level projects) and representation from HEE SW.

The Programme Board will report into HEE and also the six LWABs via the representatives on the Board itself.

The Programme and each project will produce highlight reports on a monthly basis to the Programme Board, which can be shared more widely as desired.